STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675942	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towers Nursing Home	372 Hill Road Smithville, TX 78957

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received care, consistent with professional standards of care to prevent development or promote wound healing for one (Resident #1) of three residents reviewed for pressure ulcers. The facility failed to provide treatments on 03/19/2026 and 03/25/2026 to a pressure ulcer on Resident #1 buttocks. This failure could place residents at risk for worsening pressure ulcers leading to discomfort, pain, and potential infections. Findings included: Record review of Resident #1's face sheet, dated 03/31/2026, reflected Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] and readmitted on [DATE] with a diagnosis muscle wasting and atrophy, not elsewhere classified, multiple sites (a significant decrease in muscle mass and strength that cannot be attributed to a more specific diagnosis- atrophy is defined by shrinking muscles often due to immobility or aging), iron deficiency anemia (a common condition where the blood lacks sufficient healthy red blood cells due to lack of iron), and muscle weakness (a reduced capacity to exert force with one or more muscles, often presenting as difficulty performing daily tasks like lifting, walking, or grasping objects). Record review of Resident #1's admission MDS Assessment, dated 02/25/2026, reflected Resident #1 had a BIMS score of 99 (she was unable to respond to any questions) which indicated her cognition was severely impaired. She had short- and long-term memory recall. She had was admitted with a stage 2 pressure ulcer. Resident #1 had pressure reducing device for bed. She received pressure ulcer/injury care. Record review of Resident #1's Comprehensive Care Plan revised on 03/03/2026, reflected Resident #1 had an alteration in skin integrity related to the presence of stage 2 pressure ulcer/injury on the buttocks. Interventions:Apply treatment as ordered. Assess and document on status of pressure ulcer/ injury weekly and as needed.Assess complications, including signs and symptoms of infection (drainage, redness, increased warmth, odor, tenderness, etc.). Notify Doctor with identification of skin integrity impairments. Turn and reposition as needed. Review of Resident #1's physician orders, dated 3/18/2026 reflected wound care: cleanse with wound cleanser and pat dry. Apply zinc oxide to wound bed and leave open to air once daily until resolved. Review of Resident #1's Treatment Administration Record dated, March 2026, revealed Resident #1 had the following order: Wound Care: Cleanse with wound cleanser and pat dry. Apply zinc oxide to wound bed and leave open to air once daily until resolved (every day shift for wound care). Resident did not receive wound care on 03/18/2026 and on 03/25/2026- According to the Treatment Administration Record dated March 2026. Review of Resident #1's Skin Assessment Nurses Notes, dated 03/17/2026, reflected Resident had Stage 2 pressure ulcer/injury with partial thickness, skin loss with exposed dermis to buttocks. Wound was present on admission. No undermining (a serious complication where the tissue under the wound edges separates from the underlying structure, creating a hidden pocket) or tunneling (a serious, deep wound where tissue destruction creates a narrow channel or passageway beneath the skin's surface, extending from the main wound bed). Review of Resident #1's Skin Assessment Nurses Notes, dated 03/24/2026, reflected Resident #1 had Stage 2 pressure ulcer/injury with partial thickness, skin loss with exposed dermis to buttocks. Wound was present on admission. There is no undermining or tunneling. Interview on 03/31/2026 at 2:30 pm, the Nurse Practitioner stated Resident #1's overall (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	health is improving. She stated a few weeks ago we were not expecting her to live. The Nurse Practitioner stated she was sitting up in wheelchair, eating better and her skin concerns has not deteriorated they have improved. She stated there was no negative outcome of Resident #1 not receiving treatment to her skin concerns on 03/18/2026 and 03/24/2026. She stated Resident #1's overall cognition and physical condition have improved above her baseline. The Nurse Practitioner stated it was a miracle she had recovered physically and mentally from a few weeks ago. She stated Resident #1 is doing great and there was no issues with her skin concerns deteriorating. She stated the nurses calls her of any changes with Resident #1 and she stated I am very pleased of Resident #1's care and her physical condition at this time. I have no concerns of her care at the facility. Interview on 03/31/2026 at 3:30 pm, the Director of Nurses stated Resident #1's skin concerns did not deteriorate from missing 2 treatments on 03/18/2026 and 03/24/2026. She stated she did not know why she missed those treatments; however, she would investigate and complete in services the importance of completing treatments to skin concerns. She stated a full investigation would be completed. She stated she had in-service staff on wound treatments recently. The Director of Nurses stated she could not recall the date. Interview on 04/01/2026 at 1:45 pm, the Nurse Consultant stated she reviewed Resident #1's medical record and her skin concerns did not deteriorate from missing treatment to her buttocks on 03/19/2026 and 03/24/2026. She stated her wound remained the same. The Nurse Consultant stated there was a possibility if a resident was not receiving treatment on a regular basis the wound may increase in size. She stated an investigation was in process of why these 2 treatments on Resident #1 were missed. She stated there was no evidence according to Resident #1's medical record of any deterioration of her wound from 03/19/2026 to 03/25/2026. The Nurse Consultant stated in-services were in the process with all nurses related to skin concerns and treatments. She stated at this time the treatment nurse was on leave of absence; however, he was present at the time when the treatments to Resident #1 were missed. She stated the infection control preventionist, Director of Nurses or Charge Nurse was completing wound care at this time. Interview on 04/01/2026 at 3:00 pm, the Administrator stated the treatment nurse was on leave of absence at this time. She stated she expected the nurses to follow each resident's physician orders and follow any type of treatment plan for skin concerns. The Administrator stated if treatment was not completed as ordered there was a potential the wound may deteriorate. She stated Resident #1's wound did not deteriorate when she did not receive treatment on 3/19/2026 and 3/24/2026. The Administrator stated a full investigation would be conducted of why the treatments to Resident #1 were missed. Record review of Nursing Inservice on Nursing Education, dated 08/19/2025 and 08/20/2025, reflected skin concerns and wound treatment documentation was discussed. Record review of Facility Policy on Pressure Injury Prevention and Management, dated 08/15/2022, reflected This facility is committed to the prevention of avoidable pressure injuries and promotion of healing of existing pressure injuries. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including assessment and treatment.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with indwelling catheter received the appropriate care and services to prevent urinary tract infections for 1of 3 residents (Resident #2) reviewed for indwelling urinary catheters. The facility failed to ensure Resident #2's urinary drainage bag tubing and bag were kept from touching and resting on the floor. This failure could place residents with indwelling catheters at risk of developing infections. Findings included: Record review of Resident #2's face sheet reflected Resident #2 was admitted to the facility on [DATE] with diagnosis which included need for assistance with personal care (a person required help from a caregiver to safely manage daily ADLs), unspecified dementia (a diagnosis used when a patient exhibits clear symptoms of cognitive decline in memory loss, but a specific cause cannot yet be determined), and displaced intertrochanteric fracture of left femur, initial encounter for closed fracture (a severe break in the upper thighbone, where the bone fragments have shifted out of alignment - initial encounter for closed fracture signified this is the first medical assessment for a broken bone that has not broken through the skin). Record review of Resident #2's admission MDS was in progress, dated 3/30/2026. Record review of Resident #2's Baseline Care Plan revised on 03/28/2026, reflected Resident #2 had an indwelling suprapubic catheter (a tube inserted into the bladder through a small abdominal incision): 16 foley with 10 ml balloon. Intervention: Resident #2 had 16 French foley with 10 ml balloon. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Check tubing for kinks once each shift. Monitor and document intake and output as ordered. Monitor/ document for pain/discomfort due to catheter. Monitor/record/ report to Medical Doctor for signs and symptoms of UTI (an infection in any part of the urinary system): pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. Resident #2 had a behavior problem related to hitting staff secondary to pain. Interventions: Administer medications as ordered. Monitor and document for side effects and effectiveness. Caregivers to provide opportunity for positive interaction and attention. Stop and talk with Resident #2 when passing by her. If reasonable, discuss Resident #2's behavior. Explain/ reinforce why behavior is inappropriate and/ or unacceptable to the resident. (There was not a care plan of resident throwing things such as catheter when the care plan was printed prior to 9:45 am on 3/31/2026). Observation and interview on 03/31/2026 at 9:04 am reflected, Resident #2 was sitting up in her bed. Her bed was in low position; she had fall mat beside her bed. Resident #2 had indwelling catheter. Her catheter bag had kinks in the tubing, and the bag was lying on the floor halfway underneath the bed. Resident refused to be interviewed. Observation on 03/31/2026 at 9:20 am reflected Resident #2 was lying in bed. Her bed was in low position. Resident #2's indwelling catheter continued to be kinked and was lying on the floor in a covered bag partially under the bed. Interview on 03/31/2026 at 9:23 am MDS Coordinator LVN stated Resident #2 had behavior problems and would hit staff during care and would throw things in the room. She stated her behaviors were care planned. The MDS Coordinator LVN stated the catheter bag could not on the floor and it was not to be kinked. She stated urine could back up into the bladder and Resident #2 could develop a UTI, or any type of infection such as sepsis (a life - threatening medical emergency caused by the body's extreme, dysfunctional response to an infection). MDS Coordinator LVN stated the bag should not be kinked related to it could affect the urine from not flowing into the bag. She stated the catheter bag was to be hung on side of the bed and below the bladder. She stated it was unacceptable for catheter bag to be lying flat on the floor. She stated she had been in-service on catheter bags but could not recall the date. Interview on 04/01/2026 at 11:00 am, LVN A stated anytime a resident had an indwelling catheter it was to be hanging below the bladder with tubing on (continued on next page)

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