STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676051	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Skilled Nursing Facility	4054 Northwest Loop Carthage, TX 75633

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents remained free from accidents, hazards, and each resident received adequate supervision and assistance while providing care for 3 of 8 residents (Resident #1, Resident #2, and Resident #3) reviewed for accidents and supervision. 1. The facility failed to supervise Resident #2 from assaulting Resident #3 when CNA D left the memory care unit to get additional staff to assist with Resident #2 on 08/27/25. Resident #3 suffered bruising to her face and forearm. 2. The facility failed to provide sufficient supervision on the secured unit to provide timely assistance to Resident #1 after he fell. Resident #1 fell at midnight on 06/21/25 and remained on the floor until 4:58AM. He sustained bruising to his left side area. This deficient practice was identified as past non-compliance. The Immediate jeopardy began on 06/21/25 and ended on 06/24/25, then began on 08/27/25 and ended on 08/28/25. The facility had corrected the non-compliance before the survey began. This deficient practice had the potential to affect all residents in the building by causing resident injuries, such as falls, fractures, and even death due to improper supervision. Findings included:1. Record review of Resident #2's face sheet, dated 08/27/25, reflected he was an [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included anxiety disorder (a group of mental health conditions characterized by excessive worry, fear, and nervousness that can interfere with daily life) and depression (a serious mood disorder that affects how a person feels, thinks, and acts, causing persistent feelings of sadness or a loss of interest in activities). Record review of Resident #2's quarterly MDS assessment, dated 07/30/25, reflected he had a BIMS score of 02, which indicated severe cognitive impairment. He exhibited behaviors of wandering, and the wandering placed him at significant risk of getting to a potentially dangerous place. He also exhibited behaviors of rejection of care. Record review of Resident #2's Incident Case Report, dated 08/27/25, reflected LVN E wrote the report and CNA D observed the incident. The comments section of the report reflected This [Resident] went into another [Resident's] room with a commode plunger and hit a [resident] across the face causing bodily injury. This [resident] also hit nurse in face with plunger and with a [stethoscope] in nurse side. This [resident] also went into another [resident's] room with plunger and this nurse was able to get plunger from him and the CNA gently sat [resident] on the floor. [Resident] sat there [a bit] and got up with his fist balled up at this nurse. This nurse talked [resident] into walking to the other end of hall. The only way [resident] would go was that he commanded nurse to walk in [front] of him and he followed with his fist balled up. This nurse got [resident] to [sit] down on couch and he sat there a bit. He then got up and as he did the officer walked in. [Resident] asked, who was that and what did they want. This nurse explained that an officer had come to help. Another comments section reflected: sent to [Emergency Room] .for behavioral evaluation and placement. Immediate discharge notice for resident requested. Record review of Resident #3's face sheet, dated 08/27/25, reflected she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), major depressive disorder (a mental health condition characterized by persistent sadness, a loss of interest in activities, and feelings of hopelessness, which can impact daily functioning), anxiety disorder (a group of mental health conditions characterized by excessive worry, fear, and nervousness that can interfere with daily life), and Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline). Record review of Resident #3's quarterly MDS assessment, dated 06/24/25, reflected that she had a BIMS score of 03, which indicated severe cognitive impairment. She did not exhibit behaviors of rejection of care or wandering. Record review of Resident #3's Incident Case Report, dated 08/27/25, reflected LVN E wrote the report and CNA D observed the incident. The comments section of the report reflected This [Resident] was hit in the face, unwitnessed by another [resident] with a plunger. [Resident] came out of room with plunger and this [Resident] was hollering and crying. This nurse stayed to console [resident] and the other nurse went to call [Emergency Medical Services] and the police department. NO vitals were obtained due to the distress of the [resident]. Another comments section reflected: returned from [Emergency Room] without any major injuries. Continue neuro checks. Social to follow up with resident. refer to [external psych services company]. Record review of Resident #3's Head to Toe Skin Check, dated 08/27/25 at 02:39 PM, indicated she had bruising to her left eyebrow, right eye, left eye, tip of nose, left nostril, left jawline, top of right lip, under her right lip, and her left forearm. The form was signed by LVN E. Record review of Resident #3's