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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676086	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldthwaite Health & Rehab Center	1207 S Reynolds St Goldthwaite, TX 76844

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section for 1 of 5 residents (Resident #1) reviewed for inappropriate discharge. The facility failed to include the basis for the transfer made by a physician in Resident #1's medical record. This failure placed residents at risk of unmet medical needs and rehospitalization.Findings included: Review of the hospital referral document for Resident #1 dated 12/04/2026 reflected he was struck in the head by a train guardrail on 11/03/2026 and was recovering from a severe traumatic brain injury It reflected agitation and restlessness but no aggression, verbal or physical. Review of the undated face sheet for Resident #1 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included traumatic brain injury, schizophrenia, and history of methamphetamine use. Review of the admission MDS for Resident #1 dated 12/08/2026 reflected he could not participate in a BIMS assessment. The staff assessment for mental status reflected he demonstrated inattention and disorganized thinking. The MDS reflected he exhibited the behavior of verbal aggression and other behavior symptoms (e.g. Physical symptoms, such as hitting or scratching self, pacing, rummaging, public, sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds). It also reflected Resident #1's behavior significantly intruded on privacy activity of others and significantly disrupted care or living environment. Review of the care plan for Resident #1 dated 12/08/2025 reflected the following:Focus area: (Resident #1) exhibits potential to exhibit behavioral symptoms: may refuse medications, may become agitated/angry easily, may exhibit acting out/outbursts, yelling, and can become confrontational, both physical, and verbal against other Residents/Staff. He may exhibit cursing, and verbal/physical aggression towards Staff & Residents, he may exhibit restlessness, & Psychosis, etc.Goals: (Resident #1) will not exhibit behavioral symptoms through the review date. (Resident #1) will verbalize in an appropriate manner his feelings, thoughts, needs, problems, concerns, etc., through the review date.Interventions: (Resident #1) will receive linkage to Resources/Referral Agencies as needed through the review date. LBSW will provide support to Resident, (Resident #1), re: health condition, physical, and mental limitations, problems, concerns, etc. LBSW will encourage (Resident #1) to (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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NAME OF PROVIDER OR SUPPLIER Goldthwaite Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1207 S Reynolds St Goldthwaite, TX 76844	

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