

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675835	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Cherokee Trails Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 330 E Bagley Rd Rusk, TX 75785	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident was treated with respect and dignity for 2 of 7 residents (Residents #1 and #2) reviewed for Resident Rights. The facility failed to ensure 09/10/2025, at 7:15 p.m., Resident #1 and Resident #2 were treated with dignity and respect when CNA A spoke rudely about taking them outside. This failure could place residents who smoke at risk of emotional distress and diminished quality of life. Findings included: 1. Record review of an admission Record dated 2/11/26 for Resident #1 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Hepatic Encephalopathy (brain dysfunction caused by liver failure), Acute Respiratory Failure (lungs cannot adequately exchange gases), and morbid obesity. Record review of a quarterly MDS dated [DATE] indicated Resident #1 had intact cognition with a BIMS of 14. She required setup/cleanup assistance with eating, oral hygiene, and personal hygiene; she required supervision with upper body dressing; she required moderate assistance with toileting hygiene and shower/bath; she required maximal assistance with lower body dressing and putting on/taking off footwear. Record review of a comprehensive care plan dated 6/13/24 indicated Resident #1 was a smoker and was at risk for injury. Interventions were in place including assist resident to and from smoking area as needed. 2. Record review of an admission Record dated 2/11/26 for Resident #2 indicated he was a [AGE] year-old male readmitted to the facility on [DATE] with diagnoses of Cellulitis of Left Lower Limb (infection in leg), Severe Sepsis with Septic Shock (infection in the blood that causes low blood pressure), and non-pressure chronic ulcers. Record review of a quarterly MDS dated [DATE] indicated Resident #2 had moderately impaired cognition with a BIMS of 12. He was independent in all ADL's. Record review of a comprehensive care plan revised on 3/18/25 indicated Resident #2 smoked and required supervision smoking due to noncompliance with facility policy. Interventions were in place to observe resident during smoking for unsafe smoking practices and report to nurse. During an interview on 2/10/26 at 1:35 p.m., Resident #1 said on the day of the incident CNA A took residents outside for smoke break. Resident #1 said CNA A told Resident #2 something to the effect of you're always hassling me about smoking and then turned toward her and said, and you do me the same damn way. Resident #1 said the comment upset her and she felt talked down to. Resident #1 said she reported the incident to the ADM the next day. During an interview on 2/10/26 at 3:15 p.m., Resident #2 said during a smoking break, CNA A made an inappropriate comment to him about taking residents outside to smoke. Resident #2 said he could not remember what CNA A said, but it made him feel it was a burden to take residents outside to smoke. During a group interview on 2/10/26 at 4:00 p.m., 3 of 7 residents who smoke reported hearing staff say it was a hassle taking them outside to smoke but were unable to recall dates, times, or names of staff and reported no distress from the incident(s). All residents said they got their scheduled smoking breaks on time. During an interview on 2/11/26 at 2:00 p.m., CNA A said she could not recall the specific date in question, but she never used</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>inappropriate language around residents nor told them their care was a hassle. CNA A said she no longer worked for the facility and had moved on from the incident. During an interview on 2/11/26 at 2:30 p.m., the DON said his primary focus as the new DON had been reiterating with staff they were there to serve the residents. The DON said he expected staff to maintain professional behavior at work which included not cursing or using inappropriate language. The DON said a CNA talking down to or using inappropriate language around a resident could put the resident at risk for emotional distress. During an interview on 2/11/26 at 3:00 p.m., The ADM said she was responsible for investigating allegations of abuse and neglect in the facility. The ADM said she investigated the allegation that CNA A used inappropriate language and talked down to Residents #1 and #2. CNA A said the investigation included interviews with other residents who smoked and were present at the time of the incident. The ADM said she was unable to confirm the allegation that CNA A used inappropriate language or talked down to the residents. The ADM said CNA A was terminated following the incident due to multiple reasons with customer service being one of them. Review of a facility associate disciplinary memorandum dated 9/15/25 indicated CNA A was discharged on 9/15/25. The explanation revealed .spoke to residents in a manner that could be perceived as inappropriate language/talking down to residents. Review of a facility termination form dated 9/16/25 indicated CNA A was involuntarily terminated on 9/15/26 for inappropriate behavior. Review of an undated facility policy titled Statement of Resident Rights indicated .You have the right to:.3) Be treated with courtesy, consideration, and respect.</p>		