

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Twilight Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 W Fourth Ave Corsicana, TX 75110	

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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) and refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for two (Resident #11 and Resident #56) of fourteen residents reviewed for PASARR screenings.</p> <p>The facility failed to ensure Resident #11 and Resident #56's PASARR Level One screenings accurately reflected their diagnoses of mental illness and submit a corrected PASARR level one screening.</p> <p>This failure placed residents at risk of not receiving or benefiting from specialized therapies they may require.</p> <p>Findings included:</p> <p>Review of Resident #11's MDS Assessment, dated 10/02/2024, reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of bipolar disorder, depression, and anxiety.</p> <p>Review of Resident #11's PASARR Level One Screening, dated 09/30/2024 and conducted by an acute care hospital, reflected Resident #11 was negative for mental illness, intellectual disability, and developmental disability.</p> <p>Review of Resident #11's physician's order report dated active orders as of 05/12/2025 reflected she was receiving Escitalopram Oxalate, one time a day, for major depressive disorder.</p> <p>Record review of Resident #56's quarterly MDS assessment, dated March 14, 2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included polyosteoarthritis (a form of arthritis that affects multiple joints), muscle weakness, hypertension (high blood pressure), stroke, non-Alzheimer's dementia (memory loss of thinking problem caused by changes in the brain that are not related to Alzheimer's Disease), anxiety disorder, psychotic disorder (other than schizophrenia; group of mental illnesses characterized by psychosis), delusional disorders, and auditory hallucinations. Her BIMS score was a 06, which indicated severe cognitive impairment.</p> <p>Record review of Resident #56's care plan dated 8/13/2024 reflected the resident was on an antipsychotic medication due to a personal history of auditory hallucinations.</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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #56's PASARR Level 1 screening, dated 8/13/2024, conducted by an acute care hospital, reflected Resident #56 was negative for mental illness, intellectual disability, and developmental disability.</p> <p>Observation on 5/12/2025 at 12:26 PM revealed Resident #56 sitting alone at a dining table eating lunch. The resident was content, with no distress noted. The resident was pleasant and smiling but spoke few words .</p> <p>In an interview on 05/14/25 at 11:58 AM with the RRN she stated that when the MDSC is reviewing a residents' record and comparing a PL1 with the diagnoses, and notices the PL1 is incorrect, they should do a 1012 (Mental Illness/Dementia Resident Review form) if it is determined that the resident has a new MI, ID, or MD, or complete a corrected version of the PL1 for upload into their portal.</p> <p>In an interview on 05/14/25 at 12:00 PM with the MDSC she stated that she was responsible for submitting all PASARR assessments at the time Resident #11's was submitted. She stated that the PASARR was submitted the way they received it so then it was uploaded as a negative PASARR. She stated what she should have done, was completed a corrected PL1. She stated that her process for rectifying discrepancies with PASARR's was researching where the resident's diagnosis came from, such as a doctor's progress note. She stated that if a resident with qualifying diagnoses does not get a PE by the local mental health authority the resident could miss out on certain psychiatric or psychological services.</p> <p>Interview on 5/14/2025 at 2:00 p.m. with MDSC revealed she had been the Minimum Data Set Coordinator for almost 16 years at this facility. She stated she was unsure why Resident #56's PASARR status indicated the resident did not have a PASARR II with a qualifying diagnosis. The resident's diagnoses were reviewed with MDSC and she believed the resident's diagnosis of psychotic disorder, delusional disorder, and auditory hallucinations were the qualifying diagnoses, but she would review the PL 1 and discuss the situation with corporate. If a resident has a qualifying diagnosis, MDSC stated that the facility should have reviewed the PL1 and compared it to Resident #56's diagnoses. She stated that a negative outcome for a negative PASARR Level 1 that should have been positive and required a Level 2 screening by the LIDDA could be that the residents' needs went unmet for not receiving needed services. MDSC stated Resident #56 did not suffer any negative impact from the lack of a Level 2 screening because there were no services the resident needed that she was not already receiving. MDSC stated that to ensure PASARR screenings are up to date, audits were done once monthly. She stated that there has been a lot of staff turnover and that the MDS coordinator was responsible for checking these. MDSC stated she was responsible for submitting PASARR information to the TMHP. MDSC said she has been trained on the PASSAR policy, and that she was trained prior to her employment at this facility.</p> <p>Interview on 5/14/2025 at 2:48 PM with DON revealed the MDS nurse is responsible for inputting the PASARR into the TMHP. DON said the typical submission process involves the MDS nurse receiving the completed PL1 form from the hospital and reviewing it for accuracy. If the PASARR is incorrect, it is DON's expectation that a new PL1 would be completed. DON stated the MDS nurse does review the progress notes and orders and then adds any mental health or intellectual developmental disorder(s) as they are identified. This would then trigger the MDS nurse to review the PASSAR. DON stated she is responsible for chart audits, and they were completed frequently, sometimes daily depending on resident needs and orders. DON said a possible negative outcome for a resident with an inaccurate PASSAR could be that a resident would not get their needs met.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/14/25 at 02:56 PM with the DON revealed that the MDSC was responsible for obtaining PASSAR assessments from the admitting facility and uploading them into the portal. The DON stated that she conducted chart audits monthly. She stated she would begin implementing PASARR audits more often. A negative outcome could be the residents not getting their needs met relating to services offered by the PASARR programs. She stated that if the MDSC were to notice that the referring entity incorrectly filled out a PL1, then the MDSC would complete a new PL1 and use that as the final version to be uploaded into the portal for the local authority to come out to the facility.</p> <p>Review of the facility's PASRR policy dated last revised 11/15/2023 revealed, The purpose of this policy is to ensure PASARRs are being obtained and completed timely and accurately.</p> <ol style="list-style-type: none"> 1. PASARRs are obtained from referring entity by the admissions department. 2. PASARR Level 1's are put into Simple Long Term Care by the facility within 72 hours of resident admitting to facility. The completed PASARR Level 1 must also be uploaded into the resident's Electronic Medical Record. 3. Communicate with LIDDA/LMHA to ensure all active positive PASARR Level 1's have a completed PASARR Evaluation and upload the PASARR Evaluation into the resident's Electronic Medical Record. 4. Review recommended Specialized Services on the PASARR Evaluation once the PASARR Evaluation is submitted. 5. When discharging a resident to another Nursing Facility, the facility is responsible for completing a PASARR for the Nursing Facility. 6. Follow Texas PASARR Policy for all mandatory meetings and care coordination including any changes that may require a change in resident's PASARR status 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for proper food storage.</p> <ol style="list-style-type: none"> The facility failed to store foods in 1 of 1 walk-in freezer to allow for proper circulation. The facility failed to ensure food in 1 of 1 walk-in freezer was properly sealed from air-borne contamination. <p>This failure could place residents who were served food from the kitchen at risk for consuming contaminated, expired, and/or poor-quality food.</p> <p>Findings included:</p> <p>In an observation on 05/12/2025 at 9:20 AM of the facility's 1 of 1 walk-in freezer revealed 11 boxes unshelved, stacked on top of one another on the left side of the freezer, the boxes were caving into themselves and were compromising the integrity of the cardboard, the food inside the boxes appeared to still be frozen and without freezer burn. On the right side of the freezer there was a shelved box of okra that had caved into itself due to an unreadable vegetable box on top of it, that was also smashed, and a box of lima beans that was beginning to cave in on the top due to a box of peas on top of it (a total of 4 stacked boxes of vegetables with 3 of them caving into themselves).</p> <p>In an interview with the DM on 05/13/2025 at 11:15 am she stated that they had just started a new menu cycle and a lot of the boxes that were crushed in the freezer contained bread, because they get too much of it, so the overstock goes in the freezer. When asked if the residents had ever complained to her about the texture of the food (due to poor freezer rotation, ventilation, or issues related to the overstock of items in the freezer), she stated that the residents had complained that they could not chew the food, but she had tried it herself and it was not hard for her to chew. She had offered to change residents to a mechanical diet, but they refused that. She stated that the freezer had looked like that for a long time, and no one had brought it to her attention to make any changes.</p> <p>In an interview on 05/14/25 at 10:07 AM with the RD she stated that she visited the facility every 2 weeks on a Friday. When shown photos of the walk-in freezer she stated that it was not typical for that building to look like that. She questioned how they were rotating items properly.</p> <p>In an interview on 05/14/25 at 10:19 AM with the ADM she stated that the freezer does not usually look like that, and that it could have just been the weekend staff not putting items back where they needed to be, in addition to the start of the new menu cycle and new foods coming in. She stated that food stored like that could impact all residents in the facility as everyone eats food from the kitchen. The food that was in crushed boxes could end up having compromised packaging and become prone to air-borne contaminants.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 05/14/25 at 10:28 AM with the DC, when asked how he was able to find what he needed in the walk-in freezer, he stated that he would ask the DM where it was in the freezer. He stated that he knew how to rotate stock to ensure the earliest received foods were used first. He stated that he had asked the DM what he should do about the crushed boxes and she would tell him to take the bagged items out of the box and date them and set on a shelf.</p> <p>Review of the facility's 'Storage Refrigerators' policy dated 2012 reflected,</p> <p>All Storage Refrigerators shall be maintained clean and have a proper temperature for food storage and to ensure a proper environment and temperature for food storage.</p> <p>1.</p> <p>Storage refrigerators shall be well lighted, ventilated, temperature controlled, and must have an internal thermometer.</p> <p>4.</p> <p>Storage refrigerators shall be kept clean and organized.</p>		