

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675942	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Towers Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs for 2 (Resident # 27 and Resident #30) out of 8 residents reviewed for call lights. The facility failed on 07/29/2025 to ensure Resident # 27 and Resident #30's call light was within reach to use. This failure could affect all residents who needed assistance and could result in needs not being met. Findings included: Review of Resident #27's face sheet, dated 07/30/2025, reflected [AGE] year-old female who was admitted on [DATE] and readmitted on [DATE]. Resident #27 had diagnoses which included unspecified dementia, mild, with psychotic disturbance (memory and thinking problems that are mild and not specifically identified and includes behaviors such as delusions- a false belief of reality), unsteadiness on feet (a lack of stability or coordination while walking or standing), need assistance for personal care (a person needs assistance with daily living activities such as: bathing, dressing, toileting, and grooming), and age related physical debility (characterized by decreased in strength, endurance, and balance, often leading to a higher risk of falls, disability, and hospitalization). Review of Resident #27's Quarterly MDS, dated [DATE], reflected the resident BIMS assessment was completed by staff. Resident #27 had poor short- and long-term memory recall (having difficulty remembering things that have just happened or been learned). She required partial/moderate assistance (helper does less than half the effort) with personal hygiene, dressing, showers, transfers, and toileting. Resident #27 did not reject care. Review of Resident #27's Comprehensive Care Plan, with a completion date 06/29/2025, Resident #25 had an ADL self-care performance deficit. Interventions: Resident required partial/moderate assistance with transfers, dressing, personal hygiene, and picking up objects. Resident #25 was high risk for falls related to impaired cognition with poor safety awareness, inability to bear weight without assistance. Intervention: Ensure Resident #27's call light was within reach and encourage the resident to use the call light for assistance as needed. She required prompt response to all requests for assistance. Resident #27 needed a safe environment with a working and reachable call light. Observation and interview on 07/29/2025 at 7:15 AM, revealed Resident #27 was lying in bed. Her call light was approximately 8 feet from her bed lying on the over the bed rolling table. Resident #27 was unable to reach her call light. She stated yes when asked if she knew how to use a call light. Resident #27 stated leave my room. Interview on 07/29/2025 at 7:18 AM CNA C entered Resident #27's room and stated Resident #27's call light was on the floor and Resident #27 was unable to reach the call light. She stated Resident #27 did use the call light. CNA C stated all residents call light was required to be within reach of all residents when a resident was in their room. She stated if a resident was unable to reach their call light and needed assistance, there was a possibility a resident may need nursing assistance. She stated a resident may attempt to assist self out of bed and fall trying to get assistance. She stated Resident #27 was a fall risk. She stated she had been in-serviced on placing call lights within resident's reach. CNA C stated she did not recall the date of the in-service. She stated if the nursing staff was not near the resident's room, it was a possibility the staff would not hear a resident yell for help. CNA C stated any staff entered a resident room was responsible to ensure the call light was within reach of the resident. Review of Resident #30's face sheet, dated on 07/29/2025, reflected a 88- year-old-female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia , unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety (memory and thinking problems that are mild and not specifically identified without behaviors), unsteadiness on feet (a lack of stability or coordination while walking or standing), and need assistance for personal care (a person needs assistance with daily living activities such as: bathing, dressing, toileting, and grooming). Review of Resident #30's Quarterly MDS Assessment, dated 06/06/2025, reflected Resident #30 had a BIMS score of 1, which indicated her cognition was severely impaired. Resident #30 did not reject care. She required partial/moderate assistance (helper does less than half the effort) with personal hygiene, showers, toileting and lower body dressing. She required supervision/or touching assistance (helper provides verbal cues and/ or touching assistance) with the following: upper body dressing, and oral hygiene. Review of Resident #30's Comprehensive Care Plan, with a completion date 06/28/2025, reflected Resident #30 had an ADL self-care performance deficit. Interventions: Encourage Resident #30 to use call light for assistance. She required assistance with personal hygiene, showers, dressing, and toileting. Resident #30 was a high risk for falls related to generalized weakness and poor safety awareness. Intervention: Resident #30 needs a</p>		

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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. (continued on next page)

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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, and personal and oral hygiene for two of eight residents (Resident# 30 and Resident # 65) reviewed for ADL care. The facility failed on 07/29/2025 to ensure Resident #30, and Resident #65's fingernails were cleaned. This failure could place residents at risk of not receiving services or care, diminished quality of life, and decreased self-esteem. Findings included: Review of Resident #30's face sheet, dated on 07/29/2025, reflected a 88-year-old- female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety (memory and thinking problems that are mild and not specifically identified without behaviors), lack of coordination (the inability to smoothly and precisely control movements), and need assistance for personal care (a person needs assistance with daily living activities such as: bathing, dressing, toileting, and grooming). Review of Resident #30's Quarterly MDS Assessment, dated 06/06/2025, reflected Resident #30 had a BIMS score of 1, which indicated her cognition was severely impaired. Resident #30 did not reject care. She required partial/moderate assistance (helper does less than half the effort) with personal hygiene, showers, toileting and lower body dressing. She required supervision/or touching assistance (helper provides verbal cues and/ or touching assistance) with the following: upper body dressing, and oral hygiene. Review of Resident #30's Comprehensive Care Plan, with a completion date 06/28/2025, reflected Resident #30 had an ADL self-care performance deficit. Interventions: required assistance with personal hygiene, showers, dressing, transfers and toileting. Observation and interview on 07/29/2025 at 7:28 AM, revealed Resident #30 was in her lying in bed. She had a blackish/ brownish substance underneath the middle and ring fingernails on her right hand. Resident #30 was not interview able. Record review of Resident # 65's face sheet dated 07/31/2025 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #65 had diagnoses which included unspecified dementia with mood disturbance (memory and thinking problems that are mild and not specifically identified and includes behaviors), need for assistance with personal care (a person needs assistance with daily living activities such as: bathing, dressing, toileting, and grooming), and muscle weakness (a reduced ability to generate force in one or more muscles, impacting physical performance and daily activities). Record review of Resident #65's Quarterly MDS Assessment, dated 06/28/2025, reflected Resident #65 reflected the resident BIMS assessment was completed by staff. Resident #65 had poor short- and long-term memory recall (having difficulty remembering things that have just happened or been learned). Resident #65 required substantial/maximal assistance (helper does more than half the effort) with the following: personal hygiene, dressing, showers, toileting, oral hygiene, and transfers. Record review of Resident #65's Comprehensive Care Plan, with completion date of 07/02/2025, reflected Resident #65 had an ADL self-care performance deficit related to weakness. Intervention: Resident #65 required substantial/maximal assistance with personal hygiene, dressing, transfers showers, toileting and oral hygiene. Observation and interview on 07/29/2025 at 7:40 AM, revealed Resident #65 was in her room lying in bed. She had a blackish/ brownish substance underneath the middle ring and fore fingernails on her right hand. Resident #65 was not interview able. In an interview on 07/29/2025 at 7:18 AM, CNA C stated the CNAs (Certified Nurse Assistant) were responsible for cleaning, trimming, and filing all residents' nails except for the residents with a diagnosis of diabetes (a disease occurs when blood sugar is too high). She stated the nurses were responsible for all the residents' nails with a diagnosis of diabetes. CNA C stated the residents' nails were usually cleaned on Sundays, their shower days and as needed. She stated if there was a blackish substance on the residents' fingertips or underneath their nails and the resident swallowed the blackish substance there was a possibility a resident may become ill, such as vomiting and diarrhea. CNA C stated she was in-serviced on cleaning, filing, and trimming residents' nails but she did not recall the date. She stated she had given care to Resident # 30 and Resident #65, and they did not refuse nail care. In an interview on 07/31/2025 at 9:45 AM, LVN E stated the nurses were responsible for residents with diagnosis of diabetes with nail care such as trimming, cleaning, filing. She stated the CNAs were responsible for all other residents' nail care. CNA C stated if a resident had brownish/blackish substance underneath their nails and if a resident swallowed the substance there was a possibility a resident may become ill, such as stomach problems nausea and vomiting. She stated she was in- serviced on nail care, however she did</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections and follow accepted national standards for two of six residents (Resident #10 and Resident #93) reviewed for infection control practices. The facility failed to ensure: MA B followed good nursing practices when preparing medications to prevent cross contamination of oral medications for Resident #93 on 07/30/2025 when MA B failed to perform hand hygiene and don gloves prior to touching Resident #93's medications with contaminated, ungloved hands. RN A used sanitary supplies during medication administration via g-tube (a tube inserted into the stomach) for Resident #10 when on 07/30/2025 RN A did not sanitize a tray table prior to use supplies and medications on while administering medications to Resident #10 via gastrostomy tube. This failure could place the resident at risk for cross contamination and infection. Findings included: 1. Review of Face sheet for Resident #93 reflected a [AGE] year-old female, admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease (dementia that damages the brain), Congestive Heart Failure (heart disease that affects pumping action of the heart muscles), Legal Blindness (visual impairment limiting everyday tasks), and Gastro-esophageal reflux disease (acid from the stomach frequently backs up into the esophagus). Review of Annual Assessment MDS for Resident #93 dated 06/26/2025 reflected a BIMS score of 5 (severe cognitive impairment). Section B- Hearing, Speech, and Vision section indicated she was able to understand others and is able to make her ideas and wants known to others. Review of Care Plan for Resident #93 reflected a Problem section stating, [Resident #93] has impaired cognitive function or impaired thought processes r/t Alzheimer's. Date Initiated: 04/10/2018, with related Interventions stating, Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 04/10/2018 and [Resident #93] needs supervision with all decision making. Date Initiated: 09/07/2020. Review of Physician Orders for Resident #93 reflected an order for, Regular diet, Regular texture, Regular Liquids consistency started on 03/05/2019. Observation of Medication administration for Resident #93 on 07/30/2025 at 7:54AM revealed that MA B performed hand hygiene prior to dispensing medications. She then touched the medication carts, medication cards, and computer keyboard prior to using ungloved hands to remove two pills from the medication cup for Resident #93. In an interview with MA B on 07/30/2025 at 8:00AM, she stated that she should have cleaned her hands and put on gloves before taking the pills out of the cup. She stated that the potential risk to the resident was that they, could get sick. 2. Review of Face sheet for Resident #10 reflected a [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses included Aphasia (difficulty using or comprehending language), Dysphagia (difficulty swallowing), and Gastrostomy status (gastrostomy tube in place, a tube inserted into the stomach). Review of Quarterly Assessment MDS for Resident #10 dated 05/05/2025 reflected a BIMS score of 12 (moderate cognitive impairment). Section B-Hearing, Speech, and Vision indicated that Resident #10 is usually able to understand others and usually able to make his ideas and wants known to others. Review of Care Plan for Resident #10 reflected a Problem area stating [Resident #10] has the need for Enhanced Barrier Precautions due to a feeding tube Is at risk for infection, depression, feelings of isolation, and decline in physical activity Date Initiated: 05/10/2024 and a related Intervention stating, Administer medication as ordered. Date Initiated: 05/10/2024. Review of Physician Orders for Resident #10 reflected and order for, NPO (nil per os-nothing by mouth) diet, NPO texture, Nectar Thickened Liquids consistency with a start date of 07/04/2025 and medication orders are all noted to be administered via G-Tube or PEG-Tube (percutaneous gastrostomy tube-a type of gastrostomy tube that is inserted into the stomach). Observation of medication administration for Resident #10 on 07/30/2025 at 10:49AM with RN A revealed that she asked another staff member to bring her a tray table from the resident room directly across the hall from Resident #10. She then used the tray table from the other room to set all of her supplies and medications on while administering medications to Resident #10 via gastrostomy tube. In an interview with RN A on 07/30/2025 at 12:11PM, who stated that she should have cleaned the tray table before she used it for Resident #10. She stated that the risk of sharing un-sanitized equipment between residents is the potential for infection. In an interview on 07/31/25 at 1:00PM, the ADMIN who stated that she expected staff to follow the infection control practices for the facility. She stated she would not expect staff to touch medications with their bare hands. She stated that she expected staff to</p>		