STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675978	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Grace Wellness Center	1241 W Marshall Howard Blvd Littlefield, TX 79339

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care for 1 (Resident #1) of 5 residents reviewed for behavioral health services. The facility failed to ensure Resident #1's comprehensive care plan included goals and interventions addressing her documented history of aggression, refusal of care and the use of psychotropic medication for behavioral management related to her behavioral diagnosis.This failure could place residents at risk for diminished quality of life due to the lack of treatment and prevention to maintain resident safety. Findings included:Record review of Resident #1's face sheet dated 12/22/2025 revealed she was a [AGE] year-old female resident originally admitted to the facility on [DATE] with diagnoses to include but not limited to Alzheimer's disease with late onset (memory loss, confusion), unspecified speech disturbance (difficulty in pronouncing words), intermittent explosive disorder (frequent impulsive anger outburst or aggression), major depressive disorder (depression) and generalized anxiety disorder (feeling anxious).Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed Resident #1 had a BIMS score of 14 out 15 indicating her cognition was intact. The MDS further stated Resident #1 took an antianxiety medication and rejected care 1 to 3 days.Record review of Resident #1's active physician orders revealed an order for Depakote Sprinkles 125 mg, administered twice daily, related to intermittent explosive disorder, initiated on 11/29/2025.Resident #1 did not have any active orders for Lexapro.Record review of Resident #1's discontinued physician orders revealed an order for Lexapro Oral Tablet 10 mg discontinued on 11/5/2025. Record review of Resident #1's comprehensive care plan revised on 12/11/25 revealed it did not include goals or interventions related to her behaviors. The care plan did not address her intermittent explosive disorder or her anxiety disorder. There was no mention of her medication management or behavioral monitoring related to her medication. There was no documentation of Resident #1 having aggressive behaviors or refusing care. The care plan mentioned Resident #1's major depressive disorder, receiving Lexapro and to encourage frequent socialization as an intervention.Record review of Resident #1's Administration Record for November 2025 indicated behavioral monitoring documented that Resident #1 refused care on November 8, 12, 13, 27, and exhibited aggression on November 24 and 26. Record review of Resident #1's Administration Record for December 2025 indicated behavioral monitoring documented that Resident #1 refused care on December 5, 6, 10, 11, 15, 16 and exhibited aggression on December 2, and 6. In an interview on 12/22/2025 at 10:13 AM, LVN B stated Resident #1 could be aggressive with staff. If staff had something Resident #1 wanted, she would get agitated and try to grab it from the staff, such as food. LVN B stated she had not observed Resident #1 being aggressive toward other residents. LVN B stated Resident #1 liked to walk around the building so staff would take her on walks when she was agitated. LVN B further stated that interventions should be included in the residents' care plan so staff would be aware of what works for the residents when they become agitated or aggressive. In an observation and interview on 12/22/2025 at 11:30 AM, Resident #1 was in the dining room, she was clean and dressed for the day, she appeared calm, walking around in the dining room. Resident #1 did not verbalize any concerns related to her care. In an interview on 12/22/2025 at 1:30 PM, MDS Coord. stated he was responsible for updating the resident's care plan and if he was unavailable, the responsibility would fall to Administration. The MDS Coord. stated Resident #1's care plan was missing her diagnoses, her behavioral diagnosis with the medication management, her aggression and her refusal of care. The MDS Coordinator also stated he missed revising the documentation related to her Depression and the discontinued medication Lexapro. The MDS Coord stated that he did not feel the nursing staff used the care plans to check the status of a resident, it was more for when State would come into the building. The MDS Coordinator, however, said the care plan should reflect the current status of a resident. The MDS Coord. stated the facility does not do morning meetings every morning to relay this information. In an interview on 12/22/25 at 2:45 PM, LVN A stated she was not aware of any specific behavioral interventions for Resident #1 other than redirecting. LVN A stated Resident #1 could be aggressive toward staff or if she wanted something staff had, such as food or a drink, she would grab it from staff. LVN A stated if interventions were not addressed per specific behavior, then a possible negative outcome would be that the behavior could possibly get worse. LVN A stated the MDS Coordinator was responsible for ensuring care plans reflected the resident's status. In an interview on