STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675891	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Hospital Authority	2108 15th Street Bridgeport, TX 76426

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
	675891	A. Building B. Wing	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Decatur Hospital Authority	2108 15th Street Bridgeport, TX 76426

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to keep the environment as free from accident hazards for 1 (Resident #1) of 4 residents reviewed for accidents. The facility failed to ensure Resident #1's environment was free from accidents and hazards when being pushed by another resident, with her permission, from a smoke break. While going up the ramps towards the entrance to the door, Resident#1's wheelchair got stuck on the ramp on 300 hall, as the ramp does not cover the length of the doorway, and she fell face first on 10/27/25. On 10/29/2025 at 5:22pm an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/29/25, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of accidents, hazards and a decline in quality of care. Findings included:Record review of Resident #1's face sheet, dated 10/29/25, reflected a [AGE] year-old female, admitted [DATE] and readmitted [DATE], diagnosed with but not limited to: traumatic subdural hemorrhage without loss of consciousness (a condition where a collection of blood (hematoma) forms between the brain and its outer covering (dura mater) after a head injury, without the person experiencing a loss of consciousness) -onset 10/28/25, unspecified sequelae (a condition which is the consequence of a previous disease or injury)of cerebral infarction (long-term complications or after effects of a stroke (cerebral infarction) that cannot be specifically identified or classified), type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema (high blood sugar levels over time can damage the blood vessels in the retina. This damage can lead to the formation of small, leaky blood vessels.), bilateral, morbid (severe) obesity due to excess calories, anxiety disorder unspecified, depression unspecified, hemiplegia and hemiparesis (weakness on half of the body) following (body mass index (BMI) of 40 or higher, or a BMI of 35 or higher) cerebral infarction affecting right dominant side ((stroke) affecting the right dominant side of the brain would cause symptoms on the left side of the body, such as weakness or paralysis (left hemiparesis or hemiplegia), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (person has experienced weakness (hemiparesis) or paralysis (hemiplegia) on their left side due to damage to the right side of their brain),acquired absence of right and left leg below knee (double below-knee amputation). Record review of Resident #1's BIMS Evaluation, dated 10/28/25, reflected her BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #1's care plan, dated 10/28/25, reflected at risk for falls r/tdeconditioning, incontinence, psychoactive drug use, unaware of safety needs, Biliteral BKA, Bilateral Hemiplegia, Hx of CVA, dialysis, and was non-compliant with her POC. [Resident#1] goal reflected [Resident#1] will not sustain serious injury. [Resident#1] interventions reflected: [Resident #1] to be given frequent reminders to not lean forward or over the side while in wheelchair as she will fall r/t having bilateral lower amputations and is morbidly obese with poor balance. Record review of Resident #1's weight, dated 10/28/25, reflected 271 pounds. Record review of Resident #1's care plan, dated 07/15/25 reflected, an ADL self-care performance deficit r/t limited mobility and hemiplegia. Resident #1's goal was to maintain current level of function. Resident #1's intervention included bed mobility extensive with one person assist and transfer extensive with two-person assist. Record review of Resident #1's weight, dated 10/28/25, reflected 271 pounds. Record review of Resident #1's care plan, dated 07/15/25 reflected, an ADL self-care performance deficit r/t limited mobility and hemiplegia. Resident #1's goal was to maintain current level of function. Resident #1's intervention included bed mobility extensive with one person assist and transfer extensive with two-person assist. Record review of Resident #1's progress notes, dated 10/27/25 to 10/29/25, reflected: 10/27/25 [Resident#1] witnessed fall and hospital transfer written by LVN A. 10/27/25 LVN A contacted by local ER nurse. Nurse stated cranial bleed (Involve bleeding in or around the brain) confirmed, transferred to another hospital. Trauma care pending. ER nurse stated resident was requesting to leave AMA to return to facility. LVN A informed ER nurse per facility admin resident was unable to return d/t [sic] current diagnoses. ER nurse reports resident was no longer seeking AMA and would continue to receive treatment. LVN A will continue f/u with ER on resident's condition. 10/28/25 [Resident#1] returned back to facility.Educated on staff only pushing wheelchair. Record review of Resident #1's hospital record, dated 10/28/25, reflected: diagnosed with Traumatic subdural hemorrhage without loss of consciousness, initial encounter. Record review of Resident #2's face sheet, dated 10/30/25, reflected a [AGE] year-old male, admitted [DATE], diagnosed with but not limited to: lack of coordination