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	04/01/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Resident #2, Resident #3, Resident #10 and Resident #30) of 18 residents reviewed for care plans. 1. The facility failed to ensure Resident #2 had a comprehensive care plan for hospice services. 2. The facility failed to ensure Resident #3 had a comprehensive care plan for PTSD. 3. The facility failed to ensure Resident #10 had a comprehensive care plan for dialysis services. 4. The facility failed to ensure Resident #30 had a comprehensive care plan for combative behavior. These failures could place residents at risk of not having their individualized needs met, falls, decreased range of motion and a decline in their quality of care and life.Findings included: 1. Record review of an undated face sheet revealed Resident #2 was a [AGE] year-old female admitted on [DATE] with diagnoses of anemia (a common condition caused by a lack of sufficient healthy red blood cells or hemoglobin to carry oxygen to body tissues, leading to fatigue, weakness, and shortness of breath), atrial fibrillation (a common, often rapid, and irregular heart rhythm caused by chaotic electrical signals in the heart's upper chambers), and cirrhosis (late-stage scarring (fibrosis) of the liver caused by chronic, long-term liver diseases like hepatitis, alcohol abuse, or fatty liver disease). Record review of an admission MDS assessment dated [DATE] revealed Resident #2 had a BIMS of 12 which indicated moderate cognitive impairment. Resident #2 required dependent assistance (helper does all the work) for bed mobility, personal hygiene, dressing, and transfer. The MDS reflected Resident #2 received hospice services. Record review of Resident #2's comprehensive care plan, dated 03/21/2026, reflected no care plan related to hospice services. 2. Record review of an undated face sheet revealed Resident #3 was a [AGE] year-old female admitted on [DATE] with diagnoses of diagnoses of dementia (a general term for a decline in mental ability-such as memory loss, impaired reasoning, and behavioral changes-severe enough to interfere with daily life),diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) and bipolar disorder (a chronic mental health condition characterized by intense, fluctuating mood shifts between extreme mania (highs) and depression (lows), often impacting daily life, energy, and cognitive function). Record review of the admission MDS assessment, dated 02/22/2026, revealed Resident #3 had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #3 had a history of PTSD. Record review of a ?PTSD Screen' dated 02/22/2026, revealed Resident #3 had a history of PTSD. Record review of Resident #3's comprehensive care plan, dated 02/27/2026, reflected no care plan related to PTSD, PTSD triggers, or PTSD interventions for Resident #3. 3. Record review of the face sheet dated 03/31/26 indicated Resident #10 was [AGE] years old and was admitted [DATE] with diagnoses including chronic kidney disease, end stage renal disease, and stroke. Record review a quarterly MDS dated [DATE] indicated Resident #10 was understood and understood others. Resident (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#10 had a BIMS score of 15 indicating intact cognition. The MDS indicated Resident #10 received dialysis. Record review of Resident #10's care plan dated 03/31/26 revealed no care plan related to Resident #10 receiving dialysis services. Record review of an Active Orders Report dated 03/31/26 indicated a physician's order for Dialysis Every Shift.Monitor shunt/graft/fistula for S/X (signs or symptoms) of infection and adequate circulation. with a start date of 11/19/25. 4. Record review of the face sheet dated 03/30/26 indicated Resident #30 was [AGE] years old and was admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (chronic lung disease), Alzheimer's Disease (a progressive, incurable neurological disorder and the most common cause of dementia, characterized by memory loss, cognitive decline, and brain atrophy), and anxiety disorder. Record review of a quarterly MDS dated [DATE] indicated Resident #30 was usually understood and usually understood others. Resident #30 had a BIMS score of 08 indicating moderate cognitive impairment. The MDS indicated the resident had a behavior of rejection of care. Record review of Resident #30's care plan dated 03/31/26 revealed no care plan related to Resident #30's history of resisting care or being combative with staff. During an interview on 03/30/26 at 2:24 p.m., the ADON said Resident #30 refused care. He said it was not uncommon for the resident to be combative. He said if she became combative, he would come back later or get someone else to finish the care. During an interview on 03/31/26 at 9:46 a.m., a family member of Resident #30 said if the resident was woken up or made to do something she did not want to do, she would become combative with staff. During an interview on 04/01/2026 at 11:00 a.m., the MDS Coordinator stated care plans were to include all things that were coded on the MDS. She stated the care plan should be reviewed by the nursing staff to know the individual care instructions for each resident. The MDS Coordinator stated items such as falls, high risk medication usage, hospice services, PTSD, dialysis, behaviors and diagnoses should be care planned for resident safety. She stated not care planning an important item with the interventions could result in the staff not knowing what was needed for the management of the individual resident condition. She stated the MDS Coordinator was responsible for comprehensive care plans, and the floor nurses were responsible for acute care planning. During an interview on 04/01/2026 at 11:30 a.m., the DON stated it was the floor nurse and the administrative nurses' responsibility to ensure that staff were educated about interventions for all aspects of the resident's care. She stated all major diagnoses, conditions, medications, and falls should be care planned with interventions to alert the staff of the potential of these situations recurring and to give instructions on what to do in those cases. The DON stated that not care planning important information could lead to the residents not receiving personalized care. She stated not care planning hospice for Resident #2 would not negatively impact the resident because everyone employed at the facility knew Resident #2 was on hospice. She stated Resident #3 should have had PTSD care planned because it was documented on the MDS, but she did not feel there would be a negative impact to the resident of it not being care planned. She stated Resident #10 should have had dialysis care planned but all staff were aware she was a dialysis resident. The DON stated Resident #30 definitely should have had her behaviors related to her dementia care planned so that all staff would knew the proper way to deescalate any situations that should arise with combative behaviors. During an interview on 04/01/2026 at 1:30 p.m., the Administrator stated he expected the staff to follow the interventions decided on by the MDS Coordinator and interdisciplinary team. He stated the interventions were in place, so all residents received the best quality of care possible in their situation. He stated not having the care items planned could potentially lead to the residents not receiving individualized care. He stated the MDS nurse was responsible for creating all comprehensive care plans and all nursing staff were responsible for updating care plans. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated April 2021, reflected A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative, develops and implements a comprehensive, person-centered care plan for each resident.the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.the comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;.and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.the interdisciplinary team reviews and updates the care plan. at least quarterly.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or the residents' representatives the right to participate in the development and implementation of his or her person-centered plan of care for 2 of 18 residents (Resident #2 and Resident #62) reviewed for resident rights. 1. The facility did not ensure Resident #2 was invited to participate in the quarterly care plan meetings. 2. The facility did not ensure Resident #62's family member was invited to participate in his quarterly care plan meetings. This failure could place residents at risk of not having individual needs met by depriving them of the opportunity to participate in the decision making regarding their care.Findings included: 1. Record review of an undated face sheet revealed Resident #2 was a [AGE] year-old female admitted on [DATE] with diagnoses of anemia (a common condition caused by a lack of sufficient healthy red blood cells or hemoglobin to carry oxygen to body tissues, leading to fatigue, weakness, and shortness of breath), atrial fibrillation (a common, often rapid, and irregular heart rhythm caused by chaotic electrical signals in the heart's upper chambers), and cirrhosis (late-stage scarring (fibrosis) of the liver caused by chronic, long-term liver diseases like hepatitis, alcohol abuse, or fatty liver disease). Record review of an admission MDS assessment dated [DATE] revealed Resident #2 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #2 required dependent assistance (helper does all the work) for bed mobility, personal hygiene, dressing, and transfer. Record review on 03/30/2026 at 9:50 a.m. of Resident #2's EHR revealed there was no documentation of care plan meetings completed prior. During an interview on 03/30/2026 at 10:00 a.m., Resident #2 stated she would like to participate in her care plan meetings so someone could explain her medical condition to her. She stated she had not been invited to or participated in a care plan meeting. 2. Record review face sheet, dated 04/01/2026, reflected Resident #62 was an [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of Parkinson's disease (chronic, progressive neurodegenerative disorder of the nervous system that primarily affects dopamine-producing neurons in a specific area of the brain, causing motor symptoms like tremors, rigidity, slowness, and postural instability). Record review of the quarterly MDS assessment, dated 10/02/2025, reflected Resident #62 had unclear speech, was usually understood, wand was sometimes able to understand others. Resident #62 had a BIMS score of 11, which indicated moderately impaired cognition. He had no behaviors or refusal of care. Resident #62 usually required partial/moderate assistance (helper does less than half the effort) or substantial/maximal assistance (helper does more than half the effort) for most ADLs. Record review of the quarterly care plan conference form, dated 09/25/2025, reflected a quarterly care conference was conducted. The resident representative was invited and attended the meeting. No additional care plan conference forms were available for review. During an interview on 03/30/2026 at 2:56 p.m., Resident #62's family member stated she attended a care plan meeting when Resident #62 first admitted to the facility but had not been invited to a care plan meeting in a while. Resident #62's family member stated she would have liked to attend and participated in Resident #62's care plan meetings. She stated it was important to ensure she was kept up to date on Resident #62's required care and services he was provided at the facility. During an interview on 04/01/2026 at 10:15 a.m., the Social Worker stated it was her job to keep a calendar and ensure the resident had a care plan meeting at least quarterly. She stated she sent letters out to the family to invite them to the care conferences. The Social Worker stated the IDT team met on Thursday with the residents and their families. The Social Worker said she started 4 weeks ago, and prior to that, there was a part-time social worker that tried to do all the care plan meetings, but she was only at the facility two days per week. She stated there was a possibility some care plan meetings were missed. She stated the goal was to have quarterly care plan meetings that aligned with the MDS schedule. She stated the care plan meetings (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were important, so the residents and the family felt like they had an active voice in their care. During an interview on 04/01/2026 at 11:00 a.m., the DON stated it was the responsibility of the Social Worker to coordinate care conferences for all residents. She stated they should be done quarterly, at the minimum, and all departments should be represented, such as nursing, dietary, activities, therapy, and social services. The DON stated there was a short time when the facility had only a part time social worker to coordinate care plan meetings. She stated, during that time, the entire intradisciplinary team tried to tag team it and keep the care plan meetings going, but she was unsure everyone documented the care plan meetings. The DON stated it was important to have care plan meetings. She stated discussion of care changes and care concerns could be missed if the care plan meetings weren't done routinely. During an interview on 04/01/2026 at 1:00 p.m., the Administrator stated it was the responsibility of the Social Worker and all department heads to ensure that the residents and all IDT members were present at resident care plan meetings. The Administrator stated it was the resident's right to be included in all aspects of their care and attendance of the care plan meetings was the platform used to open discussions about resident care. Record review of the Care Plan - Process policy, dated 03/27/2023, reflected The interdisciplinary team will coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process within the required time frames.the interdisciplinary team meets and reviews the care plan as follows: . quarterly and annually.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 18 residents reviewed for resident rights. (Resident #32)1. The facility failed to repair damage to the inside door of the bathroom door, and clean black marks from the bathroom door and wall near the bathroom entrance in Resident #32's room. 2. The facility failed to clean the windows in Resident #32's room as she requested.These failures placed residents at risk of an uncomfortable environment and a decrease in quality of life and self-worth.Findings included:Record review of a face sheet dated 04/01/26 indicated Resident #32 was [AGE] years old and was admitted on [DATE] with diagnoses including muscle weakness, chronic pain, and liver disease.Record review of an admission MDS assessment dated [DATE] indicated Resident #32 was understood and understood others. The MDS indicated a BIMS score of 14 indicating Resident #32's cognition was intact. The MDS indicated Resident #32 required dependent on staff for most ADLs.Record review of a Maintenance Request Log notebook at the nurse's station indicated only on maintenance repair request that was dated 04/01/26. There were no requests concerning the damage to Resident #32's bathroom door, the walls near the bathroom, or dirty windows.During an interview and observation on 03/30/26 at 12:12 p.m., Resident #32 said her bathroom door had been damaged. She said it had scrapes and black marks from a wheelchair. She said her wheelchair had not made the marks. She said the door was already damaged when she was admitted . She said it made her feel like the staff did not care. She said they had problems and did not do anything about it. She said she had not talked to anyone, because she did not think it would make any difference. The inside of the bathroom door had a deep scrap and black marks along the bottom of the white door and door frame. Outside of the bathroom there were black marks along the wall near the floor.During an interview and observation on 04/01/26 at 8:21 a.m., Resident #32 said the windows in her room were dirty on the outside. She said, it is just the filth. She said she did report the windows to the Maintenance Supervisor. She said he told her that he did not do windows. She said she did not know who was responsible for cleaning windows. She said she talked to the Administrator about her windows, and he told her it was the way the windows were made. She said she grew up poor, but their house was always clean. The upper panes of the window had a white coating on what appeared to be the outside of the panes. On the upper portion of the window, the bottom right pane had a buildup that was black, light brown and an orange color.During an interview on 04/01/26 at 10:00 a.m., CNA B said Resident #32 had not complained to her about the damaged area on her bathroom door. She said she had noticed the damaged area. She said it looked like the paint was chipping on the bottom of the door. She said she had not reported it to anyone. She said she did not think anything of it. She said Resident #32 complained to her about the dirty windows in her room. She said she noticed how dirty they were. She said the dirt was on the outside. She said she did not know who was responsible for cleaning the windows. She said she had not reported the dirty windows to anyone. She said it was important to keep the area, where the residents reside, clean.During an interview on 04/01/26 at 10:39 a.m., Housekeeper C said Resident #32 never complained to her about the windows being dirty. She said she never noticed the windows being dirty. She said she did not know who was responsible for cleaning the windows. She said if Resident #32 had complained to her she probably would have just cleaned them. She said she had never noticed the bathroom door. She said the only thing the resident had said to her was not to spray any scents in her room. She said the rooms were the residents' personal space and you want it to feel homey. She said the resident stayed in her room a lot and she would probably enjoy looking outside.During an interview on 04/01/26 at 10:46 a.m., the Maintenance Supervisor said there was no schedule in place for cleaning the outside windows. He said Resident #32 told him that her windows were dirty. He said the resident told him approximately 2 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3 weeks ago. He said he told Resident #32 he would have to speak to the Administrator about it and put a schedule in place. He said it slipped his mind, and he had not talked to the Administrator about it. He said there had been some discussion about changing out some of the windows. He said he was unaware of the damage to the bathroom door. He said no one reported the issue to him. He said there was a book at the nurse's station to put in a maintenance request. He said he checked it every morning and every evening.During an interview on 04/01/26 at 11:24 a.m., LVN D said Resident #32 had not complained to her about her windows being dirty, but she said she had noticed them being dirty. She said she did not know who would be responsible for cleaning the windows. She said she felt it would probably be maintenance since they were dirty on the outside. She said she had not noticed the black marks, and scraped paint on the door to Resident #32's bathroom. She said Maintenance would be responsible for fixing the door. She said it was important for the rooms to be clean and good repair, because it was the residents' home and should be nice to a certain standard. She said repairs should be made for safety reasons.During an interview on 04/01/26 at 2:02 p.m., the DON said she believed the Maintenance Department was responsible for cleaning the outside of the windows. She said she would have expected for the windows to have been cleaned or at least set up on a pressure washing schedule. She said she had not heard about the damage to Resident 32's bathroom door. She said she would have expected staff to have reported the damage to maintenance. She said it was important for the residents to feel like they were in a clean environment.During an interview on 04/01/26 at 2:18 p.m., the Administrator said the resident had reported the windows to him the previous week. He said the windows were on the side facing the sun and the sun had caused the white discoloration. He said it caused condensation and white residue in between the panes. He said they do an annual exterior pressure wash. He said he was not sure of the dirty area in the far lower right-hand corner of the top portion of the window. He said it was important to provide a clean homelike environment and did not want residents living in dirtiness.Record review of the facility's Resident Room Cleaning policy last revised in January 2026 indicated, .Purpose: To provide a clean, attractive, and safe environment for residents, visitors and staff.Inspect room and report all damage including to walls, furniture, room divider and window curtains (note cleanliness) .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the right to be free from any physical restraints imposed for purposes of convenience and not required to treat medical symptoms for 1 of 18 residents (Resident #30) reviewed for restraint use.The facility failed to ensure Resident #30 remained free from physical restraints when her wrists were restrained by CNA A while providing care on 03/16/26.This failure could place residents at risk for a decreased quality of life, a decline in physical functioning and injury.Findings included:Record review of Resident #30's face sheet dated 03/30/26 indicated Resident #30 was [AGE] years old and was admitted [DATE] with diagnoses including chronic obstructive pulmonary disease (chronic lung disease), Alzheimer's Disease (a progressive, incurable neurological disorder and the most common cause of dementia, characterized by memory loss, cognitive decline, and brain atrophy), and anxiety disorder.Record review of Resident #30's Active Orders Report dated 03/31/26 indicated a physcian's order for Lorazepam 2 milligrams/1 milliliter solution for restlessness and agitation, 1 milliliter by mouth every 2 hours as needed. There was a start date of 03/30/26 and a stop date of 04/13/26.Record review of Resident #30's quarterly MDS assessment dated [DATE] indicated Resident #30 was usually understood and usually understood others. Resident #30 had a BIMS score of 08 indicating moderate cognitive impairment. The MDS indicated the resident had a behavior of rejection of care.Record review of Resident #30's care plan dated 03/31/26 did not indicate Resident #30 had a history of resisting care or being combative with staff.Record review of Resident #30's Weekly Skin Data form dated 03/09/26 for Resident #30 did not indicate any bruising to her arms.Record review of Resident #30's Weekly Skin Data form dated 03/16/26 for Resident #30 indicated bruising to the left forearm and right forearm.Record review of a Mandatory In-Service for CNA A dated 12/02/25 indicated, .Behavioral Health Post-Test.Person-Centered care focuses on accommodating residents choices and preferences.A resident Alzheimer's disease start to act aggressively, shouting and call you names. What is the best response? .Take a step back and away, acknowledging his feelings and letting them know you will return later when they feel better.Record review of a Mandatory In-Service for CNA B dated 09/10/25 indicated, .Behavioral Health Post-Test.Person-Centered care focuses on accommodating residents choices and preferences.A resident Alzheimer's disease start to act aggressively, shouting and call you names. What is the best response? .Take a step back and away, acknowledging his feelings and letting them know you will return later when they feel better.Record review of a One-On-One In-service/Re-education Form dated 03/17/26 for CNA A indicated, .Title: Resident Care with agitated/combative resident. Subject: Concern over care interaction with resident on 03/16/26. Detailed concern: Resident was resistant to care/brief change when assigned CNA went in. She got this CNA to assist during change. As they were changing her the brief was off and she began to swing at them. This CNA held the wrists to keep her from hitting them while assigned CNA put new brief on.Education: If a resident refuses care, or becomes combative during care, no means no. Try to get the resident in as safe/comfortable position as possible, step away and try again later or let someone else try again later. Notify charge nurse and/or Nursing Admin of resident behavior and refusal.Employee expressed understanding and agreed to step away and give resident time before attempting change again. The for was signed by the Administrator and CNA A.Record review of a One-On-One In-service/Re-education Form dated 03/17/26 for CNA B indicated, .Title: Resident Care. Subject: Care interaction with agitated/combative resident.Detailed concern: Resident was resistant to care/brief change when this CNA went in to change her. She went to get this 2nd CNA to help. As they were changing her she began swing her arms at them. The other CNA had to hold resident's wrist to keep her from hitting them while this CNA finished a brief change.Education: If a resident refused care or becomes combative during care, no means no. Try to get the resident as safe/comfortable as (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible, step away, and try again later or let someone else try again later. Notify charge nurse and/or nursing admin of resident behavior/refusal. The for was signed by the Administrator and CNA B.During an interview on 03/30/26 at 10:39 a.m., Resident #30 said she did not like some of the CNAs. She said her arm was bruised while she was being turned in the bed.During an interview and observation on 03/30/26 at 12:21 p.m., Resident #30 said a CNA held her arms and turned her in the bed. She said she was being combative with the staff. She said she was trying to hit them. She said the CNA holding her arms caused bruising. There was a faint quarter-size bruise on her right forearm. No other bruising was visible.During an interview on 03/30/26 at 1:43 p.m., CNA A said Resident #30 was being combative while she was being changed. She said the resident already had bruises on her arms. She said she did not look at the bruises that day. She said the resident was being combative and she held both of the resident's wrists. She said the resident never told them no to the care. She said the resident said, during the care, they were hitting her.During an interview on 03/30/26 at 2:01 p.m., CNA B said she went in to change Resident #30's brief on 03/16/26. She said the resident had a history of being combative, but she normally had a good rapport with her. She said when she went to turn Resident #30 on her side, the resident began hitting her. She said the brief was halfway under her. She said she left the room to tell the nurse. She said then CNA A came in to help her. She said they explained to her what they were going to do. She said Resident #30 was complaining and did not want it done. She said she tried to talk the resident into letting them finish because the brief was halfway on. She said then the resident began hitting CNA A. She said if the resident could have, she would have knocked CNA A out. The resident was turned onto her side. She said they were both trying to calm the resident down and talk her into the care. She said, at that point, she was hitting CNA A so much. She said CNA A held both resident's wrist and told her to please quit hitting her. She said CNA A did not grab the resident hard, but the way the resident was flailing around. She said, at one point, the resident hit the arm on the assist rail. She said she did not think CNA A did anything on purpose or meant to hurt the resident. She said after they were able to get the brief on, the resident told them to get out of her room. She said they then left the room.During an interview on 03/30/26 at 2:24 p.m., the ADON Resident #30 had been refusing to be changed most of the day on 03/16/26. He said it was not uncommon for the resident to be combative. He said if she became combative, he would come back later or get someone else to do it. He said her behavior has not changed since the incident. He said the resident still had good days and bad days. He said the resident was not fearful of staff. He said she did not seem withdrawn or depressed. He said nothing has changed.During an interview on 03/30/26 at 2:30 p.m., the Administrator said he was told on the morning 03/17/26 that Resident #30's family member wanted to talk to him about an incident the day before. He said he tried to talk to Resident #30 at that time, but she was confused and could not tell him anything. He said she could not recount anything about the incident. He said the family member was not concerned anything wrong happened, but she wished the CNAs could have just walked away. The family member said she did not want to get anyone in trouble. He said CNA B tried to change the resident and got the brief most of the way off. CNA B then got CNA A to come help. He said Resident #30 was being combative and CNA A held the resident by the wrist. He said CNA A said she was not trying to hurt her. He said he was satisfied the aides were in the middle of the brief change and did the best they could to keep the resident safe. He said he did not want to second guess the CNAs in that situation. He said he instructed them in the future to step back. He said there were no other issues with either CNA. He said CNA A was a seasoned CNA.During an interview 03/30/26 at 3:44 p.m., CNA B said CNA A held Resident #30's wrist mid-air as the resident was hitting her. She said CNA A held Resident 30's hands in the air by her wrists during the remainder of the care. She said Resident #30 was flailing her arms. She said the resident kept saying leave me alone.During an interview on 03/30/26 at 3:47 p.m., CNA A said she was never frustrated or upset with Resident #30. She said she never pinned the resident down or held her down. She said she had her hands around Resident #30's wrists to keep her from hitting her in the face.During an interview on 03/31/26 at 9:22 a.m., CNA B said CNA A did not seem (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frustrated. She said CNA A never raised her voice and was kind to the resident. She said the only reason they continued with care was because the brief was part way on and part way off.During an interview on 03/31/26 at 9:46 a.m., a family member of Resident #30 said they came to the facility to visit. They said when they got to the facility Resident #30 had something on her arms that looked like a salve of some kind or lotion. They said it really brought out the bruises on her arm. They said she asked Resident #30 what happened and she told them that staff members were trying to make her do something she did not want to do, so she fought them. They said she asked CNA B what happened and CNA B told her about the incident. They said if Resident #30 was woken up or made to do something she did not want to do, she would become combative. They said Resident #30 had been pretty much normal since the incident. They said she had no depression and was not withdrawn. They said the resident actually seemed more normal.During an observation and interview on 03/31/26 at 10:15 a.m., CNA A said during the care, she still allowed Resident #30 to move her arms. She said she only blocked the resident from hitting her. CNA A demonstrated how she held the resident's arms. She indicated her hands were around the resident's wrist. The resident was still able to move her arms and was flailing her arms around.During an interview on 03/31/26 at 11:15 a.m., a family member of Resident #30 said the resident did bruise easily. They said she came to visit on 03/17/26. They said they had last been in the facility 4 or 5 days before. They said they were told the incident happened the day before. They said their thoughts on the situation were that Resident #30 could be combative and she was handled roughly.During an interview on 04/01/26 at 2:02 p.m., the DON said if a staff member was providing care for a resident and the resident became combative, they should stop, regroup, and give the resident time to settle down before resuming care.Record review of a Dementia and Related Memory Care Disorder facility policy last reviewed on 04/6/24 indicated, .Staff will provide care for resident with dementia and memory related disorders in accordance with standard practice guidelines.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the baseline care plan was developed and implemented for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for 2 of 7 (Resident #2 and Resident #71) reviewed for comprehensive resident centered care plans. 1. The facility did not ensure Resident #71's baseline care plan addressed the care of a condom catheter. 2. The facility did not ensure a RN was part of Resident #2 and Resident #71's baseline care plan process, that included the instructions for resident care needed to provide effective and person-centered care. These failures could place residents at risk of not receiving care and services to meet their needs. The findings included: 1. Record review of the face sheet, dated 04/01/2026, reflected Resident #71 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of unspecified heart block (electrical heart issue), atypical atrial flutter (an abnormal, fast, and regular heart rhythm where the upper chambers (atria) beat rapidly, often caused by scarring from the previous heart surgeries or ablations), unspecified b-cell lymphoma (non-Hodgkin lymphomas (blood cancer) that arise from abnormal B lymphocytes), chronic obstructive pulmonary disease (progressive, treatable, but incurable lung disease that restricts airflow making it hard to breathe), and type 2 diabetes (high blood sugar). Record review of the entry MDS assessment, dated 03/26/2026, reflected Resident #71 admitted to the facility on [DATE]. The comprehensive admission MDS assessment was not due to be completed yet. Record review of Resident #71's baseline care plan, dated 03/26/2026, did not address his catheter status. The baseline care plan was signed by LVN E. There was no signature of a RN or any other member of the IDT. During an observation and interview on 03/30/2026 at 11:00 a.m., Resident #71 was lying in bed with the head of the bed elevated. He had a catheter drainage bag attached to his bed frame. There was a privacy cover over the top. Resident #71 stated he received the catheter in the hospital before being admitted to the facility. During an attempted telephone interview on 04/01/2026 at 11:53 a.m., LVN E did not answer the phone. A brief message was left with call back number. No returned call was received before exit of the facility. 2. Record review of an undated face sheet revealed Resident #2 was a [AGE] year-old female admitted on [DATE] with diagnoses of anemia (a common condition caused by a lack of sufficient healthy red blood cells or hemoglobin to carry oxygen to body tissues, leading to fatigue, weakness, and shortness of breath), atrial fibrillation (a common, often rapid, and irregular heart rhythm caused by chaotic electrical signals in the heart's upper chambers), and cirrhosis (late-stage scarring (fibrosis) of the liver caused by chronic, long-term liver diseases like hepatitis, alcohol abuse, or fatty liver disease). Record review of an admission MDS assessment dated [DATE] revealed Resident #2 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident #2 required dependent assistance (helper does all the work) for bed mobility, personal hygiene, dressing, and transfer. Record review of Resident #2's EHR revealed no baseline care plan completed by the IDT including a RN. During an interview on 03/30/2026 at 10:00 a.m., Resident #2 stated she did not recall anyone visiting with her about a baseline care plan, and there was no baseline care plan meeting when she first came to the facility. She stated she would have liked to have the baseline care plan within the first few days of admission because she had many questions about her care and she was fearful she was not getting the proper medication. She stated she eventually talked to the MD and felt better about her medications. During an interview on 04/01/2026 at 11:00 a.m., the MDS Coordinator stated the baseline care plan was completed by the floor nurse, the social worker, department head nurses, and therapy. The baseline care plan meeting was scheduled by the social worker. She stated she was aware the resident was to receive a copy of the baseline care plan and that an RN was supposed to complete the care plan. She said the baseline care (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plans were not completed by an RN each time. She stated the baseline care plan was done by the admitting nurse, and that was not always an RN. She stated no other member of the IDT completed any portion of the baseline care plan. She stated the previous EHR software would not allow the baseline care plan to be closed without the signature of a RN. She stated the new EHR software had nowhere for the RN to sign the baseline care plan. She stated the facility had not come up with a way to ensure the RN signed the baseline care plan yet. During an interview on 04/01/2026 at 11:00 a.m., the DON said baseline care plans were used in place of a comprehensive care plan until one could be developed to direct resident care according to their goals and choices. She stated it was important to include all major care areas on the baseline care plan. The DON said the baseline care plan needed to be completed by the IDT and signed by an RN. She stated it was important to complete the baseline care plan process, because it allowed the resident to have an active voice in their care. She stated a RN being part of the care plan process was related more to the scope of practice of different nurse types because LVNs could not initiate care plans. During an interview on 04/01/2026 at 1:45 p.m., the Administrator said the baseline care plans were an interdisciplinary form that was discussed with the residents on admit. The Administrator said it was the entire team's (floor nurse, CNA, dietary supervisor, therapy, social services, and activity representative) responsibility to ensure the baseline care plan was completed and signed properly and a copy was provided to the resident and family. During an interview on 04/01/2026 at 2:16 p.m., the DON stated she expected catheter status to be included on the baseline care plan. She said any care or services requiring special monitoring or care should have been included on the baseline care plan. She stated the admission nurse was responsible for monitoring to ensure special care or services were included on the baseline care plan. She said it was important for continuity of care. During an interview on 04/01/2026 at 2:35 p.m., the Administrator stated he expected the baseline care plan to thoroughly and accurately reflect all nursing care needs. The Administrator stated the admitting nurse was responsible for including the care and services on the baseline care plan. He said the nurse administration were responsible for monitoring the nurses. He said it was important to ensure all care and services were included in the baseline care plan to develop accurate goals and outcomes for each resident. Record review of the Care Plan - Process policy, dated 03/27/2023, reflected .Initiate a Baseline Care Plan and complete within forty-eight (48) hours of admission based on the physician's orders and nursing evaluation.The Baseline Plan of Care facilitates care until the comprehensive Care Plan is developed within the first fourteen (14) days after admission.the team directs care planning toward attaining and maintaining the highest optimal physical, psychosocial, functional status including Advanced Directives, and signs the approved Plan of Care.

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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 interview and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 18 residents reviewed for ADLs. (Resident #44)The facility failed to ensure Resident #44 was clean shaven as was his preference.This failure could place residents who required assistance from staff for ADLs at risk of not receiving care and services to meet their needs, which could result in poor care, feelings of poor self-esteem, and lack of dignity and health.Findings included:Record review of a face sheet revealed Resident #44 was [AGE] years old and admitted to the facility on [DATE] with diagnoses including heart failure, muscle weakness, and anxiety disorder.Record review of a quarterly MDS assessment dated [DATE] indicated Resident #44 was sometimes understood and sometimes understood others. The MDS indicated Resident #44 had a BIMS score of 2 which indicated severely impaired cognition. The MDS indicated Resident #44 required moderate assistance with most ADLs including bathing and personal hygiene.Record review of Care Plan dated 04/01/26 did not indicate Resident #44 required assistance with ADLs. The care plan did not indicate Resident #44 was at risk for falls related to physical abilities, generalized weakness, impaired balance, unsteady gait, and a history of falls. There was an intervention to provide assistance with self-care task as appropriate for safety. Record review of a CNA Flow Sheet dated 03/01/26 - 03/31/26 indicated Resident #44 received assistance with bathing/hygiene on 03/30/26. The flow sheet did not indicate if the resident had been assisted with shaving. Record review of Interdisciplinary Progress Notes dated 03/29/26 - 04/01/26 did not indicate Resident #44 refused to be shaved.During an interview and observation on 03/30/26 at 10:26 a.m., Resident #44 said he preferred to be clean shaven. He said no one offered to shave him. Resident #44 had short white facial hair to beard and mustache area. He said he had not been shaved recently.During an observation on 03/31/26 at 8:51 a.m., Resident #44 was in his room. Resident #44 had short white facial hair to his beard and mustache area. There were no changes from 03/30/26.During an observation on 04/01/26 at 8:29 a.m., Resident #44 was asleep in his chair in his room. Resident #44 had short white facial hair to beard and mustache area. There were no changes from 03/30/26.During an interview on 04/01/26 at 10:00 a.m., CNA B said she shaved Resident #44 every time she helped him shower. She said she did not know what days he was supposed to be showered. She said he was supposed to be showered every other day. She said she did not know why he had not been shaved on 03/30/26. She said she was his CNA on 03/31/26. She said it was important to keep a resident shaved that prefer to be clean shaven to keep them from feeling like they were not taken care of.During an interview on 04/01/26 at 11:24 a.m., LVN D said Resident 44's shower days were Monday, Wed, and Friday. She said the CNAs were responsible for shaving the residents when they were showered. She said she would have expected for him to have been shaved at some point this week. She said it was important to keep the residents clean shaven if that was what they preferred because of dignity and that was what they chose for their appearance.During an interview on 04/01/26 at 2:02 p.m., the DON said CNAs were responsible for shaving the facial hair of residents. She said usually residents were shaved on their bath days. She said she would have expected for Resident #44 to have been shaved on 03/30/26. She said a resident wanting to be shaved was their right and not being shaved was a dignity issue. She said it was the resident's preference.During an interview on 04/01/26 at 2:18 p.m., the Administrator said the CNAs were responsible for shaving the residents when they bathed the resident. He said Resident #44's baths were on Mondays, Wednesdays, and Fridays. He said he would have expected the CNA to have at least asked him if he wanted to be shaved on 03/30/26. He said if a resident refused, the CNA should notify the charge nurse. Then the nurse should document the refusal. He said it was a resident dignity concern. He said he affects how they feel about themselves and might not feel good about their day.Record review of the facility's policy titled Hair Care - Combing and Shaving last reviewed on 04/22/24 indicated, .Hair (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care, combing and shaving will be provided for residents in accordance with standard practice guidelines.