STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675821	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madisonville Care Center	411 E Collard Madisonville, TX 77864

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 0550 Level of Harm - Actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 4 residents (R#1). 1. The facility failed to ensure R#1's preferences for showers were adhered to as he was receiving a bed bath, which made him feel dirty, down, depressed, and like a prisoner. 2. The facility failed to ensure R#1 was assessed timely for safety awareness in his electric wheelchair after his last reassessment on 12/27/25. These failures could place residents at risk of psychosocial harm. Findings include:R#1Review of R#1's admission Record, dated 03/03/26, showed he was admitted to the facility on [DATE] and was his own RP. R#1 also had diagnoses that included cerebral infarction (stroke), morbid (severe) obesity due to excess calories, other impulse disorders, depression, mood disorders, hemiplegia (total paralysis) and hemiparesis (weakness), generalized muscle weakness, and need for assistance with personal care. Review of R#1's Annual MDS, dated [DATE] , showed he had a 11/15 BIMS, which indicated he had moderate cognitive impairment. R#1 also did not exhibit any behavioral symptoms, used a manual wheelchair to turn and wheel, and was dependent on two or more staff to shower and transfer him. Review of R#1's Care Plan showed staff initiated a note on 11/26/24 that reflected R#1 required two staff for bathing assistance. There were no notes initiated or revised that reflected R#1 choice of wanting showers instead of bed baths. Staff also initiated a note on 12/03/24 that reflected R#1 required two staff participation with transfers using the mechanical lift. Staff also initiated a note on 09/14/25 that reflected R#1 was operating a motorized wheelchair that potentially poses a risk of injury to himself and others due to decreased awareness of surroundings/speed control and interventions that included therapy was required to perform a safety test on R#1 for operating his motorized chair, review and reinforce facility safety policies for use of motorized devices, reassess need for continued independent use of motorized wheelchair if unsafe behaviors persist and provide education/reinforcement on safe driving practices: speed control, awareness of pedestrians and stopping when others are nearby. This note was revised on 10/19/25 and reflected R#1 was operating a motorized wheelchair that potentially poses a risk of injury to himself and others due to decreased/impaired vision. This note was revised on 01/20/26 and reflected R#1's wheelchair was unplugged from the battery, he was dependent on staff for locomotion in the facility, and he was upset he was no longer able to use his electric wheelchair. This note was revised on 01/27/26 and reflected R#1 was now in a Geri-Chair due to comfort and safety measures. Review of R#1's BIMS Assessment, dated 02/23/26, showed he had a 15/15 BIMS, which indicated he was cognitively intact. Review of R#1's PHQ-9 Assessment (Depression Severity Assessment), dated 02/23/26, showed he exhibited depression symptoms and reported feeling bad about himself nearly every day (12-14 days). Review of R#1's Electric Wheelchair Safety Assessments showed he could return demonstration of understanding wheelchair operation safety precautions, effectively control speed, safely maneuver chain in and out of obstacles and around corners, stop the chair on command, aware of surroundings that may intercept wheelchair, stop at intersections before proceeding, been informed (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 0550 Level of Harm - Actual harm Residents Affected - Some	of privilege to operate his electric chair/cart can be revoked if he demonstrated unsafe operation or disregard to staff and resident safety and maintenance performed a safety check of the wheelchair on 09/13/25. R#1 was unable to stop at hallway intersections and benefitted from safety training on 09/15/25. R#1 could not return demonstration of understanding wheelchair operation safety precautions, effectively control speed, could not safely maneuver chain in and out of obstacles and around corners, stop the chair on command, was not aware of surroundings that may intercept wheelchair, does not check for clearance before backing wheelchair up or turning the wheelchair around, stop at intersections before proceeding, been informed of privilege to operate his electric chair/cart can be revoked if he demonstrated unsafe operation or disregard to staff and resident safety and maintenance performed a safety check of the wheelchair, eyesight diminished, discussed with family that he is not safe to operate electric wheelchair, will provide alternative mobility options and discuss with wheelchair company on obtaining a specialized manual wheelchair to accommodate his size and positioning needs on 10/07/25. R#1 was lacking in the areas indicated due to medical/physical restrictions and would be referred to evaluation and treatment if appropriate and the maintenance supervisor did not perform a safety check of the wheelchair on 12/27/25. There were no subsequent evaluations. Review of R#1's Weekly Nursing Summaries showed he did not exhibit any wandering, verbal, physical, or other behavioral symptoms on 01/03/26, 01/10/26, 01/17/26, 01/24/26, 02/01/26, 02/08/26, 02/15/26, 02/22/26 and 03/01/26. Review of R#1's care plan conferences showed his most recent one was his quarterly on 12/18/25. Review of R#1's POC, from 02/03/26 through 03/03/26, showed 1-2 staff gave him bed baths. No staff documented giving showers to R#1. Staff documented they did not observe R#1 have any types of behaviors from 02/02/26 through 03/03/26. Review of R#1's Psychological Services Progress Notes showed he reported his mood was down, appeared irritated during the discussion, required redirection due to frustration regarding current circumstances. R#1 refused the services on 2/6/26 and was ill on 1/30/26. R#1 reported his mood was alright, felt he slept too much, and discussed thought about potentially moving to live with family member and exploring home health options on 01/16/26. Review of R#1's Diabetic Exam on 01/28/26 showed he had blurred vision, did not have glasses and contacts. Review of R#1's Progress Notes showed: -The SW created a note on 01/28/26 at 1:41 p.m. that said, I also discussed with R#1 the opportunity of him transferring to one of our sister facilities in another city. At these facilities there are longer hallways for him to maneuver his chair. R#1 stated he is not interested in moving outside the current city. -LVN A created a note on 02/05/26 at 8:36 a.m. that said, During morning med pass, this nurse asked resident if he would like to get up into the Geri chair today to try it out and he agreed. When the CNA arrived to get him up, he stated, ?fuck that chair, i aren't getting up.' DON notified.-LVN B created a note on 02/07/26 at 1:35 p.m. that said, Resident asked if staff could assist him into chair and out of bed today. Resident refused. This nurse encouraged resident but resident continued to refused. Resident stated, ?Not today, I will get up on Monday.'-RN C created a note on 02/09/26 at 1:58 a.m. that said, Resident has not been up to chair in over a month at this time. He stated, ?I will get up tomorrow,' Informed him I will let the dayshift Nurse know. -LVN D created a note on 02/09/26 at 3:51 p.m. that said, resident has refused to get out of bed multiple times today when staff offered, resident stated, ?I'll get up in the morning.'During an observation and interview of R#1 on 03/03/26 at 11:32 a.m., R#1 was lying in his Geri-Chair in the living room area. He appeared clean, dressed and comfortable. During an interview of R#1 on 03/03/26 at 12:04 p.m., he said he had not received a shower in over a month. He said he often notified staff of his shower over bed bath choices and they still did not ask or shower him. He said he felt like a prisoner, dirty, down, and depressed. He said he often notified his family that staff would not shower him. R#1 said staff took and stored his electric wheelchair away approximately a month and a half ago because they told him that he was running over other residents. He said therapy told him approximately a month ago that they would reevaluate him for safety awareness and never did. He said his Geri chair that he sat in during the interview was not his usual wheelchair. He said he had (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Some	to beg staff to move him from room to room, they still would not whenever he requested to be moved, and he could not independently move himself in the Geri chair. He said he been to jail twice, felt like he was still being treated like a prisoner, was upset, felt restrained because he could not independently go anywhere and had to ask staff to move him, staff would not move him, and depressed. During an interview with R#1's FAM on 03/03/26 at 12:28 p.m., they said R#1 often called and told them that staff did not shower him in over two weeks and they did not understand why he was not being showered. They said R#1 was a paraplegic, needed help with showering himself, and was supposed to receive two showers every week. They said R#1 told them that he felt like a dog, racially discriminated against because he observed other residents receive showers, down and depressed. They also said, It's not right. He wants to be showered. Everyone deserves to feel clean. FAM said the ADM, DON and ADON took away R#1's electric wheelchair approximately a month ago and told them because his eyes were bad. They said R#1 was receiving vision treatment. They said R#1 told them that he did not like the regular Geri chair because he was a large man, he expressed he was angry and upset and cursed profanities whenever he called them because he felt like staff were messing and picking on him, R#1 was in his right mind, and they felt R#1 was being racially discriminated against because staff did not mention anything to them about reevaluating R#1 for safety awareness. They also said, The Geri chair is a restraint. They are restraining him from going anywhere without them having to push him because he can't push that chair on his own and they don't push him when he asks. He has a right to independently go where he wants. During an interview with the DOR on 03/03/26 at 1:38 p.m., she said she did not observe or interact with R#1. She said OT and PT evaluated residents for electric wheelchair safety awareness and anyone could request for the evaluation. She also said she did not know how often residents were evaluated for electric wheelchair safety awareness and started her employment with the facility last month. She said she knew the importance of reevaluating residents for electric wheelchair safety awareness and said, Because there is a big safety component. Residents could become aware and not aware. Residents want to be independent. Resident could have risk of decline in function, depression, and being able to go out and be independent. She said she oversaw and ensured OT and PT evaluated residents for electric wheelchair safety awareness. She did not receive any inquiries from R#1 or other staff about him wanting to reevaluate for electric wheelchair use. She said she must set up the evaluation for safety awareness and documented evaluations in residents' EHR.During an interview with the MDS Nurse on 03/03/26 at 2:03 p.m., she said CNAs and nurses showered residents at the facility according to their choices and schedule. She said staff try to offer residents the option of bed baths or showers and accommodated based on their preference. She said R#1 did not express and staff did not notify her that R#1 was wanting showers over bed baths. She said she knew it was important to respect residents' rights and said, Because it's their right, especially if they were able to tell us what they want. She said R#1 was unable to transfer himself, get in a car and go out on pass and currently used a Geri chair, which staff pushed to move him from room to room. She said therapy evaluated electric wheelchair safety awareness and she used that assessment to determine if the electric wheelchair was unsafe for residents to use. She was unsure how often residents could be reevaluated for safety awareness. She said she knew it was important to respect residents' rights to not be restrained and said, Makes them feel like they are still a person and they have the right. We are not a prison. They are allowed to go in and out as they please. Family is more than welcome to take them out. Residents could be at risk of feeling sad, depressed and not respected. She said R#1 never expressed wanting his electric wheelchair over the Geri chair to her. She said R#1 started to exhibit lack of safety awareness in November and December 2025 and started to show signs of vision impairment. She did not know if R#1 had been reevaluated since last year and the time frame for reevaluating. She said she knew it was important to assess residents and ensure safety awareness and said, For their safety and want to ensure they and other residents are safe. Residents could be at risk of feeling like they were not being respected as an individual. During an interview with the SW on 03/03/26 at 2:52 (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Some	p.m., she said the CNAs and nurses showered residents at the facility according to their choices and schedule. She said staff offer residents the choice of bed baths or showers and accommodated based on their choice. She said R#1 and his FAM did not report any concerns to her about not receiving any showers. She said R#1 had the capacity to consent and make informed decisions. She said R#1 expressed concern of not being able to use his electric wheelchair. She said R#1's electric wheelchair was taken away from him approximately some months back due to it being unsafe and his vision worsening. She said she did not know how often residents could be reevaluated for electric wheelchair safety awareness and therapy or nursing staff evaluated residents. She said she did not know why R#1 was not reevaluated after December 2025. She said R#1 should be able to independently go out on pass and did not know that he was denied to go out on pass. She said R#1 was referred to counseling and psychological services for depression and she was not aware he was depressed. She said she knew it was important to respect residents' right to go out on pass and said, It's important to respect all residents' rights, especially if it's within their rights. Residents could be upset if they were unable to go out on pass independently.During an interview with the ADON on 03/03/26 at 3:17 p.m., she said CNAs showered residents according to their choices and shower schedule. She said R#1 did not express to her that he wanted showers over bed baths. She also said R#1 did not want to get up and out of bed. She said R#1 could not see and ran into things last year, went to the optometrist, learned he had poor vision, she told staff to turn off his electric wheelchair and push him and she did not know if he was reevaluated for safety awareness after December 2025. She said R#1 had poor vision even with eye injections he received in mid-December 2025. She said she did not know how often residents were reevaluated for safety awareness, knew R#1 did not want to get out of bed because he did not have his electric wheelchair, and she did not know R#1 was exhibiting signs and symptoms of depression and was not notified. She said she knew it was important to respect residents' right and said, It promotes independence and helps with mood. If you prevent them from going out on pass, that's like imprisonment. During an interview with the DON on 03/03/26 at 3:46 p.m., she said she expected CNAs to shower residents according to their shower schedule and preferences. She said R#1 did not express to her wanting showers over bed baths. She said R#1 could not transfer, could no roll his wheelchair, was responsible for himself, voiced his needs, could not be reevaluated for electric wheelchair safety awareness until his eyesight improved, and she did not know when R#1's optometrist, who visited him bimonthly, communicated about his vision status. She said R#1 was seen by two different specialists regarding his vision and received eye injections to help with his vision. She said she knew it was important to respect residents rights and said, Because you don't want them to feel like they are in prison. Residents could become upset or frustrated. You don't want them to have any emotional distress. During an interview with the MD on 03/03/26 at 4:11 p.m., he said R#1 had the capacity to make informed decisions for himself. He said he had not discussed electric wheelchair safety awareness issues regarding R#1 and did not know why a reevaluation was not conducted. He said he believed a reevaluation was not completed due to the DOR being new and likely caused a lapse in reevaluation.During an interview with the ADM on 03/03/26 at 6:22 p.m., he said staff were required to adhere to residents' rights. He said he knew it was important to respect residents' choices and said, If we don't, then other staff cant access it and provide accurate care. Must provide accurate care possible. He said he heard in the past that R#1 preferred not to get in the shower and most of the time got a bed bath. He said he could not recall discussing R#1's shower choices with the IDT team. He said he could not remember if there was an incident that resulted in R#1 not being able to use his electric wheelchair, R#1's ADL status must change for him to be able to be reevaluated for safety awareness, R#1's vision must improve, December 2025 was his last evaluation because he failed it, he was unable to allow R#1 to use his electric wheelchair because he failed the assessment, and staff were expected to reevaluate quarterly and if there was a significant change. He said staff were expected to accommodate if a resident expressed wanting to use their electric wheelchair again. Review of the facility's Resident (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Some	Rights policy, undated, reflected, A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.5. The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.7b. The resident's wishes and preferences must be considered in the exercise of rights by the representative.Respect and dignity - The resident has a right to be treated with respect and dignity, including:1. The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.Self-determination -The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice.1. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or herinterests, assessments, plan of care and other applicable provisions of this part.2. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.Review of the facility's Electric or Motorized Wheelchair policy, undated, reflected, It is our policy to ensure, to the best of our ability, the safety of residents who own and use an electric wheelchair, as well as the safety of all other resident's, staff and visitors in the facility. Therefore, resident's owning/using an electric wheelchair will be assessed on admission, quarterly, and upon a significant change of condition for their ability to drive/guide the wheelchair.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to allow residents to make choices about aspects of his or her life in the facility that are significant to the resident for 1 of 4 (R#2) residents. The facility failed to revise R#2's care plan to reflect redirecting her whenever she was near or entering a male resident's room. These failures could place residents at risk of not receiving care and services according to their preferences. Findings include:Review of R#2's admission Record, dated 03/03/26, showed she was admitted to the facility on [DATE], she was her own RP and had two other RPs. R#2 also had diagnoses that included cerebral infarction, weakness, cognitive communication deficit, need for assistance with personal care, lack of coordination, dementia, generalized muscle weakness, difficulty walking, unsteadiness on feet, lack of coordination, and major depressive disorder. Review of R#2's Quarterly MDS, dated [DATE], showed she had a 4/15 BIMS, which indicated she was severely cognitively impaired. R#2 did not exhibit any wandering, inattention, disorganized thinking, altered level of consciousness, physical, verbal or other behaviors. Review of R#2's Care Plan, showed staff initiated a note on 11/25/24 that she had a communication problem, had impaired cognitive function/dementia or impaired thought processes, at risk for wandering, and staff were required to communicate with her/FAM/caregivers regarding her needs and capabilities. There were no notes initiated or revised that reflected redirecting her from male residents' rooms. Review of R#2's Psychosocial Evaluation, dated 01/16/26, showed her cognition was functionally intact, she was fully oriented, memory was intact, her judgement was adequate, and her thought process was circumstantial/confusing. Review of R#2's Psychological Progress Note, dated 01/23/26, reflected, [R#2] was seen this week in her room at the facility. She was awake, alert, and oriented times three. Grooming, hygiene, and eyecontact were within normal limits. Speech was clear, with tone and volume within normal limits. Thought processes were logical andcoherent. Reported mood was ?good,' and affect was congruent with stated mood. No acute concerns were noted regarding memory or cognition during the session. During an interview with R#2 on 03/03/26 at 12:05 p.m., she said the staff would not allow her and R#1 to be alone in each other's rooms. She said staff also told her that she was not allowed to enter and be alone in R#1's room, R#1 would get her pregnant if she did, and because her FAM had an issue with her being alone in R#1's room. She said she was alert, oriented, knew who to consent and refuse, and her and her FAM did not have any issues or concerns with her and R#1 being alone and having privacy time together. She said she felt rotten and down because staff did not allow her and R#1 to have privacy time alone together and she felt update because she had no privacy from staff at all. During an interview with the MDS Nurse on 03/03/26 at 2:03 p.m., she said R#2's FAM expressed on an unknown date that they did not want R#1 alone in the room with R#2 because she fluctuated cognitively throughout the day. She said she was not present when the conversation with R#2's FAM took place and was informed by the SW and DON on unknown date. She said she revised the care plans after the IDT team, which comprised of nursing, therapy, dietary, and social services department heads, met, discussed and decided on revisions to residents' plan of care. She did not revise R#2's care plan to reflect her FAM not wanting R#1 alone in the room with R#2. She said she knew it was important to revise residents' care plans to reflect their choices and said, Because it's their right, especially if they were able to tell us what they want. During an interview with the SW on 03/03/26 at 2:52 p.m., she said the DON told her that R#2's FAM expressed on unknown date that they did not want R#1 alone in the room with R#2 because she did not have the capacity to consent and make informed decisions for herself. She said R#2's FAM was listed as her RP, she did not know if R#2 had an MPOA, and she did not know who made informed decisions on R#2's behalf. She said the MDS Nurse revised care plans after the IDT team met, discussed and decided on changes to residents' care and services and said, All staff were responsible for ensuring (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' rights were accommodated.During an interview with the ADON on 03/03/26 at 3:17 p.m., she said the DON told her sometime in 2025 that R#2's FAM did not want R#2 in R#1's room alone because they did not want her in the room alone with R#1 and they did not want R#2 going into any male residents' rooms. She said the MDS Nurse revised care plans after the IDT team met and discussed changes. During an interview with the DON on 03/03/26 at 3:46 p.m., she said R#2 voiced she wanted to go into R#1's room on unknown date and her FAM was contacted and wanted staff to redirect her whenever she entered male residents' rooms. The surveyor attempted to call R#2's FAM twice on 03/03/26 and left a voicemail and call back number. R#2's FAM did not return the surveyor's calls before exit. During a follow-up interview with the DON on 03/03/26 at 5:27 p.m., she said her and the MDS nurse revised residents' care plans. She said she did not know R#2's care plans was not revised to reflect preferences and choices. She said she knew it was important to revise residents' care plans to reflect their choices and said, Because it's reflection of care and everyone knows how to provide adequate care for them. Residents could be at risk of staff not adhering to their or their family's wishes.During an interview with the ADM on 03/03/26 at 6:22 p.m., he said the IDT team met before revising residents' care plans. He said the MDS nurse revised residents' care plans. He said he knew it was important to revise residents' care plans to reflect their choices and said, If we don't, then other staff cant access it and provide accurate care. Must provide accurate care possible. He said he expected whoever spoke with R#2's FAM should have revised her care plan and implemented interventions. He said this was the first time he heard that R#2's interventions were not implemented in her care plan. Review of the facility's Comprehensive Care Planning policy, undated, reflected, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals.Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility.Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.