

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: 676014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Twilight Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 West 4th Avenue 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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 14 residents (Resident #33, and Resident #67) reviewed for accuracy of assessments. The facility failed to ensure Resident #33's annual MDS, dated [DATE], accurately reflected her smoking status. The facility failed to ensure Resident #67's annual MDS, dated [DATE], accurately reflected his smoking status. These failures could place residents at risk of inadequate supervision due to an inaccurate assessment for smoking status. Findings include: 1. Record review of Resident #33's face sheet, dated 07/07/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #33 had diagnoses which included muscle wasting lack of coordination, chronic obstructive pulmonary disease (chronic progressive lung disease), and neurocognitive disorder with Lewy bodies (type of progressive dementia that leads to a decline in thinking, reasoning, and independent function. Record review of Resident #33's annual MDS, dated [DATE], revealed Resident #33 had a BIMS score of 07, which indicated severe cognitive impairment. The MDS also revealed that current tobacco use was marked as no. Record review of Resident #33's care plan, dated 04/06/2026, revealed: Focus: Resident smokes. Goal: Resident will be able to smoke without causing injury. Interventions: Ensure smoking occurs in designated smoking areas. Ensure that no oxygen is located in the smoking area while the resident is smoking. Ensure that the resident and/or responsible is made aware of the facility smoking policy. No smoking materials or igniter's will be stored in the resident room. Safe Smoking Assessment every month. The resident will be supervised by a visitor or facility staff member at all times. Record review of Resident #33's Smoking Assessment on 06/29/2026, revealed Resident #33 required direct supervision while smoking. Observation of Resident #33 on 07/07/2026 at 4:03p.m., revealed Resident #33 was sitting in her wheelchair outside with her family member smoking. 2. Record review of Resident #67's face sheet, dated 07/07/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #67 had diagnoses which included dementia (memory, thinking, difficulty), chronic obstructive pulmonary disease (chronic progressive lung disease), hypertensive heart disease without heart failure (damage to heart due to chronic high blood pressure), and cerebrovascular disease (a range of conditions that affect the blood flow to the brain).Record review of Resident #67's annual MDS, dated [DATE], revealed Resident #67 had a BIMS score of 03, which indicated severe cognitive impairment. The MDS also revealed current tobacco use was marked as no. Record review of Resident #67's care plan, dated 03/11/2026, revealed: Focus: Resident smokes. Goal: Resident will be able to smoke without causing injury. Interventions: Ensure smoking occurs in designated smoking areas. Ensure that no oxygen is located in the smoking area while the resident is smoking. Ensure that the resident and/or responsible is made aware of the facility smoking policy. No smoking materials or igniter's will be stored in the resident room. Safe Smoking Assessment every month. The (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident will be supervised by a visitor or facility staff member at all times. The resident is safe to smoke unsupervised at this time. Record review of Resident #67's Smoking Assessment, on 04/30/2026, revealed Resident #67 was safe to smoke unsupervised. During an interview with the MDSN on 07/09/2026 12:24p.m., she said she had been trained on completing the MDS. She said the MDS was an Assessment for everything about the resident all put together. She said she was responsible for completing the MDS. She said she had 7 days to complete the MDS. She said if a data entry was incorrect she would go into the MDS and modify the entry to ensure accuracy. She said she was the one who put the resident smoking status on the MDS. She said the smoking status went on the annual, significant change and, on the Admission, MDS.' She said she was notified through the morning meeting and through the IDT meeting that a resident smoked. She said if the smoking status was not documented correctly she did not know how it would affect the resident. She said the DON monitored to ensure that the information was complete and then would sign the MDS. She said she did not know how the DON monitored. She said she did not know why the smoking status was not on Resident #33 and Resident #67's MDS. During an interview with the ADM on 07/09/2026 at 1:04p.m., she said she had not been trained on MDS. She said she did know some stuff about MDS. She said everything about the resident went on the MDS. She said the MDSN was responsible for completing the MDS. She said the MDS should be updated when there was a change with the resident, annually and quarterly. She said the MDS did have the smoking status of the resident on the Annual and admission MDS. She said the MDSN would look to see if the resident was a smoker and if so the MDSN would mark yes to the tobacco use on the MDS. She said she did not think having the smoking status incorrect on the MDS would affect the resident. She said the smoking status was on the care plan and the resident had a smoking assessment. She said staff who worked on the floor did not see the MDS. She said the MDSN monitored to ensure the MDS was correct. She said the MDSN monitored by reviewing and checking the MDS before completing it. She said the smoking status was not correct on Resident #33 and Resident #67's MDS because it was a human error. Record review of the Resident Assessment Policy dated 2023 revealed A comprehensive assessment will be completed within 14 days of admission and annually on each resident. The facility will utilize the RAI. The facility will examine each resident and review the minimum data set expanded core elements specified in RAI no less than once every three months and as appropriate. Results must be recorded to assure continued accuracy of the assessment.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 5 residents (Resident #9) reviewed for care plans. The facility failed to implement Resident #9's care plan interventions for a low bed and fall mats had been implemented. This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met. Findings included: Review of Resident #9's face sheet dated 07/07/26 reflected Resident #9 was a [AGE] year-old male admitted on [DATE] with diagnoses that included paraplegia (a medical condition characterized by partial or complete paralysis of the lower half of the body, which typically affects the legs, abdomen, and pelvic organs), anxiety (intense, excessive, and persistent worry and fear about everyday situations), insomnia (a common sleep disorder marked by persistent difficulty falling asleep, staying asleep, or getting quality rest, leading to daytime fatigue, irritability, poor concentration, and mood issues, and it can be short-term (acute, from stress) or long-term (chronic, lasting months), hypertensive heart disease with heart failure (when high blood pressure (hypertension) weakens the heart over time, leading to heart failure), and chronic obstructive pulmonary disease (COPD) (a lung disease characterized by chronic respiratory symptoms and airflow limitation). Review of Resident #9's quarterly MDS assessment dated [DATE], reflected a BIMS of 7 which indicated Resident #9 had severe cognitive impairment. Review of the active diagnosis section reflected Resident #9 required supervision or touching assistance with eating, substantial/maximal assistance with personal hygiene, and was dependent on staff for toileting and showering. Resident #9 was dependent on staff for chair/bed-to-chair transfer. Review of Resident #9's care plan dated 11/07/24 and revised 11/26/24 reflected Resident #9 is risk for falls & has actual falls. Goals: Resident #9 will be free of falls through the review date and will not sustain serious injury through the review date. Interventions included: Floor Mats and Low bed implemented. Record review of Resident #9's clinical physicians orders dated 07/07/26 reflected Low bed with floor mats every shift with a start date of 12/11/24. In an observation on 07/07/26 at 11:47 AM, Resident #9 was lying in bed with the bed in a regular to high position. Signage on Resident #9's wall to the top and left of bed read ATTN: LOW BED. Resident #9 was sleeping and did not respond to his name being called. Resident #9 appeared to be clean and groomed and showed no signs of pain or distress. In an interview and observation on 07/07/26 at 1:08 PM, Resident #9 stated he was ok and staff treated him well. He stated he felt safe in the facility. Resident #9 was in bed with the bed in a regular to high position and no fall mats were present to the floor on either side of Resident #9's bed. Resident #9 stated it did not bother him if his bed was up higher or not and he had no concerns. In an observation on 07/07/26 at 2:33 PM, Resident #9 was in bed with the bed in a regular to high position and no fall mats were present to the floor on either side of Resident #9's bed. Signage remained on wall above and to the left of the head of bed which read ATTN: LOW BED. Resident #9 was sleeping and did not respond to his name being called. Resident #9 showed no signs of pain or distress. In an observation on 07/08/26 at 11:23 AM, Resident #9 was in bed with the bed in a regular to high position and no fall mats were present to the floor on the left side of residents bed. Fall mats were observed to the floor on the left side of Resident #9's bed only. Observed signage which remained on wall above the top left side of Resident #9's bed that read ATTN: LOW BED. Resident #9 was asleep (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and showed no signs of pain or distress. In an interview on 07/07/26 at 1:00 PM, LVN A stated Resident #9's bed was up in a normal to high position at that time and sometimes he liked it that way so he could hang his legs down to eat. She stated she was not sure why the sign was there on the wall and she would have had to check Resident #9's physician orders. She stated Resident #9 was only a fall risk if he was sitting up in his bed. She stated she did not feel like Resident #9 would fall if the bed was up in a higher position and did not think Resident #9 was a fall risk unless he was sitting up in his bed. She stated Resident #9 has not had any falls. In an interview on 07/07/26 at 2:36 PM, CNA C stated she was assigned to Resident #9 at that time and she was not sure if Resident #9 should have had fall mats to the side of his bed but Resident #9's bed should have been in the lowest position, and it was not. She stated Resident #9's bed was electric and could have been lowered closer to the floor. She stated she had been trained on falls and fall prevention. She stated resident had not had any falls since she worked there as far as she knew and she did not think resident was a fall risk because he did not try to roll around or get up by himself. She stated if residents bed was in a high position or he was a fall risk, and his fall mats were not in place, the resident could have fallen and broken something. In an interview on 07/07/26 at 2:44 PM LVN, A stated she was not sure if resident had an order and was care planned for fall mats or a low bed and she was going to check Resident #9's orders and care plan at that time. She stated after checking the orders there was an order for the fall mats and low bed and it was care planned as well. She stated she had been trained on following doctors' orders, falls/fall prevention, and following residents care plans. She stated if a resident was a fall risk and the orders for the low bed and fall mats were not being followed, the resident would have been at risk for falling and being injured. In an interview on 07/08/26 at 11:27 AM, LVN B stated she was the nurse responsible for Resident #9 on that shift. She stated when Resident #9 first admitted to the facility he was combative and would try to throw himself on the floor. She stated Resident #9 was on hospice services and he was much better than before. She stated Resident #9 had not done those things anymore and the low bed or fall mats were not needed anymore. She stated she was going to go with the hospice nurse and get those orders discontinued but for now with the physicians orders and care plan that said resident should have the fall mats and low bed, those interventions should have been in place. She stated the hospice aide had been at the facility recently and provided care for Resident #9 and she was not sure who left Resident #9 in that position. She stated she had been trained on following physicians orders, falls/fall prevention, and residents care plans. She stated if there were no fall mats in place or the bed was not in the lowest position, and the resident fell out of bed, it could have placed resident at risk for having a major injury. She stated there should have been better communication for nursing staff because it was care planned for resident to have the bed low and fall mats placed beside the bed and the care plans should be followed for the benefit of the resident. In an interview on 07/08/26 at 12:02 PM, the HSPC stated she was one of the nurses that cared for Resident #9 and she was not sure if resident had an order for a low bed or fall mats. She stated Resident #9 had car wreck in the 1980's and has been a paraplegic (a medical condition characterized by partial or complete paralysis of the lower half of the body, which typically affects the legs, abdomen, and pelvic organs) ever since. She stated she felt that Resident #9's bed needed to be kept in the lowest position but not that the bed had to be on the floor, and she did not feel like resident needed fall mats to the floor on the side of his bed. She stated Resident #9 had upper body strength, but he stayed put in bed. She stated she was not aware of Resident #9 having any falls since she took care of him. She stated Resident #9's care plan should have been updated to his bed being in lowest position only but not to have his bed on the floor and not to have fall mats. She stated she would have been surprised if Resident #9 had a fall and it would not (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have put Resident #9 at risk of falls if fall mats were not in place or his bed was not in lowest position, but if resident fell and the bed was in a high position and there were no fall mats, it could have placed resident at risk of sustaining an injury. She stated resident was an active participant in his own care. In an interview on 07/08/26 at 2:32 PM, the DON stated staff were in-serviced on following residents care plans including care plan interventions. She stated staff should have been following residents care plans, including the care plan interventions. She stated fall mats should have been in place and resident's bed should have been in a low bed if it was care planned for resident to have a low bed with fall mats to the floor beside bed. She stated if there were no fall mats in place and residents bed was not a low bed or in the lowest position, it could have caused resident to be at risk for injury. In an interview on 07/09/26 at 11:31 AM, the ADM stated staff were in-serviced on following residents care plans including care plan interventions. She stated staff should have been following residents care plans, including the care plan interventions. She stated fall mats should have been in place and resident's bed should have been in a low bed if it was care planned for resident to have a low bed with fall mats to the floor beside bed. She stated if there were no fall mats in place and residents bed was not a low bed or in the lowest position, it could have caused resident to be at risk for potential injury. 07/09/26 07/09/26 12:15 PM Requested policy for following physicians orders, not available. Record review of the undated facility policy titled Comprehensive Care Planning reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented.		

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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. **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 1 of 10 residents (Resident #31) reviewed for ADL care. The facility failed to ensure Resident #31's nails were cut and cleaned on 07/08/2026 and 07/09/2026. This failure could place residents at risk of scratching themselves and diminishing quality of life. Findings included: Record review of Resident #31's face sheet dated 07/08/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included type 2 diabetes mellitus without complications (high blood sugar), muscle wasting, and lack of coordination. Record review of Resident #31's quarterly MDS assessment, dated 04/27/2026, reflected a BIMS score of 0, which indicated severe cognitive impairment. [Resident #31] was supervision or touching assistance for personal hygiene (helper provides verbal cues and/or touching/steading and/or contact guard assistance and the resident completes activity. Assistance may be provided throughout the activity or intermittently.) Record review of Resident #31's care plan, dated 06/09/2026, reflected the following: Focus: [Resident #31] The resident has an ADL Self Care Performance Deficit Goals: [Resident #31] The resident will maintain or improve current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene through the review date. Interventions: Assist with personal hygiene as required: hair, shaving, oral care as needed. During an observation of Resident #31 on 07/07/2026 at 10:41a.m., revealed she was sitting on the side of her bed. Her nails were long and had a brown substance underneath them. During an interview with Resident #31 on 07/07/2026 at 10:42a.m., said her nails needed to be cut and she said staff had not cut her nails or assisted her in cutting her nails in a month. She said that her that her nails needed to be cut and cleaned. She said she did not like the nails long and dirty. During an interview with CNA D on 07/09/2026 at 11:39a.m., she said she had been trained on ADLS. She said the policy for nail care was to clip, file and clean the resident's nails as needed for all residents except for a resident who is diabetic. She said the staff were to look at the residents nails every day to see if they needed care. She said all nursing staff were responsible for cutting and cleaning the residents nails. She said if the resident's nails were dirty and long it can cause the resident to cut themselves or cause an infection. She said it was also a dignity issue. She said the CNAs monitored to ensure the resident's nails were cut and cleaned. She said the CNA's monitored through observation. She said Resident #31 wanted her nails to be cut but she was scared to let staff cut them. She said they were working with her on staff cutting her nails. During an interview with LVN B on 07/09/2026 at 11:56a.m., she said she had been trained on ADLS. She said the policy for nail care was the CNA's could trim the residents nails, but the nurse was to cut the nails of residents who are diabetic. She added if the resident was a high-risk diabetic the facility would have the podiatrist come in and cut the resident's nails. She said the CNA's were responsible for cutting and cleaning the residents nails. She said the nurse was responsible for cutting and cleaning the resident's nails if the resident was diabetic. She said if the resident's nails were long and dirty the resident may feel uncomfortable, not clean and that their hygiene was not well maintained like others. She said the CNA and Nurses monitored to ensure the resident's nails were cut and clean. She said the CNA's and nurses monitored through observations. She said the staff had a hard time cutting and cleaning Resident #31 nails because Resident #31 would refuse or tell staff to come back later. She said she did not document Resident #31's refusals of nail care. During an interview with the DON on (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/09/2026 at 12:42p.m., she said she had been trained on ADLs. She said the policy for nail care was that staff were to check the residents nails when the resident was given their shower. She said she had also instructed the staff if they were busy and could not do the residents nails, staff were to bring the resident to her, and she would cut and clean their nails. She said everyone in the nursing department was responsible for doing nail care. She said if a resident's nails are long and dirty a resident may feel dirty. She said all management monitored to ensure resident's nails were cut and clean. She said management monitored through rounds every morning and talking to the residents. She said Resident #31 sometimes liked her nails long. She said Resident #31 may have gotten into something for her nails to be dirty. She said staff should document if a resident refused nail care. During an interview with the ADM on 07/09/2026 at 12:59p.m., she said she had been trained on ADLs. She said the policy for nail care was that the CNA's cut and clean the resident's nails on shower days or as needed. She said if the resident was diabetic the nurse should be doing the nail care for that resident. She said all nursing staff were responsible for cutting and cleaning the resident's nails. She said if the resident's nails were long and dirty the resident may feel dirty, uncomfortable, or embarrassed. She said everyone should be monitoring to ensure the resident nails were cut and cleaned. She said everyone should be monitored by doing rounds to ensure the resident's nails are done every morning. She said she did not know why Resident #31's nails were dirty and long. She said staff should be documenting the refusal of nail care. Record review of the Nail Care Policy dated 3/10/2000 revealed Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions. Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions. The resident will be free from infection.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food and safety in the facility's only kitchen reviewed for dietary services. The facility failed to ensure opened packaged food in the freezer had correct dates on them on 07/07/26. This failure could place residents at risk of foodborne illnesses. Findings include: Observation of the kitchen on 07/06/26 at 9:12 AM revealed the following: There was an opened package of frozen okra in the freezer that did not have an open date or a used by date on it. There was an opened package with 5 frozen round pizza crusts that was in an opened, dated box. However, the plastic package was left opened. There was an opened undated package of frozen circle shaped chocolate chip cookie dough in the freezer. During an interview with the DM on 07/08/26 at 11:25 AM, she stated all kitchen staff were responsible for ensuring that correct dates were on opened packages of food in the freezer. She said the facility had a policy on labeling and dating food. DM said that kitchen staff were trained on the policy when they were hired. DM said when an opened undated package of food was left in the freezer, it was hard to keep track of its freshness. Failing to correctly date packages of food in the freezer could result in serving the residents spoiled or outdated food, which could make residents sick. During an interview with the CC on 07/09/26 at 10:38 AM, she stated the facility had a policy on food labeling and dating. CC stated that kitchen staff were trained in the policy after they were hired. She said that an unopened package of food in the freezer should have an opened date on it if it was not in the original dated box. She stated if the opened package was in the original dated box, the box should be closed, and the opened package should be tied either in a knot or closed with a zip tie with a used by date on the package. If there was not a manufacturer's used by date on the opened package, staff should date the opened package seven days from the opened date, with the opened date counted as day one. CC said that ensuring the dates were correct on food packages in the freezer preserved the food and kept it fresh and nutritious for the residents. If kitchen staff did not date mark food in the freezer when they opened it, then this could increase the risk of foodborne illnesses, which could make the residents sick. During an interview with the ADM on 07/09/26 at 1:08 PM she said there was a policy on food labeling and dating at the facility and the kitchen staff were trained on this policy when they were hired. She said the kitchen staff received continuous training on food labeling and dating at least once a month to ensure the kitchen staff were familiar with the policy. ADM said if there was an opened package of food in the freezer that was out of the box, it should have an open date and a used by date on it. If there was not a manufacturer's used by date on the opened package, staff should date the opened package seven days from the opened date, with the opened date as day one. ADM said it is important for the facility to date food in the freezer correctly once it is opened to keep the facility from serving old, expired food to the residents. ADM said if staff failed to date mark food in the freezer correctly, it could make them sick if used outside of the usage date. Record review on 07/09/26 of the food and labeling policy, dated 05/12/2022 and revised 04/09/2025, revealed the following: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. Open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. If a frozen food does not have an expiration date or a dated shipping label it will be dated when received or is removed from the original packaging.		