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 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Acres Health and Rehabilitation Center	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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record reviews, the facility failed to utilize the services of a RN for 8 consecutive hours 7 days a week and designate a RN as a DON on a full-time basis for 1 of 1 facility reviewed for nursing services. The facility failed to ensure an RN worked for 8 consecutive hours for 20 of 116 days reviewed in January, February, March and April 2026. The facility failed to designate an RN as a DON on a full-time basis for 30 of 87 days reviewed in February, March and April 2026. This failure could place residents at risk of not having their nursing and medical needs met, and other direct care staff not receiving sufficient oversight. Findings included: During an record review and interview on 04/29/26 at 09:30 a.m. with the facility HR Director and record review of the facility's RN staff payroll hours for the period of 01/01/26 - 04/29/26 indicated no RN Services on the following dates: 01/03/26, 01/04/26, 01/17/26, 01/18/26, 01/22/26, 01/31/26, 02/01/26, 02/21/26, 02/22/26, 02/23/26, 03/01/26, 03/05/26, 03/10/26, 03/15/26, 03/19/26, 03/28/26, 03/29/26, 04/24/26, 04/25/26 and 04/26/26. The HR Director said the facility had not hired a full-time DON when DON R resigned 02/18/26 with notice until DON S hired 02/24/26 totaling of 6 days without a DON in February 2026. The HR Director said DON S resigned 03/04/26 and the facility was without a DON until DON H hired on 3/20/26 totaling 16 days in March 2026 without a DON. The HR Director said DON H resigned last week 4/20/26 with no notice and the Facility has been without a DON for 8 days for April 2026 so far. The HR Director said the facility Administrator was responsible for making sure the facility had RN coverage daily and hiring a DON. The HR Director said the Administrator had conducted interviews with DON candidates but had not hired anyone. The HR Director said the risk of not have a DON is getting cited for no DON or RN coverage, she said the residents have had no negative outcomes. Record review of Incidents & Accidents for 01/2026, 02/2026, 03/2026, and 04/2026 did not reveal any negative outcomes to residents related to not having RN services. During an interview on 04/29/26 at 11:00 a.m., ADON (who is a LVN) said she had worked for the facility for over 20 years and the DON quit last week through a text message to the Administrator. The ADON said she felt the lack of RN and DON coverage was a concern as an LVN because on certain occasions it could pose a challenges like needing the DON or RN to physically look at a patient to do a more in depth assessment. She said, the facility had no corporate oversight, and although the facility occasionally employed RNs and DONs, there were periods when neither was present. The ADON said in such instances, she would seek supervisory guidance by consulting the DON from another facility, physicians, or Nurse Practitioner. The ADON stated that when appropriate, she would seek advice from the pharmacy or dietitian as well. The ADON said she and the Administrator had been reviewing the staffing schedule and the Administrator was responsible for hiring a DON. The ADON said the DON had a critical role in a nursing facility because the DON was responsible for overseeing nursing staff, providing guidance as needed, and ensuring compliance with regulations, policies, and procedures to maintain quality of care. She stated it was important to have RNs, as they provided guidance, support, and performed nursing tasks beyond the scope of CNAs and LVNs. The ADON said there was no negative outcome because of no DON because you could still call someone. During an interview on 04/29/26 at 11:45 a.m., the Administrator said he was aware the facility did not have RN coverage or (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

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 04/29/2026
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	an acting DON. He said he expected the facility to have an RN working eight consecutive hours a day every day of the week. He said he expected there to be an acting DON or full-time DON in the facility. The Administrator said the previous DON quit last week via text on 04/20/26 with no notice and the facility had been actively advertising for the DON position. He said the facility had been attempting to hire and a DON, advertising the position on different platforms in the past, and just recently added incentives to make the position more desirable. He said they had one or two applicants to interview for DON next week. He said his desire to hire someone more experienced in management of resident care and staff, and the fact that the area is rural led to the failure of the DON position not to be filled. He said he was the one who was responsible for making sure there was a DON and the facility had RN coverage. The Administrator said he was not aware there was no RN coverage on those dates, but what could he do if there were no RNs available to work. Administrator said there was no corporate RN or Regional RNs to assist in the DON roll until one is hired. The Administrator said he was aware of the importance of having an RN at the facility for clinical management. The Administrator said the Director of Nurses was responsible for ensuring RN coverage as required and notifying Administrator of non-coverage. He stated there was improvement to be made, and the management was aware of the issue prior to today. The Administrator said that there were no reported quality concerns attributable to the lack of RNs or DONs coverage. He said no residents missed services or treatment because an RN was not onsite. The Administrator said it was important to have RN coverage because they were more skilled than an LVN and were able to assess patients differently. He said he had some quality LVNs better than the last DONs hired. The Administrator said they were interviewing one or two candidates for an RN DON at the end of the week. Record review of the facility's policy titled Director of Nursing Services, dated August 2006, read in part: Policy Statement: The Nursing Services department is under the direct supervision of a Registered Nurse.1. The Nursing Services Department is managed by the director of nursing services. The director is a registered nurse licensed by this state and has experience in nursing service administration rehabilitation and geriatric nursing. 2. The directors employed full-time 40 hours per week.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's 1 of 1 kitchen reviewed for food safety requirements. The facility failed to ensure there was no fly tape with bugs on it approximately 12 inches away from refrigerator B.The facility failed to ensure floors did not have a sticky substance.The facility failed to ensure there were no fuzzy green spots on refrigerator A's wire rack.The facility failed to ensure the ice machine was free of lime build up.The Dietary Supervisor and Dietary Aide/ [NAME] C did not have bread restraints on their beards. These failures could place residents at risk of foodborne illness, and food contamination. Findings included: During initial tour on 04/27/2026 at 8:51 a.m., the following were identified: The Dietary Supervisor and Dietary Aide/ [NAME] C did not have bread restraints on their beards. There was a long brown tape hanging from the ceiling approximately 12 inches from refrigerator B filled with bugs. The floors had debris on them and were sticky throughout the kitchen. Inside refrigerator A, there were small fussy green spots on the refrigerator wire rack. There was lime build up on the outside and inside of the ice machine. During a follow-up tour on 04/27/2026 at 10:52 a.m., the following were identified: The Dietary Supervisor did not have a beard restraint on his beard. there was a long brown tape hanging from the ceiling approximately 12 inches from refrigerator B filled with bugs. The floors had debris on them and were sticky throughout the kitchen. Inside refrigerator A, there were small fussy green spots on the refrigerator wire rack. There was lime build up on the outside and inside of the ice machine. During an interview on 04/27/2026 at 12:40 a.m., the Dietary Supervisor said he knew he and Dietary Aide/Cook C should have had a beard restraint on to prevent hairs getting into the residents food. He said the kitchen staff clean the floors by mopping daily multiple times a day but were unable to get the sticky substance up unless boiling hot water was used. The dietary Supervisor said the potential risk was residents being risk of foodborne illness and cross contamination due to beard hairs not restrained, kitchen floors unsanitary, and fly tape with bugs approximately 12 inches from refrigerator B. He said he did not know when the last time was the ice machine was drained and cleaned. He said the ice machine should be cleaned weekly by kitchen staff to ensure there was no lime built up. He said he did not have a person designated to clean the ice machine.The Dietary Supervisor said the kitchen staff are scheduled for cleaning but could not provide documentation. During an interview on 04/27/2026 at 1:00 p.m., Dietary Aide/ [NAME] C said the bug tape should not have been in the kitchen nor within approximately 12 inches of refrigerator B. He said he was responsible for cleaning the kitchen (refrigerator and ice machine included) daily after-meal services to prevent cross contamination and foodborne illnesses. He said he did not know when the last time ice machine was drained and cleaned. He said it had been a while. Dietary Aide/ [NAME] C said he forgot to put his beard restraint on. He said he should have had a beard restraint on to prevent any hair falling into residents' food. During an interview on 04/28/2026 at 12:45 p.m., the Administrator said the bug tape should not have been in the kitchen nor within approximately 12 inches of refrigerator B. He said the Dietary Supervisor was responsible for overseeing the kitchen (refrigerator and ice machine included) was cleaned daily and after each meal service to prevent cross contamination. The Administrator said all staff with beards of any length should wear beard restraints to prevent hairs getting into residents food. Record review of facility's policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices revision date: October 2017, indicated: Policy Statement- Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. 12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Record review of facility's policy titled Sanitization revision date: October 2008, indicated: Policy Statement- The food service area shall be maintained in a clean and sanitary manner. Policy Interpretation and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implementation1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair.3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. 12. Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy. Plasticware, China and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze shall be discarded. Damaged or broken equipment that cannot be repaired shall be discarded.16. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.17. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. Record review of https://www.fda.gov/media/164194/download?attachment accessed on 3/31/2026 indicated: Chapter 4. Equipment, Utensils, and Linens Multiuse 4-101.11Characteristics. Multiuse equipment is subject to deterioration because of its nature, i.e., intended use over an extended period of time. Certain materials allow harmful chemicals to be transferred to the food being prepared which could lead to foodborne illness. In addition, some materials can affect the taste of the food being prepared. Surfaces that are unable to be routinely cleaned and sanitized because of the materials used could harbor foodborne pathogens. Deterioration of the surfaces of equipment such as pitting may inhibit adequate cleaning of the surfaces of equipment, so that food prepared on or in the equipment becomes contaminated. Inability to effectively wash, rinse and sanitize the surfaces of food equipment may lead to the buildup of pathogenic organisms transmissible through food. Studies regarding the rigor required to remove biofilms from smooth surfaces highlight the need for materials of optimal quality in multiuse equipment.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were free of significant medication errors, for 1 of 14 residents reviewed for significant medication errors. (Residents #3)The facility failed to ensure staff held Resident #3's two blood pressure medications when the blood pressure was outside the prescribed parameters.This failure could place residents receiving medication to lower the blood pressure at risk for adverse consequences and decline in health.Findings included:Record review of Resident #3's face sheet reflected a [AGE] year-old male admitted on [DATE] with a diagnosis of hypertension (high blood pressure).Record review of Resident #3's quarterly MDS assessment, dated 03/11/26, indicated a BIMS score of 03 indicating Resident #3 was cognitively severely impacted. Hypertension was included as one of Resident #3's diagnoses.Record review of Resident #3's care plan dated 01/03/2026 indicated a diagnosis of hypertension. Interventions included Give anti-hypertensive medications as ordered.Record review of Resident #3's April 2026's physician orders indicated the following:1.Lisinopril 10 mg. daily. Give 1 tablet by mouth daily for hypertension. Hold if SBP less than 110 or DBP less than 60. SBP (systolic blood pressure) is the pressure in the arteries when the heart contracts and is the top number in BP recordings). DBP (diastolic blood pressure) is the bottom/lower number in BP readings and it measures the pressure your blood is pushing against your artery walls while the heart is at rest.2. Metoprolol tartrate 25 mg. Give 1 tablet by mouth twice daily for hypertension. Hold if SBP less than 100 or DBP less than 60 or heart rate less than 60. Record review of Resident #3's April 2026 MAR indicated the following:1. On the following dates and times, LVN A administered Lisinopril 10 mg. to Resident #3 when the vital signs were outside the prescribed parameters:On 04/05/2026 at 8:00 a.m., the BP was 100/56;On 04/08/2026 at 8:00 a.m., the BP was 115/57; On 04/09/2026 at 8:00 a.m., the BP was 103/53;On 04/14/2026 at 8:00 a.m., the BP was 108/52; [NAME] 04/23/2026 at 8:00 a.m., the BP was 107/52.2. Metoprolol tartrate 25 mg. Give 1 tablet by mouth twice daily for hypertension. Hold if SBP less than 100 or DBP less than 60 or heart rate less than 60. On the following dates and times, LVN A administered Metoprolol tartrate 25 mg. to Resident #3 when the vital signs were outside the prescribed parameters:On 04/05/2026 at 8:00 a.m., the BP was 100/56;On 04/08/2026 at 8:00 a.m., the BP was 115/57; On 04/09/2026 at 8:00 a.m., the BP was 103/53;On 04/14/2026 at 8:00 a.m., the BP was 108/52; [NAME] 04/23/2026 at 8:00 a.m., the BP was 107/52. During an interview on 04/28/2026 at 1:15 p.m., LVN A said it was a careless mistake administering the B/P medications to Resident #3. She said she should have held the medications as prescribed by the physician. LVN A said she had been educated and re-educated on administering medications with parameters. LVN A said she should have paid more attention to the directions prescribed for the blood pressure medications. LVN A said Resident #3 had not experienced any adverse signs or symptoms such as decreasing blood pressure or increased heart rate. During an interview on 04/28/2026 at 1:40 p.m., the ADON said her expectations were for all medications to be administered by physician orders including according to parameters. She stated this failure could result in resident's blood pressure becoming lower, cause fainting and injury, or resulting in fall with major injuries.During an interview on 04/29/2026 at 12:00 p.m., the Administrator said his expectations were for all medications to be administered by physician orders.A facility policy titled Administering Medications dated revised April 2019 indicated the following:. Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frames.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional principles on 2 of 3 medication carts observed (Hall D and Hall C medication carts).The facility failed to ensure Hall D and Hall C medication cart drawers did not have loose pills in the bottom of the carts. These failures could place residents at risk of misappropriation of drugs, not receiving prescribed drugs or contaminated medication.Findings included:During an observation and interview on 04/28/2026 at 2:25 p.m., during review of the Hall D medication cart with the QA nurse, she said she was giving patient medication off this cart today. The cart review revealed the 2nd drawer contained 18 whole and 5 broken loose unidentified pills. The QA nurse said the medication cart should be cleaned and no loose pills should be in the drawers.During an observation and interview on 04/28/2026 at 2:39 p.m., during review of the Hall C medication cart with the QA nurse, she said she was giving patient medication off this cart today. The cart review revealed the 2nd drawer contained 5 whole and 1 broken loose unidentified pill she said the medication cart should be cleaned and no loose pills should be in the drawers. The QA nurse said the nurses giving medication off the medication cart were responsible for ensuring no loose pills were left on the medication cart and the back up to double check was herself as the QA nurse or DON. She said she had been working the floor a lot recently and had not been able to do QA duties more than a day or two a week. The QA nurse said all the nurses had been educated to keep the medication carts clean with no loose pills on the medication cart. She said the loose pills were overlooked. The QA nurse said the risk of loose pills on the medication cart was that a resident could run out of their prescription too soon.During an interview on 04/28/2026 at 2:47 p.m., the ADON said the nurses giving medication off the nurse's medication cart were responsible for ensuring no pills were loose on the medication cart at the end of the shift and the DON and QA nurse were the back up to double check the medication carts. She said there was no current DON. She said the nurses were all educated to keep the medication carts clean and remove loose pills. She said the pills were overlooked. The ADON said the residents risk if loose pills on the medication cart was a resident could run out of prescribed medication and they would have to be refilled too soon. During an interview on 04/29/2026 at 12:25 p.m., the Administrator said the nurses providing medication off the medication cart were responsible for ensuring the medication cart was clean with no loose medication. He said the QA nurse and DON were the backup and they were responsible to ensure the medication carts were clean with no loose medication. He said the DON quit last Wednesday (04/22/2026) without notice.The Administrator said the loose medication was overlooked. He said the residents risk of loose medication on the medication cart was that a resident could run out of prescribed medication too soon. Record review of a facility policy revised April 2019, titled, Storage of Medications indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner.2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #5) reviewed for infection control. The facility failed to ensure CNAs E and F wore PPE when providing ADL care to Resident #5 who was on enhanced barrier precaution. These failures could place residents at risk for cross contamination, spread of infection and sepsis, in violation of infection prevention and control requirements.Findings included:Record review of Resident #5's face sheet reflected a [AGE] year-old male admitted on [DATE] with a diagnosis of dysphagia (difficulty swallowing).Record review of Resident #5's quarterly MDS assessment, dated 03/12/26, indicated a BIMS score of 03 indicating Resident #3 was cognitively severely impacted. Feeding tube was included as one of Resident #5's nutritional approaches.Record review of Resident #5's care plan dated 02/23/2026 indicated requires a tube feeding. Interventions included the resident is dependent with tube feeding and water flushes.Record review of Resident #5's April 2026's physician orders indicated tube feeding only diet.During an observation on 04/27/26 at approximately 9:35 AM, Resident #5 had EBP signage in place and PPE (Personal protective equipment) was noted at the entrance to the resident room. During an observation on 04/27/26 at approximately 9:40 AM, CNA E entered Resident #5's room to perform ADL care and failed to don (put on) a gown to perform ADL care. Resident #5 was on enhanced barrier precaution due to his gastrostomy tube (a tube directly in abdomen to the stomach to deliver liquids for food, medication and hydration) CNA E cleaned Resident #5's peri-area, changed his brief and CNA F entered the room and helped CNA E pull Resident #5 up in bed. During the procedure both CNAs bare uniform clothes touched Resident #5's gown and his bed linens. During an interview on 04/27/26 at approximately 10:00 AM with CNA's E and F both stated they both failed to put on a gown to do ADLs with Resident #5 and his room had sign indicating EBP, they said they knew the resident was on Enhanced Barrier Precaution, but they forgot to put a gown on. They stated they did not know why they had forgotten. CNA E and F confirmed it was a risk of cross-contamination for the resident and both CNAs said they received infection control training on EBP and PPE. During an interview with the ADON the infection control preventionist, on 04/28/26 at 10:30 a.m., the ADON stated that a resident with a gastrostomy tube was on Enhanced Barrier Precaution and the staff should wear a gown and gloves while providing care. She stated the staff were provided with infection control and Enhanced Barrier Precaution training and the risk of not following the EBP increases the risk of cross-contamination. In an interview on 04/29/26 at 11:45 AM the Administrator stated staff in the building had all been trained and retrained on EBP (Enhanced Barrier Precautions). He said those failures could place residents at risk for cross contamination, spread of infection and violated the infection prevention and control requirements. The Administrator said staff needed to wear a gown and gloves for residents on enhanced barrier precaution to prevent the spread of infection to the residents but also the staff. The Administrator stated infection control training was provided and skills were checked annually. Record Review on 04/27/26 of EBP Enhanced Barrier Precautions Policy dated 03/2024 indicated, EBP employs targeted gown, and gloves use in addition to standard precaution during high contact residents care activities when contact precaution do not otherwise apply . Record Review of the EBP signage states: When providing care for Dressing, bathing/Showering, transferring, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care any skin opening requiring a dressing.