

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675981	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Mineola Gardens Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 716 Mimosa Dr Mineola, TX 75773	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 3 residents reviewed for misappropriation. (Resident #1) The facility failed to prevent CNA A from taking Resident #1's debit card and spending \$1103.11 from 06/27/26 through 07/13/26. This failure could place residents at risk for decreased quality of life, misappropriation of property, and loss of dignity. Findings included: Record review of Resident #1's face sheet, dated 07/28/26, reflected that he was a [AGE] year-old male, most recently readmitted to the facility on [DATE]. His diagnoses included altered mental status (any sudden or gradual change in a person's thinking, awareness, or level of consciousness), cirrhosis of liver (permanent scarring of the liver caused by long-term damage, leading to symptoms like fatigue, yellow skin, and belly swelling), and spinal stenosis (a narrowing of the spaces within your spine that puts pressure on your spinal cord and nerves, most commonly caused by wear-and-tear arthritis, aging changes, or bone spurs). Record review of Resident #1's quarterly MDS assessment, dated 07/20/26, reflected that he had a BIMS score of 05, which indicated severe cognitive impairment. Further record review indicated Resident #1 was able to understand others and he was able to make himself understood. This MDS indicated Resident #1 did not exhibit behaviors of rejection of care or wandering and was completely dependent on staff for toileting, bathing, dressing, and transfers. He required substantial assistance for eating, oral hygiene, personal hygiene, and rolling left and right. Record review of a police report, dated 07/20/26, reflected that Resident #1 was the victim. Friend A was the reporter. It identified that a debit card was stolen. The report reflected the following: On Monday, July 20, 2026, at approximately [11:23AM], I, [Officer B], of the [facility city] Police Department Patrol Division, was dispatched to [facility address], [facility city], [facility county], Texas [facility zip code] on the report of fraud. [Dispatcher name] of the [facility city] Police Department Communications Division advised the reporting party contacted the [facility city] Police Department and stated someone used [Resident #1's] debit card without him knowing. Upon arrival at approximately [11:23AM], I, [Officer B], made contact with the reporting party, [Friend A]. [Friend A] stated that his neighbor and friend, [Resident #1], is a resident at this location. [Friend A] advised me that he has been helping [Resident #1] pay his bills and sort out his affairs after he became sick. [Friend A] stated that on today's date he arrived at this location to assist [Resident #1] in sending money from his bank account to his landlords. [Friend A] advised that upon opening [Resident #1's] banking account, he found his account was in the negative. [Friend A] stated he knew this was not right, as [Friend A] does not make transactions other than his bills, which he assists him with. [Friend A] advised that he thinks that a staff member at this location assisted [Resident #1] in paying his phone bill with his debit card and afterward kept the debit card, which they began using. I, [Officer B], asked [Friend A] which bank [Resident #1] uses, to which he stated [Bank Name]. [Friend A] also advised that the total (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	amount spent by the suspect was \$1003.00. [Friend A] advised [Officer B] that he looked at [Resident #1's] cell phone and found multiple transactions, all local to the [facility area] in various businesses. [Friend A] stated he asked [Resident #1] which staff member helped him, but due to his failing health and mental condition, he could not remember. [Friend A] advised he also checked to see if anyone else had visited [Resident #1] but no one did. [Friend A] advised that about a week and a half ago he had come to assist [Resident #1] with making his cell phone payment, but once he arrived, he could not find [Resident #1's] wallet. [Friend A] stated staff found the wallet at the nurses' station, but [Friend A] advised the debit card was not inside. Thinking that [Resident #1] had misplaced the card, [Friend A] did not file a report at that time. [Friend A] advised that he would like to file charges on behalf of [Resident #1] as his caretaker. Record review of a series of undated screenshots provided by Friend A, reflected there were a total of 50 disputed transactions totaling \$1103.11. The screenshots indicated these transactions were disputed on 07/20/26. During an interview on 07/28/26 at 11:04AM, Resident #1 was unable to describe what had happened related to his debit card. He spoke of other unrelated stories. He said he does have a friend that helps him pay his bills. He was unable to describe anyone else that may have helped him pay his bills. He said if someone took over \$1000 from him, he would be very upset. During an interview on 07/28/26 at 11:25AM, the HR Director said she was in the facility when CNA A was arrested. She said the police showed up to the facility and arrested CNA A while he was working on 07/22/26 around 6:00PM. She said the police told her that they arrested him on prior warrants and when they searched him Resident #1's debit card and social security card were on his person. She said she was not the HR director when he was hired but he did have criminal mischief charges and jumping bail charges on his background check and she would not have hired him. She said his criminal history and NAR checks were completed prior to hire on 01/16/26. During an interview on 07/28/26 at 11:29AM, Friend A said he was a friend of Resident #1. He said he went to the nursing facility and they found his wallet at the nurse's desk. He said he looked through it and could not find the debit card. He said he looked at Resident #1's bank account and the charges started on the 27th of June, 2026, and continued through 13th of July, 2026. He said after this it stopped because Resident #1 ran out of money. He said the total amount of money that was stolen from Resident #1 was \$1103. He said there were charges at dollar general, dollar tree, and a liquor store in [approximately 30 miles from the facility]. He said the debit card was also used at the facility vending machines several times. He said he reported all this to the police and the police said that CNA A had Resident #1's debit card and social security card on him when he was arrested. He said they did put stop payments on Resident #1's account with the bank and they were working with the bank to get the money recovered. During an interview on 07/28/26 at 12:58PM, Sergeant C of the [facility city] Police Department said they arrested CNA A because he had outstanding warrants from another county. He said when they searched his person, they found Resident #1's debit card and social security card on CNA A. He said he was unable to share anything else because the investigation was ongoing. During an interview on 07/28/26 at 02:00PM, the DON said the DON and ADON were newly hired as of 07/27/26 and did not have any firsthand knowledge of Resident #1's stolen card, or CNA A. During an interview on 07/28/26 at 02:02PM, the Administrator said she took over as the Administrator about 5 weeks ago. She said Friend A arrived to the facility to help Resident #1 pay bills. She said Friend A was unable to locate Resident #1's debit card. She said Friend A looked at Resident #1's bank statements and saw unauthorized charges. She said the police were notified and they began their investigation. She said they did not have any reason to suspect CNA A had taken this card. She said she had never seen Resident #1 leave out his debit card. The police took a report on July 20th 2026. She said they (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	returned on July 22nd, 2026 and arrested CNA A. She said the police did not speak with her. She said the police would not share anything with them, including bank statements. She said she expected CNA A to not steal Resident #1's debit card. She further said the Abuse Prevention and Prohibition Program policy covers misappropriation of property, and they did not have another policy that covered misappropriation. Record review of the facility's policy, Abuse Prevention and Prohibition Program, last revised 10/24/22, reflected: .Policyl. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property.Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.		