STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675889	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Manor Healthcare Rehabilitation	3650 S Ih 35 E Waxahachie, TX 75165

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #13) of 6 residents reviewed for quality of care and change in conditions.The facility failed to obtain daily weights for Resident #13 for the dates of 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, 2/21/26, 2/22/26, 2/23/26, 2/24/26, 2/28/26, 3/1/26, and 3/3/26.These failures placed residents at risk of weight gain, disease exacerbation, shortness of breath, decreased quality of life, heart problems, such as arrhythmia (irregular heartbeat).Findings included:Review of Resident # 13's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE]. She had the following diagnoses: heart failure, hypertension (elevated blood pressure), chronic obstructive pulmonary disease (a lung disease that makes it hard to breathe), and depression. Resident #13 had a BIMS score of 13, indicating she was cognitively intact. She required partial/moderate assistance with upper and lower body dressing. Resident #13 had shortness of breath or trouble breathing when lying flat and required oxygen therapy. Review of Resident #13's comprehensive care plan reflected Has coronary artery disease, at risk for activity intolerance, impaired circulation, Date Initiated: 06/22/2024 revision on: 10/30/2025. Interventions included: Obtain weight as ordered.Review of Resident #13's Order Summary Report dated 03/03/2026 reflected an order for daily weights to be completed. Notify MD of weight gain of 3 pounds or more in 24 hours every day. Start date 03/29/2025 .Record review of Resident #13's weights and vital signs dated 03/03/2026 reflected the following weights that had been recorded: 2/26/26 -228.5 Lbs. 2/25/2026 -228.0 Lbs. 2/20/2026 -238.5 Lbs. 2/15/2026 - 238.0 Lbs. 2/6/2026 -239.5 Lbs. 2/1/2026- 235.0 Lbs. Record review of Resident #13's weights and vital signs dated 03/03/2026 reflected there were no daily weights recorded for Resident #13 for the dates of 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/7/26, 2/8/26, 2/9/26, 2/10/26, 2/11/26, 2/12/26, 2/13/26, 2/14/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, 2/21/26, 2/22/26, 2/23/26, 2/24/26, 2/28/26, 3/1/26, and 3/3/26. In an interview on 03/05/2026 at 8:28 AM, Resident #13 stated sometimes the staff obtained her weight and sometimes they did not. She stated the staff needed to weigh her to monitor the edema (swelling) in her legs because she had heart failure. In an interview on 03/05/2026 at 10:22 AM, the ADON stated the charge nurses were responsible for obtaining daily weights and notifying the physician of any weight variance. She did not know why Resident #13's weight was not obtained daily. The DON monitored the nurses to ensure their work was completed. Risk to residents for not obtaining a daily weight could include excessive edema and shortness of breath. In an interview on 03/05/2026 at 4:32 PM, the CDON stated the charge nurses were responsible for obtaining daily weights. The DON and ADON were responsible for monitoring to ensure weights were being done. They did not get notification for missed weights on their dashboards, and the dashboards were reviewed daily. The nurses needed to notify the doctor of any weight variance specified on the order. The risk to residents not obtaining daily weights could include volume overload. In an interview on 03/05/2026 at 4:59 PM, the ADM stated the CNAs were responsible for daily weights for Resident (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#13. The CNA reported to the DON. He was not sure how weights were monitored. He stated negative impacts for not obtaining daily weights could be not catching weight gain. In an interview on 03/05/2026 at 05:05 PM with the ADM revealed that failure to notify of a change in the resident's condition could lead to a further decline in the resident's condition. Record review of facility policy titled Quality of Care revised 11/2007, 07/2013, 10/2025 reflected It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drug and biologicals) to meet the needs of each resident for 2 (Resident # 53 and Resident 68) of 6 residents reviewed for pharmaceutical services.The facility failed to ensure Resident #53 had his prescribed Zofran (a medication for nausea) 4mg available for administration. When the facility failed to order it from the pharmacy and Resident #53 administered another resident's medication (Resident #68's Zofran 4 mg tablet).This failure could place residents at risk of not receiving the intended therapeutic benefit of the medications.Findings included:Record review of Resident #53's significant change in status MDS assessment dated [DATE] reflected a[AGE] year-old male who admitted to the facility on [DATE]. He had the following diagnoses: Myocardial infarction (heart attack), Chronic Respiratory failure, muscle weakness, and difficulty walking. Resident #53 had a BIMS score of 15, indicating he was cognitively intact. Resident #53 was receiving hospice services. Record review of Resident #53's order summary report dated 03/04/2026 reflected an order for Zofran (a medication used to treat nausea and vomiting) Oral Tablet 4 MG Give 1 tablet by mouth four times a day for nausea dated 02/19/2026. Record review of Resident #53's medication administration record for February 2026 reflected that he had received 26 doses of Zofran 4mg which had not been delivered from the pharmacy. Record review of Resident #53's medication administration record for March 2026 reflected he had received 7 doses of Zofran 4mg which had not been delivered from the pharmacy. In an interview on 03/04/2026 at 10:30 AM, Resident #53 stated he had been waiting for his nausea medication since last month. He stated he was supposed to take it 4 times a day and they kept telling him the medication was supposed to come in but it had not. Resident #53 stated he was receiving 1/2 of a pill four times a day. He stated he asked where the medication came from and was told by the MA, they had other residents that took the same medication, so they had plenty. Record review of Activity Transaction for facility emergency drug supply for the month of March 2026 reflected that 1 (one) Zofran 4mg had been pulled for administration on 03/04/2026 at 11:51 AM for Resident #53.Record review of Resident #68's quarterly MDS assessment dated [DATE] reflected a[AGE] year-old female who admitted to the facility on [DATE]. She had the following diagnoses: unspecified dementia (a decline in mental abilities), urinary tract infections, unspecified fall, unspecified protein calorie malnutrition. Resident #68 had a BIMS score of 02, indicating severe cognitive impairment.Record review of Resident #68's order summary report dated 03/05/2026 reflected an order for Zofran (a medication used to treat nausea and vomiting) Oral Tablet 4 MG Give 1 tablet by mouth every 8 hours as needed dated 01/14/26.Record review of Resident #68's medication administration record for March 2026 reflected that she had not received any doses of Zofran 4mg. In an observation on 05/05/2026 at 12:00p.m. of Resident #68's Zofran 4mg prescription revealed she had received 30 tablets delivered on 01/14/26. Resident #68 had 1 tablet left in her prescription. Resident #68 could not be interviewed.In an interview and observation on 03/04/2026 at 1:28 PM, revealed the MA was unable to locate Resident #53's Zofran 4mg tablets in the medication cart. She stated it was not there. She stated she signed out for the medication as given because she was told by RN C to do that. She stated she did not actually see the nurse give the medication. She assumed the nurse had pulled the Zofran 4mg tablet for Resident #53 from the emergency kit. She stated on the other days she worked she could not recall who was working and why she had signed out the Zofran 4mg as administered if the medication was not in the building. In an interview on 03/04/2026 at 1:31 PM, RN C stated that she did not give the medication Zofran 4mg to Resident #53. She stated she did not pull the Zofran 4mg tablet from the emergency cart. RN C stated Resident #53 has had not had any Zofran in the building because it was never delivered from the pharmacy after it was ordered. She (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she had not contacted the pharmacy to see why the medication was not delivered. She stated she followed the five rights of medication administration which included the right resident. In an interview on 03/05/2026 at 12:55 PM, the CDON stated that an investigation was initiated into the missing medication for Resident #53. She stated both the MA and RN C were suspended pending investigation. She stated the facility had pulled orders for all residents receiving Zofran 4mg and it was discovered Resident #68 was missing 29 tablets of the Zofran 4mg. Resident #68 had not received any dosages of her Zofran 4mg tablets. In an interview on 03/05/2026 at 1:15 PM, with RN D, case manager with hospice services for Resident #53, stated she was new to this case. She stated she had reported that the Zofran was not available to the facility nurse last week. RN D stated hospice did not order the medication because it was not related to his diagnosis for hospice admission. Hospice did not pay for that medication, so the facility needed to order it from their pharmacy. She stated the resident told her as well that the facility had been giving him someone else's medication. She stated she did talk to the DON and made it clear to her the medication was ordered routine four times daily from the primary care doctor. RN D stated not having the medication available could lead to uncontrolled symptoms such as increased nausea and abdominal pain . In an interview on 03/05/2026 at 1: 23 PM, the facility Pharm stated it was her expectation that the facility order medications for each resident individually, so they were readily available when needed. She stated if medications were not available the nurses should follow up and call the pharmacy to see what was holding up delivery or orders. She stated she was unsure if RN C had notified the pharmacy regarding resident #53's medication. She stated she completed a medication pass with the medication aides and nurses quarterly, at random, to ensure they followed proper medication administration procedures. She stated the nurses had an emergency kit in the facility with commonly used drugs available to get an emergency supply of medication if needed. She stated the negative effects of not having medications available could be exacerbated symptoms including nausea. Sharing medications could lead to medication errors or lack of supply and residents could run out. In an interview on 03/05/2026 at 3:45 PM, the MD stated all residents should be administered their own medications. It was not appropriate to share medications at the nursing facility. He stated sharing medications could lead to medication errors and medication shortages for residents who needed them. In an interview on 03/05/2026 at 4:32 PM, the CDON stated anytime a medication was ordered and hospice was not going to cover the medication they should let the facility know. The nurses should call hospice and the pharmacy to see why the medication for Resident #53 was not in house. The staff were administering Resident #68's Zofran 4mg tablets to Resident #53. The MA should have informed the nurse that the medication was not available. The CDON stated all nursing staff were in-serviced and those involved were reprimanded and terminated. She stated she expected staff to follow up on medications that were not available. Not having medications available could lead to delays in treatments for other residents that needed their medications. The ADON and DON completed system review audits each day, and they received notifications on the dashboards and 24-hour reports for new orders, to follow up on those notifications daily for review of new orders, and pharmacy delivery identifying any complications by receiving or ordering medications.In an interview on 03/05/2026 at 4:59 PM, the ADM stated it was his expectation that medications be administered as ordered. The staff should not be sharing medications, and that was not common practice at the facility. The ADON and DON should mentor the medication aides and nurses to ensure they followed policy for medication administration. The ADM stated negative effects could be other residents would be out of their medications leading to nausea. Record review of facility undated policy titled Ordering and Receiving Medications from The Pharmacy reflected Medications and related products are received from Pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. A licensed nurse: receives medications delivered to the facility and documents delivery on the medication delivery receipt, verifies medications received and directions for use with the medication order form, promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interviews and record review, the facility with more than 120 beds failed to employ a qualified social worker on a full-time basis for 1 of 1 facility reviewed for qualifications of a Social Worker.The facility, licensed for 121 beds, did not employ a full-time, qualified social worker.This failure could place residents at risk for unmet social services and psychosocial needs. Findings included:Review of the Facility Summary Report from the Texas Unified Licensure Information Portal (TULIP) dated 02/10/2026 reflected the facility had a total licensed capacity of 132 beds.Review of the All-Staff list, undated, provided by the ADM on 03/03/2026 to the state surveyor, revealed the USW next to the job title Licensed Social Worker. Review of the job description for the facility's ?Social Worker' revealed the qualifications for ?Education and/or Experience' included to Hold current license through the state board as a LSW or a higher-level license. This was signed by the USW on 11/12/2024.Review of an email from the HR dated 10/13/2025 revealed a request to the USW for the USW's social worker's license, to which the USW responded that she had not gotten it yet, she would be testing 12/8/2025.In an interview on 03/05/2026 at 2:45 PM with HR, she stated that she had been working at the facility for about 7 years and that she was responsible for hiring. She stated that she was not the one responsible for hiring the USW, however, that was the ADM. She stated that the USW was hired on 11/11/24 by the ADM. She stated that her process for verifying professional licensure for staff in licensed roles such as social work, would be that she checked to see if they had a current license before hiring. She stated that as of now, the USW did not hold a license through the Texas Behavioral Health Executive Council. She stated that the USW was hired under the title ?Licensed Social Worker', and that the minimum qualifications for that position were what was written on the job description. She stated that when the USW was hired, the USW was supposed to obtain her license, but failed the exam in January 2025, and was supposed to retake it soon. In an interview on 03/05/2026 at 2:55 PM with the ADM, he stated that he began his AIT at this facility in January 2024. He stated that he was responsible for hiring the USW in November 2024. He stated that the facility identified the qualified social worker responsible for social services as the USW. He stated that the ADM at a sister facility was a licensed social worker who provided supervision or consultation for the social services program and did not work for this facility everyday as a licensed social worker but provided oversight if needed. He stated that the USW represented herself to residents, families, and staff as a social worker. He stated that he ensured compliance with the qualified social worker position by utilizing the USW as the social worker, and that she was a good social worker, if there were issues, she could call the sister facility ADM for oversight. He stated that the USW signed psychosocial assessments as the social worker, and that she participated in the interdisciplinary team as the social worker. He stated that when the USW failed her licensure exam in January 2025, he told her that she had 1 more chance to pass before they would need to find a qualified candidate. The ADM provided the surveyor with a picture of the USW's Master of Social Work diploma. Review of the facility's policy titled Social Services, Provision of Medically-Related undated, revealed, Social Services is responsible for providing for the medically related social services needs of each resident. It is not required that the social worker provides these services but assures that they are provided. Examples of these services may include but are not limited to the following:a. Transportation,b. Lost or missing items,c. Resident grievances,d. Scheduling appointments,e. Resident errands,f. Satisfaction surveys,g. Faxing request for discharge orders,h. Arranging for equipment needs.

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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 observation, interviews, and record reviews, 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 2 of 6 residents (Resident's #50, and #20's) reviewed for resident rights.The facility failed to ensure Resident #50 and #20's call lights were within reach on 03/03/2026 and 03/04/2026This failure could place residents at risk of needs not being met.Findings included:Record review of Resident #20's face sheet dated 03/05/2026 reflected the resident was an 83- year-old female admitted on [DATE]. Her diagnoses included Alzheimer's disease (a brain disorder that causes memory and thinking skills to decline over time), repeated falls (falling multiple times, usually within a short period), lack of coordination (uncoordinated movement, coordination impairment, or loss of coordination), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities).Record review of Resident #20's quarterly MDS assessment, dated 02/18/2026 reflected a BIMS score of 00 indicating severe cognitive impairment. Section GG (functional abilities) reflected resident was dependent assistance for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand, rolling from side to side, and all transfers.Record review of Resident #20's care plan dated 11/22/2021 and revised 10/06/2025 reflected [Resident #20] was at risk for communication problem r/t TIAs, dementia, usually understood/understands, difficulty hearing. Goal: [Resident #20] would to be able to make basic needs known on a daily basis through the review date. Interventions included: Call light in reach.Focus: [Resident #20] had ADL Self Care Performance Deficit r/t impaired balance and Dementia. Goal: [Resident #20] would maintain current level of function through the review date. Interventions included: Encourage to use bell to call for assistance. [Resident #20] was at risk for falls r/t incontinence, psychotropic medication use, gait, imbalance and cognitive impairment/dementia. Goal: [Resident #20] would not sustain serious injury through the review date. Interventions included: Be sure the call light is within reach and encourage to use it to call for assistance asneeded and a working and reachable call light.In observation on 03/03/2026 at 11:06 AM, revealed Resident #20 was lying in bed with the covers pulled up to her chest area. The resident did not respond when her name was called. The resident's call light was observed hanging to the right side of the head of her bed, out of the resident's reach. The resident was resting quietly and had no signs of pain or distress.Record review of Resident #50's face sheet dated 03/05/2026 reflected the resident was an [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), abnormalities of gait and mobility (a change in walking patterns), lack of coordination (uncoordinated movement, coordination impairment, or loss of coordination), hypertension (a condition in which the force of the blood against the artery walls is to high), muscle weakness (a, often sudden, reduction in physical strength where muscles cannot contract or function normally, causing difficulty with tasks like lifting or walking). Record review of Resident #50's quarterly MDS assessment dated [DATE] reflected a BIMS score of 04 indicating severe cognitive impairment. Section GG (functional abilities) reflected resident required supervision or touching assistance for toileting hygiene, baths, upper dressing, lower dressing, sit to stand, and chair/bed- to chair transfer. She required setup or clean up assistance for oral hygiene, putting and taking off footwear, personal hygiene, roll left to right, lying to sitting, walking 50 feet, and walking 150 feet. She was independent with eating, bed to lying, toilet transfers, and she used a walker. Record review of Resident #50's care plan dated 03/05/2025 reflected Resident had a risk for fall r/t poor safety awareness and high-risk medication. Goal: Resident #50 would be free of falls through the review date. Interventions included: Be sure the call light is within reach and encourage to use it to call for assistance as needed.In an observation (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and interview on 03/05/2026 at 11:25 AM, Resident #50's call light was hanging over the left side of the bed rail, and was on the floor. Resident #50 was asked if she could reach the call light and she was unable to reach it. She stated if she needed assistance and was unable to reach her call light she would yell for help.In an interview and observation on 03/03/2026 at 11:20 AM, LVN A stated that all staff that entered the resident's room were responsible for ensuring the call light was within reach. She stated Resident #20's call light should be within reach at all times. She entered Resident# 20's room and observed the resident's call light hanging to the right side of the head of her bed, and out of resident's reach. She stated she did not feel that Resident #20 was capable of pressing the call button, but the call light was not in an appropriate place, and she could not have pressed the button if she tried. She stated she had been trained on call light placement and if a resident did not have their call light in reach, the resident could have fallen or may not have been able to call for help.In an interview on 03/03/2026 at 11:30 AM, CNA B stated that staff should make rounds every two hours or as needed to check to see if a resident needed assistance, ensuring call lights were within reach, and making sure all residents were comfortable. She stated all residents' call lights should be in reach at all times. She stated she had been trained on call light placement and if a resident's call light was out of reach, they could fall trying to get to the light or could not call for help. In an interview on 03/05/2026 at 11:27 AM LVN B stated that staff should make rounds every two hours or as needed to check to see if a resident needs assistance, ensuring call lights were within reach, and making sure all residents were comfortable. She stated residents' call lights should be within reach at all times. She entered Resident #50's room and saw the call light hanging over the left side of the bed rail, on the floor, and out of reach. She stated the resident was capable of pressing the call button, but the call light was not in reach, and she could not have pressed the button if she tried. She stated she had been trained on call light placement and if a resident did not have their call light in reach, the resident could have fallen or may not have been able to call for help.In an interview on 03/05/2026 at 11:45 AM, the CDON stated that all staff that entered the resident's room were responsible for ensuring the call light was within reach. She stated it was her expectation that all residents had their call lights within reach for residents to call for assistance. She stated staff had been trained on call light placement. She stated if a resident call light was out of their reach, they may have had a need that was unmet.In an interview on 03/05/2026 at 1:30 PM, CNA A stated that staff should make rounds every two hours or as needed to check to see if a resident needed assistance, ensuring call lights were within reach, and making sure all residents were comfortable. She stated she was trained on call light placement and if a resident did not have their call light within reach could cause a resident not to be able to call for assistance and result in a fall or resident choking. In an interview on 03/05/2026 at 4:59 PM, the ADM stated staff completed morning rounds to ensure the residents' call lights were within reach. He stated staff had been trained on call light placement. He stated it was his expectation that all residents have their call lights within their reach at all times. He stated if a resident's call light was out of reach they may not receive assistance in a timely manner. Record review of the facility policy titled Call Light/Bell Policy and revised date 08/03/2021; 10.2025 reflected It is the policy of this facility to provide the resident a means of communication with nursing staff. Procedures: 1. Answer the light/bell within a reasonable time2.Listen to the resident's request/need.3.Respond to the request. If the item ., not available or you are unable to assist, explain to the resident and notify the charge nurse for further instructions.4.Leave the resident comfortable. Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to reassess, report, and document changes in condition in accordance with the person-centered service plan for 1 (Resident #19) of 8 residents who were reviewed for changes in condition.The facility failed to reassess and report Resident #19's blood pressure in accordance with the facility policy.These failures could lead to heart problems, such as arrhythmia (Irregular heartbeat).Findings included: Review of Resident #19's Face Sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: Congestive Heart Failure, Alzheimer's disease, and muscle weakness. Review of Resident #19's care plan and BIMS Evaluation dated 03/02/2026 reflected that Resident #19 was assessed with a BIMS score of 99, indicating severely impaired cognition. Resident #19's Blood Pressure Summary dated 01/30/2026 at 10:10 reflected Resident #19's blood pressure was 94/39 mmHg, Sitting r/arm (Right arm). The blood pressure medication was ordered: Valsartan Oral Tablet 320 MG [Give 1 tablet by mouth one time a day for HTN (Hypertension), HOLD FOR SBP (Systolic Blood Pressure) LESS THAN 110 OR DBP (Diastolic Blood Pressure) LESS THAN 60)] had been held by MA F. However, no other readings had been taken, except for the one of 94/39 mmHg on 01/30/2026, and no notes of low blood pressure were noted in Resident #19's progress note. In a telephone interview on 03/05/2026 at 11:33 AM with the Hospice Coordinator revealed that there were no changes in condition for Resident# 19, addressed to hospice on 1/30/2026. In an interview on 03/05/2026 at 02:50 PM with LVN E, revealed that at any point, if LVN E found the resident's vital signs were abnormal, she checked the doctor's order, rechecked the vital signs if needed, informed the doctor of the abnormal results, documented it in her progress note, and entered it in PCC. In an interview on 03/05/2026 at 09:30 AM with the DON, revealed that if abnormal vital signs were a change in condition and were outside the parameters, nurses needed to report them to the doctor or the nurse practitioner. Nurses documented changes of condition in PCC. If a medication aide found abnormal findings, they would notify the charge nurse, who would then recheck the vital signs. However, nurses would only report to the doctor or nurse practitioner if the machine was functioning properly and the vital signs were abnormal. In an interview on 03/05/2026 at 09:40 AM with MA F revealed that, whenever MA F observed abnormal vital signs, MA F reported them to the charge nurse. After finding abnormal results, MA F entered her notes in PCC each time. MA F could not recall the significant vital sign changes on 1/30/2026 for Resident #19.In an interview on 03/05/2026 at 09:52 AM with the ADON revealed that at any point, if the medication aides saw a change in condition, such as abnormal vital signs, they notified the charge nurse, who would recheck the vitals. If the abnormality was not due to a machine malfunction, the nurse would notify the doctor. Nurses should document abnormal vital signs in PCC. If it was a hospice patient, then the nurse would notify the hospice provider.In an interview on 03/05/2026 at 01:31 PM, with RN F revealed that no one reported any low blood pressure or changes in condition among residents during her shift on 1/30/2026. At any point, if RN F finds or the CMA reports that the resident's vital signs are abnormal, she checks the doctor's order, rechecks the vital signs if needed, informs the doctor of the abnormal results, documents it in her progress note, and enters it in the PCC. In an interview on 03/05/2026 at 05:05 PM with the ADM, revealed that failure to notify of a change in the resident's condition could lead to a further decline in the resident's condition. Review of an in-service dated 03/04/2026 of the facility policy titled Holding Blood Pressure Meds per parameters, revealed: When a Certified Medication Aide holds a medication because the parameters are low, the Licensed Nurse must be notified and intervene as appropriate (re?check vital signs, inform physician/hospice provider.)Review of an in-service dated 03/04/2026 of the facility policy titled Holding Blood Pressure Meds per parameters, revealed: When a Certified Medication Aide holds a medication because the parameters are low, the Licensed Nurse must be notified and intervene as appropriate (re?check vital signs, inform physician/hospice provider.).

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Pleasant Manor Healthcare Rehabilitation	3650 S Ih 35 E Waxahachie, TX 75165

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide a safe, clean, comfortable and homelike environment for 1 of 1 facility observed in that:The facility foyer had 2 of 4 skylights in disrepair for an unknown amount of time.This deficient practice could affect residents, staff, or visitors who entered through the facility front doors by placing them at risk of being exposed to leaks or an unsanitary environment. Findings included:In an observation on 03/03/2026 at 9:08 AM the facility foyer revealed 2 of the 4 skylights were broken, with visible holes, that had been repaired with tape that was adhered to the outside of the skylights. The broken shards of skylight were visible underneath the tape.In an interview on 03/03/2026 at 10:50 AM, with the LM, he stated that the skylights in the foyer broke due to wind, and they were hard to replace. He stated he did not remember exactly when the skylights broke, but he thought it was at the beginning of 2026. He stated that he was not sure when the facility's maintenance director got ahold of the contractor to come out to the facility to measure and replace with new skylights. In an interview on 03/04/2026 at 2:37 PM, the ADM stated that the skylights in the foyer had just been fixed. Additionally, he stated that he thought the work order was in their maintenance system but later stated he could not find anything to support they had reached out for the skylights to be fixed before the survey team arrived. He stated that he really did not remember when the skylights broke or when the technician taped over it. He stated that all maintenance concerns should be documented in the TELS system (system used for inputting and tracking maintenance requests), and any immediate concerns should be relayed to the corporate maintenance technician. He stated that the FMD would only report things to him (ADM) if it required immediate attention or work outside of his capability, like from a contractor. In an observation on 03/04/2026 at 3:03 PM of the facility foyer ceiling revealed the 2 previously broken skylights were now in good condition. In an interview on 03/04/2026 at 3:28 PM with the FMD, he stated that on Monday (3/2/2026) he identified the skylights broken in the facility foyer. He stated he reached out to the roofing company who did a measurement, and they came back today (3/4/2026) and installed new skylights. He stated that the skylight was not broken at the beginning of the year. He stated that the tape was put on there by the vendor. He stated he was not sure how the hole got there and he did not put it in the TELS system because he just called the roofing company. He stated that since he started in April 2025, this was the first time any skylights had broken. He stated that the skylight being broken could lead to weather hazards, or birds flying in. Review of the facility policy titled Maintenance/Request for repairs undated, revealed, All requests may be entered into Tels system, this will create a work order. Information will include: repair needs, area in need of repair, and name of staff member requesting repair.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from chemical restraints that were not required to treat the residents' medical symptoms for 1 (Resident #9) of 6 residents reviewed for unnecessary medications.The facility failed to ensure Resident #9's GDR was attempted and non-pharmacological approaches to care were implemented for Quetiapine Fumarate, an antipsychotic medication (drug used to treat psychosis and related mental health conditions by modulating brain neurotransmitters).This failure could place residents at risk for adverse reactions and negative side effects from the administration of medication and dependence on unnecessary medications. Findings included:Review of Resident #9's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old male who admitted to the facility on [DATE]. He had the following diagnoses: unspecified dementia (a decline in mental abilities), other lack of coordination, aphasia (difficulty with speech), dysphagia (difficulty with swallowing), and muscle weakness. Resident #9 had a BIMS score of 04, indicating severe cognitive impairment. Resident #9 was taking an antipsychotic medication on a routine basis. There had been no GDR attempted and no physician documented GDR as clinically contraindicated.Review of Resident #9's comprehensive care plan dated 08/20/2024 and updated 07/06/2025 reflected Psychotropic medications use with a goal Will reduce the use of psychoactive medication through the review date.Review of Resident #9's physician orders dated 03/05/2026 reflected he had an order for Quetiapine Fumarate Oral Tablet 200 MGGive 200 mg by mouth two times a day related to depression. The medication was started on started 06/01/2024.Record review of Resident #9's medical records from 05/2005-03/2026 reflected there had not been a GDR for his Quetiapine Fumarate tablets.Record review of Resident #9's medication administrations record dated March 2026 reflected he was receiving Quetiapine Fumarate Oral Tablet 200 MG tablets two times a day related to depression.Review of Consultant Pharmacist/Physicians Communication dated 05/19/2025 reflected [Resident #9] is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for trial dose reduction. The physicians' area was blank, regarding if they agreed/disagreed with the GDR.Quetiapine 200mg BID (for depression) reduce to Quetiapine 150mg BID? If dose reduction is contraindicated or resident failed previous reduction attempt, please document below. Signed by the Pharm.In an interview on 03/05/2026 at 3:45 PM, the MD stated he had just started with the facility back in June 2025, and that if a GDR were requested prior to that date, it may not have been addressed. He stated the DON or ADON left all pharmacy recommendations in his box at the nursing home so he could address them on his rounds. He stated he was normally in the building twice weekly. He stated he would have to evaluate Resident #9's medical records and behaviors to determine if a GDR would be beneficial. He stated that by not addressing pharmacy recommended GDR residents may receive medications they possibly do not need.In an interview on 03/05/2026 at 4:32 PM, the CDON stated the pharmacist reviewed and gave recommendations on psychotropic medications, and the nurse practitioner or physician approved or denied medication recommendations after they reviewed the medical record. She stated that nurses followed the doctors' recommendations and noted in the care plan any new orders or changes. A progress note as to why the GR was approved or denied was also entered into the resident's medical record. She was not sure why Resident #9's GDR recommendation was not addressed. She stated the DON was responsible for all follow-ups for pharmacy recommendations. She stated that the GDR not being evaluated could lead to ineffective medication treatment.In an interview on 03/05/2026 at 4:59 PM, the ADM stated the DON/ADON were responsible for monitoring the GDRs, and all pharmacy recommendations, and by not monitoring psychoactive medication recommendations, could lead to residents not having the best quality of life. Record review of facility policy titled Chemical Restraints and Psychotropic Medication (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Management Original Date: 05.2007 Revision/Review Date(s): 12.2019; 2.2022; 12.2023; 04.2025; 10.2025 reflected: It is the policy of this facility to ensure that residents are free from chemical restraints imposed for purposes of discipline or convenience or that are not required to treat a specific condition as diagnosed and documented in the clinical record. Psychotropic medications shall not be administered for the purpose of discipline or convenience. Based on a comprehensive assessment, the facility will ensure that: Residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 1 (Resident #25) of 6 residents reviewed for comprehensive care plans. The facility failed to care plan Resident #25's verbal behaviors and document interventions to address them.The facility failed to update Resident #65's care plan to reflect he no longer required the use of disposable dinnerware.This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met.Findings included:Review of Resident #25's quarterly MDS assessment dated [DATE] reflected a [AGE] year-old female who admitted to the facility on [DATE]. Resident #25 had the following diagnoses: non-Alzheimer's dementia (a variety of dementia that is not cause by Alzheimer's disease), malnutrition (undernutrition and/or overnutrition), hyperlipidemia (abnormally high levels of lipids in the blood), diabetes mellitus (when the body cannot properly use blood sugar, leading to high blood sugar levels), and anemia (blood disorder characterized by a reduced number of red bloods cells). In Section E - Behavior, Resident #25 was indicated as not exhibiting physical, verbal, or other behavioral symptoms during the look back period. Resident #25's Section C - Cognitive Patterns indicated ?No' that Resident #25's brief interview for mental status should not be conducted because she was rarely/never understood. Review of Resident #25's comprehensive care plan dated 01/14/2026 reflected a focus of At risk for a communication problem r/t hearing deficit and impaired cognition/dementia Interventions included, Anticipate and meet needs. Ensure/provide a safe environment: call light in reach, adequate low glare light, bed in lowest position and wheels locked, avoid isolation. Occupational, physical, speech-language therapy evaluation and treatment per physician orders. Refer to speech therapy for evaluation and treatment as ordered. Resident #25 had a focus of psychotropic medication use, the interventions included to monitor/record occurrences of pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others.Review of Resident #65's face sheet dated 03/05/2026 reflected a 79-year-old-male who was admitted to the facility on [DATE]. His diagnoses included alcohol use (drinking in a manner, situation, amount, or frequency that could cause harm to the person who drinks or to those around them), alcohol polyneuropathy (nerve damage caused by long-term, excessive alcohol consumption, resulting in pain, numbness, and weakness, primarily in the hands and feet), dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), type 2 diabetes(condition in the way the body regulates and uses sugar as a fuel).Review of Resident #65's quarterly MDS assessment dated [DATE] reflected a BIMS score of 01, indicating severe cognitive impairment. Section GG (functional abilities) reflected Resident #65 required supervision or touching assistance with eating and used a wheelchair.Review of Resident #65's care plan initiated on 12/12/2022 and revised on 03/03/2026 reflected Resident #65 was care planned for impaired cognitive functions or impaired thought process r/t ETOH induced dementia.2/14/23: drawers with moldy food. Washing dinnerware in toilet. Notified dietary for disposable plates only - (discontinued 3/3/26 (behaviors no longer applicable)6-29-23: Resident observed washing dinnerware in toilet. Dietary informed that resident is to only have disposable dinnerware. (discontinued 3/3/26 (behaviors no longer applicable). Interventions included COMMUNICATION: Identify yourself at each interaction. Face when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc. Use simple, directive sentences. Provide with necessary cues- stop and return if agitated. Needs supervision/assistance with all decision making. Monitor/document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficultyexpressing self, difficulty (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understanding others, level of consciousness, mental status.Initiated 12/13/2022 and revised 11/21/2025- Focus: ADL Self Care Performance Deficit r/t impaired cognition, ETOH dependance/withdrawal, impaired mobility. Interventions included: Provide with a homelike environmentFocus: initiated 10/10/2023 Focus: At risk for impaired cognitive function/dementia or impaired thought processes r/t dx alcoholic induced dementia.Interventions included: Initiated 10/25/2023- Provide with a homelike environment, initiated 12/20/2022 Monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function.Review of Resident #65's progress note dated 03/03/2026 reflected, Discussed resident's current behaviors related to washing dishes in his toilet from 2023. Resident has no current behaviors of such. Resident no longer needs Styrofoam plates for meals. Social Services to provide psychosocial support as needed. In an observation on 03/03/2026 at 10:44 AM revealed Resident #25 in her room. She began to scream out, with no other apparent signs of pain or distress, while lying in bed. In an observation on 03/03/2026 at 12:23 PM, Resident# 65 was observed in the dining room being served his lunch on a foam plate.In an observation on 03/04/2026 at 11:00 AM revealed Resident #25 in the sitting room of the facility. She was sitting in her wheelchair with a wedge behind her left side. She was observed grabbing at things that were not visible and occasionally screamed out with no other apparent signs of pain or distress. In an interview on 03/03/2026 at 12:11 PM with LVN A, she stated that Resident #25 had been yelling out since LVN A began working at the facility on 2/1/2026. She stated that Resident #25 was often taken out of her room and put in the living area of the facility to watch television with other residents. She stated that the resident yelled out for no particular reason, and her cognition was very low and she was not able to communicate with staff or residents. In an interview on 03/05/2026 at 9:24 AM with CNA A, she stated that she worked with Resident #25, and that the resident would pull on things, and reach for things that were not there. She stated that staff watched her in case of falls. She stated it was the resident's normal behavior to yell out and there was no particular reason identified. She stated that the resident would just yell and then stop. She stated that some other normal behaviors for Resident #25 were yelling, disrobing, and hanging her feet off the side of her bed. She stated that if the resident yelled out around other residents the staff would take her back to her room. She stated the resident's cognition was not there to participate in activities. In an interview on 03/05/2026 at 9:32 AM with LVN B, she stated she was the charge nurse on Resident #25's hall. She stated that Resident #25 would mumble, but staff were never able to understand her. She stated that yelling had always been Resident #25's normal behavior and LVN B was not sure what the root cause was. She stated that when the resident yelled out, staff would just talk to her, and even though they could not understand her, they tried to have a normal conversation with her. She stated that the care plans were more for the management staff, and DCS did not look at them, but at the tasks on the Kardex (program used for nurses to document tasks). She stated that nurses monitored behaviors. She stated behaviors were communicated in the orders. In an interview on 03/05/2026 at 12:25 PM with the MDSC, she stated that she was responsible for comprehensive care planning. She stated that when completing the MDS assessment, she looked at the progress notes to determine behaviors. She stated that there was an IDT that came together to discuss. She stated she thought that maybe the verbal outbursts by Resident #25 just became so normalized, that the DCS did not document them, therefore she would not be able to mark it as a verbal behavior in the MDS, which would then not translate over to the care plan. She stated that the communication part of the care plan could be more specific to include her verbal outbursts, and any interventions. In an interview on 03/05/2026 at 3:07 PM with the ADM, he stated that his expectation was for resident specific behaviors to be care planned. He stated that direct care nurses attended the morning meetings. He stated that yelling out was a behavior for Resident #25 that they discussed almost every morning, it just failed to be care planned. In an interview on 03/05/2026 at 4:32 PM, the MDSC stated she had worked at the facility for nine months. She stated she was responsible for completing comprehensive care plan and MDS assessments on all residents. She stated the nurses (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed acute changes. She stated that she was not aware of any behaviors and that his care plan should have been updated.In an interview on 03/05/2026 at 4:39 PM with the CDON, she stated that Resident #25 was admitted to this facility from a sister facility, and exhibited the behavior of yelling, at that facility as well, so Resident #25 had been yelling out since her admittance to this facility. She stated she did not know what interventions the IDT determined to help manage or reduce Resident #25's yelling. She stated that there were individualized interventions staff should follow when the resident began yelling, she just did not know what they were. She stated that staff were supposed to document what interventions they attempted and whether they were effective in the progress notes. She stated she did not know why the behavior was not addressed in the care plan. She stated that any interventions that worked should be listed in the care plan, even if it was medication. In an interview on 03/05/2026 at 4:40 PM, LVN B stated she had not witnessed Resident #65 exhibiting any behaviors since she started working on the 600 hall in July 2025. She sated if a resident had behaviors, management staff would notify the nursing staff of how long the resident would need to be monitored. She stated Resident #65 was a good resident and she had no issues with his behaviors.In an interview on 03/05/2026 at 5:07 PM, the ADM stated that he had worked at the facility since 2024. When asked how familiar he was with Resident #65, he stated he would have to look at the resident chart. He stated he had not witnessed Resident #65 washing his dinnerware in the toilet. He stated he was not aware Resident #65 was being served meals on a Styrofoam plate. He stated he was unsure how Resident #65's behaviors were being monitored. He stated that the MDSC was responsible for updating the care plan. He could not give an explanation as to why Resident #65's care plan was not updated to reflect his current status. He stated a negative impact of a resident being served off of a foam plate could create the perception of different treatment compared to other residents.In an interview on 03/05/2026 at 5:22 PM, CNA C stated she had worked at the facility for 15 years. She stated she had not witnessed any behaviors from Resident #65 related to him washing dishes in his toilet. She stated she did not know why he would be served meals on a foam plate. She stated Resident #65 ate all his meals in the dining room. She stated if she were to notice any behaviors she would report to her nurse. She stated serving meals on foam plate could affect the resident's dignity as it did not promote a home-like dining environment.Review of the facility's policy titled Comprehensive Person-Centered Care Planning dated 10/2025 reflected, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person ?centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 (Resident #12) of 6 residents reviewed for ADLs.The facility failed to trim and cut Resident #12's fingernails.This failure could place residents at risk of not receiving services/care and decreased quality of life. Findings included:Review of Resident # 12's significant change in status MDS assessment dated [DATE] reflected an [AGE] year-old male who admitted to the facility on [DATE]. He had the following diagnoses: diabetes mellitus (elevated blood sugar), unspecified dementia (a decline in mental abilities), myopathy (a stiffing of the muscles), and unspecified abnormalities of gait and mobility. Resident #12 had a BIMS score of 07, indicating severe cognitive impairment. Resident #12 required partial/moderate assistance with personal hygiene.Review of Resident #12's comprehensive care plan reflected an ADL Self Care Performance Deficit related to neuropathy (nerve pain) and generalized muscle weakness. Date Initiated: 10/22/2020 revision on: 11/18/2022. Interventions included: Staff will physically assist with all ADLs as needed.Review of Resident #12's visual bedside Kardex (a snapshot of requires care for residents) report dated 3/03/2026 reflected staff will physically assist with all ADLs as needed.In an interview and observation on 03/03/2026 at 10:44 AM, Resident #12 had long and jagged fingernails going past his fingertips with black dirt and debris under them. He stated the nurses refused to cut his fingernails and he did not like them long. He was not sure why no one would take care of his fingernails. In an interview on 03/4/2026 at 11:49 AM, CNA A stated she was responsible for the care of Resident #12. She stated he had diagnosis of diabetes and the CNAs were not supposed to clip the nails of diabetic residents. She stated she had not told the nurse Resident #12's fingernails needed to be cut. She stated having fingernails that were long and dirty could result in infection and a lack of dignity for Resident #12. In an interview on 03/04/2026 at 12:03 PM, RN C stated she was just informed today that the nurses were responsible for clipping residents' fingernails. She stated there was no order for nail care that she was aware of. She stated having fingernails that were dirty, long, and jagged could result in skin tears or infection. In an interview on 03/05/2026 at 4:32PM, the CDON stated that if residents were diabetic the CNAs could clean and file fingernails and the nurses were responsible for clipping the fingernails. She stated Resident #12 was not on a scheduled date for trimming fingernails. She stated that on shower days the CNAs should notify the nurse when a resident's fingernails needed to be clipped. She stated nurses should perform a full body head to toe assessment weekly, that should include fingernails, and at that time if the nurses saw residents' fingernails are long, they should be trimmed unless the resident refuses. The only time fingernail care was placed on the care plan was if there was a specific preference on nailcare. The CDON stated the negative impact of long dirty fingernails could be infection.In an interview on 03/05/2026 at 4:59 PM, the ADM stated fingernails should be cleaned when residents were showered. Long jagged fingernails were not acceptable and if the nurses and CNAs saw that, then they needed to clean them. He stated he was not sure who was responsible for nail care. The ADM stated the negative impacts of long dirty fingernails could be infection. Record review of facility policy titled Quality of Care ADL, Services to carry out revised 11/2007, 07/2013, 10/2025 reflected It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. If a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal oral hygiene will be provided by qualified staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675889	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Manor Healthcare Rehabilitation	3650 S Ih 35 E Waxahachie, TX 75165

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible to prevent accidents for 1 (Resident #77) of 6 residents reviewed for accidents and hazards.The facility failed to ensure Resident #77 did not keep disposable razors in her possession and use them without supervision. This failure could place residents at risk of cuts or scrapes. Findings included:Review of Resident #77's comprehensive MDS assessment dated [DATE] reflected an [AGE] year-old female with an original admit date of 12/07/2025 and a re-admission on [DATE]. Resident #77 had the following diagnoses: high blood pressure, renal insufficiency (poor kidney function), hyponatremia (abnormally low sodium level), glaucoma (group of eye diseases that can lead to damage of the optic nerve), muscle weakness, and cognitive communication deficit. In Section GG - Functional Abilities, she was indicated as needing partial/moderate assistance with oral hygiene, upper body dressing, lower body dressing, and personal hygiene. Resident #77 had a BIMS of 12-indicating she had moderately impaired cognition. Review of Resident #77's comprehensive care plan dated 12/17/2025 reflected she was at risk for impaired visual function r/t glaucoma. Her interventions included consulting with eye care practitioner as required and monitor/document/report to MD the following s/sx of acute eye problems: Change in ability to perform ADLs, Decline in mobility, Sudden visual loss, Pupils dilated, gray or milky, c/o halos around lights, double vision, tunnel vision, blurred or hazy vision. She had another focus area of ?ADL Self Care Performance Deficit r/t weakness, unsteady gait, impaired cognition'. The interventions were that staff would provide the appropriate level of physical assistance with ADLs as needed, and that her self-ability may fluctuate throughout the day.Review of Resident #77's active physician orders as of 03/03/2026 reflected an order for dorzolamide solution .5% related to unspecified glaucoma, and an order for pramipexole Dihydrochloride for tremors. In an observation on 03/03/2026 at 11:45AM, Resident #77 was shaving herself with a disposable razor in one hand, and a handheld mirror in the other, in front of an exit door at the end of her hall, using the outside light to help her see. She was able to shave her chin without staff approaching her for approximately 5 minutes. In an observation and interview on 03/03/2026 at 10:54 AM with Resident #77, she stated that she had glaucoma and she had to use eye drops for it. She stated that she thought the eye drops were causing a skin allergy due to her under eyes being irritated. She was observed sitting in a wheelchair.In a follow-up interview on 03/05/2026 at 9:45 AM with Resident #77, she stated that she had left her tweezers at home, and she preferred to use tweezers to pluck her chin hair. She stated that she kept a plastic bag of disposable razors in her purse, which she showed the surveyor, and the bag contained approximately 5 disposable razors. She asked the surveyor not to take them from her. In an interview on 03/05/2026 at 11:01 AM with CNA D, she stated that when residents admit to the facility the admitting nurse or CNAs would help fill out an inventory sheet of what residents had brought into the facility. She stated that they would inventory what was in a purse if it were valuables such as wallets and jewelry. She stated that due to Resident #77's vision problems she did not think the resident was safe to shave herself, and she was not aware that Resident #77 had disposable razors in her possession and had not previously seen the resident shave herself. In an interview on 03/05/2026 at 10:00 AM with the ADON, she stated that the admitting nurse would take inventory of resident belongings upon a resident admitting to the facility, and that they only inventoried important items like wallets and jewelry. She stated that they had confiscated a couple items from Resident #77 before, and they had not had to confiscate disposable razors, and she was not aware she had them in her possession. She stated that she could have medical supply get tweezers for Resident #77. In an interview on 03/05/2026 at 3:00 PM with the ADM, he stated that the facility will take an inventory sheet, every morning they do angel rounds (walk throughs done by department heads done usually in (continued on next page)

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	675889	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Manor Healthcare Rehabilitation	3650 S Ih 35 E Waxahachie, TX 75165

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the mornings) to make sure any hazardous materials are put away. He stated that no one was assigned to check Resident #77's room, so unfortunately daily checks were missed. He stated that he just got back in town and was not familiar with Resident #77. He stated a negative impact of Resident #77 having disposable razors in her possession could be that a cognitively impaired resident could wander into her room and obtain the razors if they were not put up. An email request for a policy pertaining to shaving, and/or self-shaving, and/or assessments for determining safety/supervision for using disposable razors was requested on 03/05/2026 at 9:13 AM, and a policy was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675889	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Manor Healthcare Rehabilitation	3650 S Ih 35 E Waxahachie, TX 75165

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure all mechanical, electrical, and patient care equipment was in safe operating condition for 1 of 1 facility's reviewed for water leakage.The facility failed to maintain dry, water-leak-free conditions in the facility's only laundry room.This failure could put all residents at risk of infection and laundry service workers at risk for slips and falls.Findings included:In an observation on 03/05/2026 at 12:13 PM, revealed a water leak in a plumbing line on the dirty side of the laundry room, located behind the washing machine. Water was leaking onto the floor of the room, flowing behind the washing machine, along its side, and into the dirty laundry collection room. A blue type of cloth had been placed at the back of the main water-leakage area to soak up the water, and white blankets had been placed at the corners of the washing machine nearest to the main wall of the room to soak up the water from the leakage area. In an interview on 03/05/2026 at 12:15 PM with the Laundry Service Staff I revealed that the recent leak in the laundry area happened last year, around the end of December 2025. At around the same time, Staff I notified the FMD. Since that time, Staff I had been using dry blankets to soak up the water. Staff I stated water leaks from the main water line to the wall behind the washing machine, then flowed through to the side of the washing machine, and sometimes into her work area on the dirty side of the laundry room. Staff I stated FMD was trying to fix it, but it kept leaking. Staff I stated that a negative outcome would be that laundry staff could slip and fall if the water was there and the floor was wet. She stated that if the water stood for too long, it could create mold. In an interview on 03/05/2026 at 12:40 PM, with the FMD revealed that Staff I reported the leakage to him two weeks ago. The FMD stated that at any point, if anything in the facility needed fixing, he took care of it. For the leakage in the laundry area behind the washer, FMD applied Flex Seal spray (black), but it started leaking again. The FMD mentioned that the leak was so minor that it was at the bottom of the pipe and could easily be dried with a dry blanket. The FMD could not address any negative outcomes of the leakage.In an interview on 03/05/2026 at 12:55 PM with the ADM, revealed that the FMD did not need to report any maintenance to the ADM, since the facility had life-safety and maintenance resources in place. However, if anything was more maintenance-intensive, the FMD could let him know. He stated that failing to fix the laundry leak could pose a fall hazard to laundry service staff.In an interview on 03/05/2026 at 12:59 PM with the LM, revealed that the LM's expectations of the facility FMDs were that they fix everything themselves, but if at any point the FMD could not fix something, they could call the LM for help or submit a work order via the Tels system (system used for inputting and tracking maintenance requests),. The LM mentioned that the leak may not require a licensed plumber if they could fix it themselves. He stated it should not take more than two weeks to fix a problem unless the FMD had already tried to fix it and the problem came back. Review of the facility policy titled Maintenance/Request for Repairs, undated, revealed All requests may be entered into Tels system, this will create a work order. All work orders generated in Tels will automatically be sent to maintenance for completion. Review of the facility's maintenance logbook did not address the water leak in the laundry room. The review of the facility's Tels system's Work Order Report did not include a summary of the water leak in the laundry room .Review of the facility policy titled Maintenance/Request for repairs undated, revealed, All requests may be entered into Tels system, this will create a work order. Information will include: repair needs, area in need of repair, and name of staff member requesting repair.