STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675884	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Teague Nursing and Rehabilitation	884 Hwy 84 W Teague, TX 75860

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received services in the facility with reasonable accommodations of resident's needs and preferences except when to do so would endanger the health and safety of the resident or other residents for 1 of 6 residents (Resident #5) reviewed for resident rights. The facility failed to ensure Resident's #5's call light was within reach on 02/24/26. This failure could place residents at risk of their needs not being met.Findings included:Record review of Resident #5's face sheet, dated 02/24/26, reflected a [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), dysphagia (difficulty in swallowing), cerebrovascular disease - a general term for conditions that affect the blood vessels in the brain and spinal cord, which can lead to serious complication, muscle wasting and atrophy (the loss of muscle tissue and strength, typically caused by inactivity, malnutrition, aging (sarcopenia), or diseases affecting nerves or muscles), and history of falling (indicates a patient is at high risk for future falls). Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected Resident #5 required partial/moderate assistance with showering, toileting, and personal hygiene and required supervision or touching assistance for eating. The MDS reflected Resident #5 had a BIMS score of 07 which indicated Resident #5 was severely cognitively impaired. Record review of Resident #5's care plan, dated 01/11/24 and revised on 01/24/24, reflected an ADL self-care performance deficit.Goal: Resident #49 would maintain current level of function in (Specify: Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review.Interventions included: The resident requires (1) staff participation to use toilet. The resident requires (1) staff participation with transfers. Duringn interview and observation on 02/24/26 at 10:28 a.m., Resident #5 stated she was ok. She stated things were going alright and the staff all treated her well. She stated she had a call light she used to call for help when needed. She stated she knew how to pull the cord to call for help and when she did the staff usually got to her in a timely manner. She stated she could not reach her call light where it was at that time. Observed residents call light on the top right side of the bed hanging from the wall, along the side and in front of resident's nightstand with a teddy bear tied to the end. Resident #5 stated she did not get out of bed by herself and it would not have been safe for her to try to get the call light where it was. During an interview on 02/24/2026 at 10:31 a.m., CNA B stated she was in-serviced on call light placement and keeping residents call light's within their reach. She stated Resident #5's call light was not in a place where she could have reached it and if a resident's call light was not within their reach it could have caused a resident to need something and not be able to tell staff or a resident could have fallen and not been able to call for help. During an interview on 12/11/26 at 9:17 a.m., the DON stated it was her expectation all residents call lights be within the residents reach at all times. She stated all staff were trained on residents call lights being within reach at all times. She stated if a residents call light was not within their reach, the residents could hurt themselves trying to get out of bed or could have a need that may not be met. During an interview on 02/26/26 at 9:22 a.m., the ADM stated it was her expectation all residents call lights be within the residents reach at all times. She stated all staff had been trained on (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' call lights being within reach at all times. She stated if a resident's call light was not within their reach, the resident would not be able to ask for assistance and that was the residents line of communication with staff. Record review of facility policy titled, Call System, Resident, dated September 2022 reflected, Policy Heading: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 1 of 6 residents (Resident #2) reviewed for comprehensive assessments. The facility failed to complete an accurate comprehensive assessment for Resident #2 due to MDS assessment reflected resident did not receive anti-anxiety medication. This failure could place residents at risk of not having their care and treatment needs assessed to ensure necessary care and services were provided.Findings included: Record review of Resident #2's face sheet, dated 02/25/26, reflected the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included generalized anxiety disorder (GAD) (chronic, uncontrollable, and excessive worry about everyday events lasting at least 6 months, often accompanied by physical symptoms like muscle tension, fatigue, and headaches), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), post-traumatic stress disorder (PTSD) (a mental health condition triggered by experiencing or witnessing terrifying, life-threatening events, such as abuse, accidents, or combat), and transient cerebral ischemic attack (a brief stroke like attack that, despite resolving within minutes to hours, still requires immediate medical attention to distinguish from an actual stroke). Record review of Resident 2's Quarterly MDS, dated [DATE], reflected Resident #2 was independent for eating, and required substantial/maximal assistance with toileting, showering, and personal hygiene. The MDS reflected Resident #2 had a BIMS score of 15 which indicated Resident #2 was cognitively intact. Resident #2's Quarterly MDS assessment reflected the resident was not receiving an anti-anxiety medication. Record review of Resident #2's care plan, dated 07/02/25, reflected, Resident used anti-anxiety medications (diazepam) r/t Anxiety disorder.Goal: Resident #2 would be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date.Interventions included: Give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. Anti-anxiety side effects: drowsiness, lack of energy clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, Impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Paradoxical side effects: Mania, hostility and rage, aggressive or impulsive behavior, hallucinations. Record review of Resident #2's Physician's Orders, dated 02/04/26 with a start date of 02/05/26, reflected resident had an order for Diazepam Oral Tablet 5 MG (Diazepam) *Controlled Drug* (a drug or chemical whose manufacture, possession, and use are regulated by government, typically due to risks of abuse, addiction, or safety concerns) Give 1 tablet by mouth one time a day related to generalized anxiety disorder During an interview on 02/24/26 at 10:56 a.m., Resident #2 stated he was ok and things were going well. He stated the staff treated him well. He stated he got his medications correctly and he felt safe at the facility. He stated he used his call light a lot and staff got to him quickly when he called for them. He stated he had no concerns. During an interview on 02/24/26 at 1:13 p.m., LVN A stated she was responsible for completing the MDS assessments. She stated she was trained on completing MDS assessments accurately. She stated she was not sure if Resident #2 received an anti-anxiety medication or not and she would have to look, but she thought she remembered care planning Resident #2 for that medication recently. She stated she completed all of the MDS assessments for the facility. She stated if a resident was receiving an anti-anxiety medication it should have reflected that they did on the MDS. She stated if an MDS assessment was completed inaccurately, it would not affect the resident in any way that she could think of. During an interview on 02/26/26 at 9:17 a.m., the DON stated it was her expectation that MDS assessments were completed accurately and reflected the resident individually. She stated the MDS nurse was responsible for completing the MDS assessments and she was trained on completing the MDS assessments accurately. She stated if a resident received an anti-anxiety medication, the MDS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment should have reflected that. She stated if a resident's MDS did not reflect that a resident received an anti-anxiety medication, it could have affected the MDS submission and reimbursement for the care that is provided to the resident but not caused any direct harm to the resident or affected the residents care in any way. During an interview on 02/26/26 at 9:22 a.m., the ADM stated it was her expectation that MDS assessments were completed accurately and reflected the resident individually. She stated the MDS nurse was responsible for completing the MDS assessments and she had been trained on completing the MDS assessments accurately. She stated if a resident received an anti-anxiety medication, the MDS assessment should have reflected that. She stated if a resident's MDS did not reflect that a resident received an anti-anxiety medication, it could possibly have some adverse effect but not cause any major harm to the resident. Record review of the facility's policy titled CMS's RAI Version 3.0 Manual and dated October 2025: High-Risk Drug Classes: Use and Indication - Steps for Assessment: 1. Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day lookback period (or since admission/entry or reentry if less than 7 days). 2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room). Coding Instructions: Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days). N0415: High-Risk Drug Classes: Use and Indication (continued). Antianxiety: Check if an anxiolytic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).