

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2025
NAME OF PROVIDER OR SUPPLIER Shady Acres Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 405 Shady Acres Lane Newton, TX 75966	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse and neglect for 7 of 10 residents (Resident #1, #2, #3, #4, #5, #6, and #7) reviewed for abuse. 1. The facility failed to ensure Resident #1, and Resident #6 were free from sexual abuse when Resident #6 was observed in the secure unit TV room with her hand down Resident #1's pants and Resident #1 was holding Resident #6's hand and arm and would not allow it to be removed. Nursing staff had to manually remove Resident #6's hand from Resident #1's penis and Resident #1 became angry on 03/12/2025. 2. The facility failed to ensure Resident #1 did not touch Resident #2 inappropriately when CNA A witnessed Resident #1 was up behind Resident #2 in dining room/nook area and put his hands on her shoulders and waist and started rubbing his privates against her backside (dry-humping - both residents clothed) on 08/20/2025. 3. The facility failed to ensure Resident #4 was free from physical abuse when Resident #3 picked up silverware from the dining table and hit Resident #4 on top of her right hand on 04/19/2025. 4. The facility failed to ensure Resident #3 & #7 was free from physical and verbal abuse when Resident #3 threw coffee and threatened to kill Res #7. Resident #7 reacted and hit Resident #3 on side of the head with her fist on 05/14/2025. 5. The facility failed to ensure Resident #7 was free from verbal abuse when Resident #3 was cussing at her and calling her an evil bitch and Resident #7 responded she would beat her ass on 05/18/2025. 6. The facility failed to ensure unidentified resident was free from physical abuse when Resident #3 punched an unidentified resident in the chest on 5/27/2025. 7. The facility failed to ensure Resident #5 was free from physical and verbal abuse when Resident #3 was verbally and physically aggressive to Resident #5 and hit her in the face on 6/11/2025. An Immediate Jeopardy (IJ) was identified on 10/21/2025. The IJ template was provided to the facility on [DATE] at 5:23 pm. While the IJ was removed on 10/23/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of emotional distress, fear, decreased quality of life and further abuse. The findings included: Resident #6 Record review of Resident #6's face sheet, dated 10/21/2025, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #6 was discharged on 09/25/2025 to a hospital. Resident #6 had diagnoses which included dementia (loss of cognitive functioning), and personal history of traumatic brain injury (sudden injury that causes damage to the brain). Record review of Resident #6's admission MDS Assessment, dated 03/04/2025, indicated she had a BIMS score of 99 indicating that she was unable to complete the brief interview for mental status, and severely impaired cognitively for daily decision making. She had inattention behaviors and disorganized thinking, behaviors of rejecting care 1 to 3 days and wandering 4 to 6 days (but less than daily) during the 7 days look back period. No behaviors of abusing others sexually or public sexual acts identified. She required assistance for self-care and was independent with transfers and required supervision with ambulation. Record review of Resident #6's care plan with a target date of 09/08/2025 indicated Resident #6 had an impaired cognitive function/dementia or impaired thought process. Interventions included clear communications, to ask yes or no questions, staff identification and make eye contact, keep routine consistent, provide homelike environment, cue, reorientate and supervise as needed, supervision/assistance with decision making, and monitor/document/report as needed any changes in cognitive functions, administer medications as ordered, and consult psychiatric/psychogeriatric as indicated. The care plan did not indicate Resident #6 had an updated or revised care plan for receiving sexual behaviors from another resident on 03/12/2025. Resident #1 Record review of Resident #1's face sheet, dated 10/20/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #1 had diagnoses which included schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges), dementia (loss of cognitive functioning), and impulse disorder (conditions that involve difficulties in controlling emotions and behaviors, particularly those that are aggressive or antisocial). Record review of Resident #1's quarterly MDS Assessment, dated 09/09/2025, indicated he was severely impaired cognitively with a BIMS score of 6. He had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) occurring 1 to 3 days during the</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately to the abuse coordinator for immediate intervention and all alleged violations involving abuse were reported no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or bodily injury, to the administrator of the facility and to other officials, including the State Survey Agency in accordance with State law through established procedures for 7 of 10 residents (Resident #1, #2, #3, #4, #5, #6, and #7) reviewed for abuse. 1. The facility failed to ensure LVN H reported a verbal and physical abuse allegation immediately to the Abuse Coordinator when Resident #3 threw coffee and threatened to kill Resident #7. Resident #7 reacted and hit Resident #3 on side of head with her fist on 05/14/2025. 2. The facility failed to ensure LVN K reported a verbal abuse allegation immediately to the Abuse Coordinator when Resident #3 was cussing at her and calling her an evil bitch and Resident #7 responded she would beat her ass on 05/18/2025. 3. The facility failed to report a physical abuse allegation to the State Agency within 2 hours when Resident #3 picked up silverware from the dining table and hit Resident #4 on top of her right hand on 04/19/2025. The physical abuse allegation was not reported to the state agency. 4. The facility failed to report a physical abuse allegation to the State Agency within 2 hours when Resident #3 punched an unidentified resident in the chest on 5/27/2025. 5. The facility failed to report a physical abuse allegation to the State Agency within 2 hours when Resident #3 was verbally and physically aggressive to Resident #5 and hit her in the face on 6/11/2025. 6. The facility failed to report sexual abuse allegation to the State Agency within 2 hours when it was reported that dietary staff witnessed Resident #6 in the secure unit TV room with her hand down Resident #1's pants and Resident #1 was holding Resident #6's hand and arm and would not allow it to be removed. Nursing staff had to manually remove Resident #6's hand from Resident #1's penis and Resident #1 became angry on 03/12/2025. 7. The facility failed to report sexual abuse allegation to the State Agency within 2 hours when on 8/20/2025 at 4:30 p.m. CNA A witnessed Resident #1 was up behind Resident #2 in dining room/nook area and put his hands on her shoulders and waist and started rubbing his privates against her backside (dry-humping - both residents clothed). The sexual abuse allegation was not reported to the State Agency until 8/21/2025 at 11:32 a.m. greater than 2 hours after the incident occurred. 8. The facility failed to report neglect allegation to the State Agency within 24 hours when it was reported on 7/13/2025 at 12:30 a.m. Resident #2 had an unwitnessed fall and sustained multiple injuries. The neglect allegation was not reported to the State Agency until 7/14/2025 at 9:44 a.m. greater than 24 hours after the incident occurred. An Immediate Jeopardy (IJ) was identified on 10/21/2025. The IJ template was provided to the facility on [DATE] at 5:23 pm. While the IJ was removed on 10/23/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The failures could place residents at risk of continued abuse, physical harm, mental anguish, and emotional distress due to violations not being reported as required. Findings included: Resident #3 Record review of Resident #3's face sheet, dated 10/20/2025, indicated a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses which included Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #3's quarterly MDS Assessment, dated 06/20/2025, indicated she was able to make herself understood and understood others. She was severely impaired cognitively for daily decision making. She had inattention behaviors and disorganized thinking, and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) 4 to 6 days within the 7-day look back period. She required moderate to supervision assistance for self-care and was independent with mobility using a manual wheelchair, required supervision to walk. Record review of Resident #3's care plan revision dated 10/23/2024 indicated Resident #3 had behavior/mod issues and had impaired cognitive function/dementia or impaired thought processes related to Alzheimer's with agitation and aggression. Interventions included to ask yes or no questions, staff identification and make eye contact, keep routine consistent, provide homelike environment, cue, reorientate and supervise as needed, supervision/assistance with decision making, and monitor/document/report as</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 7 of 10 residents (Resident's #1, #2, #3, #4, #5, #7, and #8) reviewed for care plans. 1. The facility failed to develop, revise and implement interventions in Resident #1's care plan on 03/12/2025, 07/01/2025 and 08/20/2025 to include interventions to prevent sexual abuse of other residents. 2. The facility failed to ensure Resident #3's care plan was updated to indicate Resident #3 had alleged abuse allegations on 04/19/2025, 05/14/2025, 05/18/2025, 05/27/2025 and 06/11/2025. 3. The facility failed to ensure Resident #8's comprehensive care plan was completed to maintain the resident's highest practicable physical well-being for skin integrity, meeting emotional, intellectual, physical, and social needs, ADL self-care, fall risk and diagnosis within 7 days of comprehensive assessment. 4. The facility failed to develop Resident #4's care plan to address residents' safety after Resident #4 was involved in a resident-to-resident incident on 04/19/2025. 5. The facility failed to develop Resident #7's care plan to address residents' safety after Resident #7 was involved in a resident-to-resident incident on 05/14/2025 and 05/18/2025. 6. The facility failed to develop Resident #5's care plan to address residents' safety after Resident #5 was involved in a resident-to-resident incident on 06/11/2025. 7. The facility failed to develop Resident #2's care plan to address residents' safety after Resident #2 was involved in a resident-to-resident incident on 08/20/2025. An Immediate Jeopardy (IJ) was identified on 10/21/2025. The IJ template was provided to the facility on [DATE] at 5:23 pm. While the IJ was removed on 10/23/2025, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of their needs not being identified and services put in place to address their needs. Findings included: 1. Record review of Resident #1's face sheet, dated 10/20/2025, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #1 had diagnoses which included schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges), dementia (loss of cognitive functioning), and impulse disorder (conditions that involve difficulties in controlling emotions and behaviors, particularly those that are aggressive or antisocial). Record review of Resident #1's quarterly MDS Assessment, dated 09/09/2025, indicated he was severely impaired cognitively with a BIMS score of 6. He had physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) occurring 1 to 3 days during the 7-day look back period. He required supervision assistance for self-care and mobility. Record review of Resident #1's care plan with a revision date of 06/17/2025 indicated Resident #1 had psychosocial wellbeing problems to include disorganized thinking, hallucinations, delusion, verbal aggression, easily annoyed, concentration problems, lack of energy, sleep problems, resist care and wandering related to schizophrenia and insomnia with interventions to include encourage participation from resident who depends on others to make own decision, psych services with continue to monitor patient for changes in mood/behaviors and medication management, and support the resident to set realistic goals. The care plan did not indicate Resident #1 had an updated or revised care plan for sexual behaviors on 03/12/2025, 03/16/2025, 06/30/2025, and 08/20/2025. Record review of Resident #1's progress note/behavior note dated 03/12/2025 indicated DS C alerted LVN K to check on Resident #1 & #6 who was both sitting in dining room, LVN K observed Resident #6's hand down the front of Resident #1's pants and Resident #1 was holding Resident #6's hand and arm in place when LVN K told Resident #6 to remove her hand from Resident #1's pants, Resident #1 would not let go of Resident #6's arm. LVN K had to manually remove Resident #6's hand which was wrapped around Resident #1's penis. Resident #1 became angry yelling at the nurse to leave them alone. Record review of Resident #1's progress note/behavior note dated 03/16/2025 authored by LVN K indicated CNA notified LVN K that Resident #1 entered his room while she was assisting roommate back to bed and was observed by CNA and roommate masturbating, CNA requested Resident #1 to stop, and he became angry and screamed at the CNA. CNA was able to redirect Resident #1. Record review of Resident #1's progress note/health status</p>		