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	05/14/2026

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

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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 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, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. 1.The facility failed to dispose of 3 expired cereal containers located on the dry goods storage shelves.2.The facility failed to dispose of 1 expired chocolate topping located in the kitchen's walk-in refrigerator.3.The facility failed to dispose of used cooking oil.4.The facility failed to label and date all food items located in the designated resident refrigerator located in the dining room. 5.The facility failed to ensure dietary staff followed policy and procedure for hand hygiene.6.The facility failed to ensure staff followed policy and procedure for hand hygiene prior to serving food to residents. These failures could place residents at risk for food contamination and foodborne illness. Findings included: During the initial tour of the kitchen on 05/12/2026 at 9:03 AM, the following was observed: The facility's kitchen dry goods storage shelving revealed there were 3 sealed plastic cereal containers labeled with date received of 03/05/2026 and shelf life identified as 30 days (04/04/2026). The facility's walk-in refrigerator revealed 1 chocolate topping bottle with an open date of 04/23/2026 and an expiration date of 05/02/2026. Observed used oil in a 20-quart pot dated 05/04/2026. The pot was located beside the stove top. Observation during a walk-thru of the facility's1 dining room on 05/12/2026 at 9:28 a.m., the following was observed:A standalone refrigerator contained 5 food items, each were unlabeled and undated . In an interview on 05/12/2026 at 9:01 AM, with the DS revealed staff had been trained in food safety and prevention of cross contamination. The DS stated it was her responsibility to make sure food storage requirements were met. She stated that the facility guidelines required that food was to be labeled and dated to include the date it was received and the expiration or used by date. She stated that it was her expectation that proper hand sanitation was used by all staff members while they were performing kitchen tasks. She stated that staff were expected to wash hands every time they touch something or start a new task. The DS stated the cereal containers were refilled on 05/06/2026 and that she forgot to label the containers with the correct dates. She stated the chocolate topping bottle was expired and it should have been discarded by the expiration date. The DS stated the oil in the 20-quart pan had been used several times, and it should have been discarded after the first use. The DS stated the nursing staff was responsible for the refrigerator that was in the dining room. She stated the refrigerator in the dining room was to be used for residents' personal food items or food items brought into the facility by family or friends. The DS stated the RD had been working with the facility on kitchen sanitation training. In an interview on 05/12/2026 at 11:05 AM, the DA revealed that handwashing was a requirement for any staff member who worked to prepare or to serve food. The DA stated her job duties included using the dishwasher, stocking food in the refrigerator and on the storage shelves. The DA stated she could not remember when or how she should wash her hands. She stated she had been trained in kitchen sanitation. She said she must use a hair net and that she should not touch anything without washing her hands first. She stated that residents could be susceptible to cross contamination if staff did not use safe sanitation practices. In an interview/observation on 05/12/2026 at 11:11 AM the DC stated she had been trained in hand hygiene and DC stated that residents could get sick if staff do not use proper (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hand hygiene. Upon observation of the DC during food preparation, it was revealed that she failed to wash her hands between puree preparation tasks. Observed the DC fail to wash her hands prior to beginning puree # 1 (sweet and sour pork). Observed the DC fail to wash her hands prior to beginning puree # 2 (rice). Observed the DC fail to wash her hands prior beginning to puree # 3 (green beans). Observed the DC fail to wash hands upon completion of the purees; she then obtained a milk container from the refrigerator. During an observation 05/13/2026 at 7:13 a.m., observed the DC walk across the kitchen from the food preparation area to the food distribution line. The DC failed to wash hands prior to serving food to plates.During a telephone interview on 05/14/2026 at 1:06 PM, the RD stated that she was a contractor and was not an employee of the facility. She stated she visited the facility once per month and that she had been coming to the facility for over 10 months. The RD said she interviewed residents, and if residents had complaints, if they were newly admitted or readmitted or if there was an unexpected weight loss or gain. She stated she would observe staff in food preparation and on the food line. She said she watched puree, mechanical and regular meal preparation and she observed meal presentation, size and she checked the diet plan being served to each resident. The RD said she believed every staff member should be following protocol regarding hand washing between tasks, and that residents could be at risk for illness if staff did not abide by hand washing policy. She said staff only needed to wear gloves when handling food itself. She stated that staff were supposed to wash their hands between tasks. The RD stated she had a plan for the training of staff regarding handwashing and sanitation, and she expects that she would do the training in her upcoming visit to the facility. In an observation/interview on 05/12/2026 at 11:47 PM, CNA E was observed in the dining room pouring drinks and serving drinks to 9 residents. CNA E failed to use hand sanitation between all 9 drinks being served. CNA E stated she has been trained in hand washing and hand sanitation. She stated her training included the explanation and reason for hand sanitation was to prevent germs from spreading. CNA E stated she had been given a bottle of hand sanitizer but she lent it to another staff member, and she forgot to use hand sanitizer while she was passing drinks and food trays. In an observation/interview on 05/13/2026 at 7:23 PM, the H? stated she had been trained on resident rights and hand washing. She stated her role was to provide indirect care for the residents. She stated that her duties included bringing orange juice or water and snacks to the residents. She stated, We are all responsible for sanitation while delivering food. She said, If we don't use hand sanitizer, it could cause cross contamination and cause sickness. The HA was observed using her hands to lift her necklace and putting it to her lips. The HA failed to sanitize her hands before continuing with the duties of serving breakfast trays. Observed the HA deliver food trays on hallway # 3. Observed HA fail to use hand sanitizer prior to delivering meal tray to rooms # 44, # 38, 37 and # 36. The HA could not explain why she was not using hand sanitizer between food service. In an interview on 05/14/2026 at 1:57 PM, the ADM stated that he had been trained in hand sanitation. The ADM stated all staff had been trained in hand sanitation. He stated he believed the nursing staff trained the CNAs on the criteria for hand sanitizing during food service. He said it was his expectations that all the staff who serve food should be using hand sanitizer between meal tray services. He stated if staff failed to follow hands sanitization procedures or food storage and labeling requirements it could cause cross contamination and residents are at risk for food borne illness. Record review of dietary safety training certificates revealed that 5 of 5 staff members had current food safety certifications. The DS's certificate was posted and was current. Review of the most recent training plan records that include Competencies for Food and Nutrition Services Employees revealed the training plan included training on infection control practices and employee hygiene. Review of 5 of 5 staff quizzes confirmed all staff had passing scores. Review of Dietary Services Policy & Procedure Manual 2012.Dry Storage and SuppliesAll facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin and insects. Procedures:3. Dry bulk foods (such as Flour, sugar) are stored in seamless metal or plastic containers with tight covers or bins which are (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	easily sanitized. Containers are labeled. Scoops should not be left in the food containers or bins. Containers are cleaned regularly. 4. Open packages of food are stored in closed containers with tight covers and dated as to when opened.Hand WashingWe will ensure proper hand-washing procedures are utilized. Employees are too frequently perform hand washing as outlined below.Procedures:1 Hand washing occurred in sinks provided for that purpose, sink areas provide hot/cold running water, soap in dispensers, and paper towels, and should have a sign posted conspicuously near or about wash basin. 2 The hand-washing technique is as follows:a.Remove rings and watches if they cannot be sanitized during the hand-washing process.b. Competencies For Food And Nutrition Services Employee by (Association of Nutrition & Foodservice ProfessionalsCurriculum:Infection Control Practices/ Employee HygienePractice appropriate hand hygiene during food preparation. to prevent cross contamination.Employs hygienic practices (e.g., not touching hair o face without hand washing) before and during food handling. Property wash hands before serving food to residents after collecting soiled plates and food waste. Demonstrate understanding of infection control precautions per facility's policy/ infection Preventionist. Food Safety RequirementsLabel date and store all food items correctly and in a timely manner.Record review of Hand Hygiene Policy revised 6/2020, revealed, The facility considers hand hygiene the primary means to prevent the spread of infections. Procedure:I.Facility Staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. II.Hand hygiene observation may be observed and recorded by the Infection Control Designee monthly and results reported to QA.III.Facility Staff follow the hand hygiene procedure to help prevent the spread of infections to other staff, residents, and visitors. IV.Hand hygiene products and supplies (sinks, soap,.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policy. V.Facility Staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited too.A.Wash hands with soap and water:V.After contact with. Environmental surfaces.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide reasonable accommodations to meet the needs and preferences for 4 residents (Residents # 20, # 24, #28 and # 120) of 14 residents reviewed for accommodations.The facility failed to ensure that Residents # 20, # 24, #28 #47 and #120 had the call light button device in reach. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included:Record review of a face sheet dated 05/13/2026 indicated that Resident #20 was a [AGE] year-old female readmitted to the facility on [DATE] with diagnoses including: Dementia (confusion due to aging with inability to remember), ANXIETY DISORDER, (Characterized by feelings of fear or apprehension about what's to come and persistent and excessive worry) and PARKINSON'S DISEASE, (A movement disorder of the nervous system.). Record review of a Quarterly MDS assessment dated [DATE] for Resident #20 indicated that she had a BIMS score of 03, indicating that she had severe problems with thinking and memory. Resident # 20 was sometimes able to be understood and she sometimes understood others. The MDS indicated she was dependent for all ADLS. Record review of Resident # 20's comprehensive care plan with a revision date 04/07/2026, revealed Resident # 20 requires total assistance to eat and interventions included to encourage the resident to use bell to call for assistance. Record review of a face sheet dated 05/14/2026 indicated that Resident #24 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: CEREBRAL INFARCTION, (is the pathologic process that results in an area of necrotic tissue in the brain), SENILE DEGENERATION OF BRAIN, (encompasses a range of neurological disorders characterized by a progressive decline in cognitive function), VIRAL HEPATITIS (is an inflammation of the liver that can be caused by viral infections, autoimmune diseases, alcohol, drugs, or toxins.). Record review of a Quarterly MDS assessment dated [DATE] for Resident #24 indicated that his BIMS score was 12, indicating he had moderate problems with thinking and memory. The MDS assessment of Resident # 24's mobility indicated he was dependent; helper does all the effort. Record review of the Care Plan dated 03/16/2026, Revealed Resident #24 has a communication problem r/t Neurological symptom, Stroke. Interventions included, staff are to be sure call light is within reach, respond promptly and encourage the resident to use bell to call for assistance. Record review of Resident #28's face sheet dated 04/23/2026 indicated that Resident #28 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: INTRACRANIAL INJURY, (Head injuries in adults can range from mild bumps to severe traumatic brain injuries), UNSPECIFIED DEMENTIA (Condition which involves memory loss, affecting thinking, and social abilities which interfere with their daily lives) and ANXIETY DISORDER, (Characterized by feelings of fear or apprehension about what's to come and persistent and excessive worry). Record review of a Quarterly MDS assessment dated [DATE] for Resident #28 indicated a BIMS score of 8 indicating he had moderate cognitive impairment. The assessment of Resident #28's mobility indicated he needed partial / moderate assistance with transfers. Record review of the Care Plan dated 05/12/2026, for Resident #28 indicated the resident's call light was to be within reach and encourage the resident to use it for assistance as needed. Record review of Resident #120 's Face sheet dated 05/13/2026 indicated that Resident #120 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: SENILE DEGENERATION OF BRAIN, (encompasses a range of neurological disorders characterized by a progressive decline in cognitive function) TYPE 2 DIABETES MELLITUS (is a chronic condition characterized by insulin resistance and high blood sugar levels), ANXIETY DISORDER, (Characterized by feelings of fear or apprehension about what's to come and persistent and excessive worry). Record review of a Quarterly MDS assessment dated [DATE] for Resident #120 indicated a BIMS score of 99 indicating she had severe problems with thinking and memory. The assessment of Resident #120's mobility indicated she was dependent and helper does all the effort. The assessment indicated the (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident sometimes understood other people and sometimes she could be understood by other people. Record review of the care plan dated 02/26/2026, for Resident # 120 indicated the staff was to be sure the resident's call light is within reach and to encourage the resident to use it for assistance. Resident #120 needs prompt response to all requests for assistance. In an observation on 05/12/2026 at 11:15 AM of the restroom in hall 2 that was shared amongst residents revelae3d the call light device to the left of the toilet had no string attached to the metal arm that stuck out approximately half an inch from the wall. In an observation/interview on 05/12/2026 at 2:05 PM with Resident #20, revealed her call light was observed to be hanging off the right side of the bed, out of Resident #20's reach. Resident #20 shook her head no when asked if she was able to locate the call light button. In an observation/interview on 05/12/2026 2:08 PM., with Resident #24, revealed call light was located in his room, on the bedside table and resident was not able to reach it. Resident #24 responded that he did not know where his call light was located, and he did not know how he would contact staff if he required help. In an observation/interview on 05/12/2026 at 3:52 PM, with Resident #28's, revealed call light button was observed in his room and to be hanging off the right side of the bed, out of the resident's reach. Resident #28 stated that he was not aware of the call light location. In an observation/interview on 05/12/2026 at 2:07 PM of Resident #120, revealed she was lying , in her bed on her right side facing the wall. Her call light was located between the mattress and bedframe. Resident #120 did not have access to a call light button. Resident #120 responded to questions regarding the call light by shaking her head no. Resident #120 indicated she did not know where the call light was and she could not use it to get in touch with the staff. In an interview on 05/13/2026 at 8:01 AM, LVN D stated she has been trained in resident rights and it was the residents right to get the care they needed while living at this facility. LVN D stated that the facility policy on call lights reflected that call lights were to be within reach of each resident. She stated everyone was responsible for the call light location. She stated that CNAs and nurses each did rounds every 2 hours. She said, Residents are observed at least 1 time per hour. She said she did not know why anyone's call light was not located in a place that they could reach it. She said a resident may not get appropriate care if they can't call for help. In an interview on 05/13/2026 at 12:00 PM, with CNA E, it was revealed that she had been trained on call light placement and call light response times. CNA E stated it was her responsibility to provide direct care for the residents. She stated she worked 6am-6pm and she was responsible for making sure the residents' call lights were within reach of each resident. She stated if she saw a call light on the floor, she was to pick it up and make it accessible for the resident. CNA E said stated she thought a resident could fall or get hurt if they did not have a call light in reach. In an Interview on 05/14/2026 at 1:57 PM , with ADM, it was revealed that he stated staff are trained on call light location and response times when staff are in orientation. He said after orientation, staff are in-serviced about call light placement location. Review of the facility's policy titled ?Answering the Call Light' dated September 2022, reflected, The purpose of this procedure is to ensure timely responses to the resident's requests and needs.1.Upon admission and periodically as needed, explain and demonstrate use of the call light to the residents.2. Ask the resident to return the demonstration.3.Explain to the residents that a call system is also located in his/ her bathroom.4.Be sure that the call light is plugged in and is always functioning.5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.6. Report all defective call lights to the nurse supervisor promptly.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible for 2 (hall 2 and hall 3) of 2 resident shared restrooms and 2 (room [ROOM NUMBER] and room [ROOM NUMBER]) of 8 resident rooms reviewed for cleanliness and homelike environments.1.The facility failed to promote a clean, homelike environment in hall 2's resident shared restroom , which had overflowing trash, dirty light switches, and a wet towel in the corner.2.The facility failed to promote a clean, homelike environment in hall 3's resident shared restroom , which had a filthy call light string, corroded caulking and limestone tiles, broken/missing grout in the shower, and the vent fan was covered in dust. 3.The facility failed to have insect screens on the outside of 2 resident room windows observed, and 1 window in hall 3. These failures had the potential to leave residents' feeling like their living space was dirty and hinder the promotion of a homelike environment. Findings included:In an observation on 05/12/2026 at 10:21 AM revealed resident room [ROOM NUMBER]'s window to the outside courtyard was open, and there was air flowing into the room. There was no insect screen on the outside of the window. In an observation on 05/12/2026 at 11:15 AM of the restroom in hall 2 that was shared amongst residents revealed a trashcan overflowing with toilet paper and/or paper towels, onto the floor; urine was still in the toilet bowl; and a wet towel was on the floor near the hand-washing sink. The light switch had an unknown visible brown substance on it.In an observation on 05/12/2026 at 12:42 PM of restroom in hall 3 that was shared amongst residents revealed brown stains on the wall to the left of the toilet; the call light string near the toilet was beige at top and dark brown toward the bottom with obvious signs of wear and filth. Observed damaged and deteriorated grout/caulking at the floor-to-wall transition to the right of the toilet. The seam contained dark discoloration and gaps. In an observation on 05/13/2026 at 9:55 AM of the window in hallway 3 to an outside courtyard revealed the window to have no insect screen affixed to the outside. Resident room [ROOM NUMBER] was able to be observed from this window and also did not have an insect screen affixed to the outside. In an additional observation on 05/14/2026 at 9:21 AM of the restroom in hall 2 that was shared amongst residents revealed the small trashcan was overflowing with toilet paper and/or paper towels onto the floor, and the light switch still had an unknown visible brown substance on it.In an additional observation on 05/14/2026 at 10:15 AM of resident room [ROOM NUMBER] revealed the window to the courtyard was open, letting in air, and no insect screen was affixed to the outside. A lotion bottle was observed holding the window open.In an interview on 05/14/2026 at 10:33 AM with CNA B, she stated that maintenance was responsible for replacing the strings, and the staff could verbally tell maintenance their request. She stated she had not noticed how dirty the hall 3 bathroom floor or call light string was, but that residents did not use that shower as often as they used the hall 1 shower, but the hall 3 shower was still in use.In an interview on 05/14/2026 at 11:12 AM with the DON, she stated that they needed to make the call light string accessible from the shower in the hall 3 restroom. She stated that the grout in the shower would need to be reported to maintenance to see what could be done, and the stains on the wall could be wiped off by anyone, but housekeeping mopped the floors and was responsible for cleaning on a regular basis. She stated she thought there was area of improvement in the bathroom. The DON stated that as far as it not being a homelike environment, that depended on what home was to some people. In an interview on 05/14/2026 at 1:32 PM with the MTD, he stated he would replace the call light cords in the shared bathrooms when it was reported to him. He stated he was notified on 05/14/2026 that the cord in the hall 2 resident shared bathroom needed replacement. He stated that he checked his maintenance log every morning when he came into work. He stated that in the hall 3 restroom they used sandstone, and limestone, and they could corrode if there was a lot of moisture in (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the air. He stated he was also aware of the residents' rooms needing window screens, for privacy, bug prevention and comfort. In an interview on 05/14/2026 at 2:00 PM with the ADM, he stated that he was not sure how long the call light cord was missing from the hall 2 resident shared restroom because he hardly ever went in there unless he was helping the MTD with something. He stated that if a resident was on the floor they would not be able to reach the call light switch in that restroom without the pull cord. The ADM stated he had not been to the hall 3 restroom lately to see the condition of the corroded floor. He stated that he and the MTD could look at fixing the caulking/grout. He stated that he did not think the restroom conditions had affected any of his residents because no one had complained about it yet, and that the residents were typically very vocal. He stated that they were attempting to obtain more window screens but had not been able to have a company go out to the facility yet.A request for a physical environment/homelike environment policy was made on 05/13/2026 at 12:25 PM, and the a policy on laundry and bedding was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help to prevent the development and transmission of communicable diseases and infections for 4 out of 5 residents (Resident #20, Resident #40, Resident #48, Resident #42) reviewed for infection control. MA H failed to disinfect the blood pressure cuff between residents (Resident #20, Resident #40, Resident #48, Resident #42) while performing medication administration. The failure placed residents at risk for cross contamination and the development of infections.Findings include: In observation on 5/12/2026 at 9:03 AM, MA H utilized the blood pressure cuff on Resident #20 and then failed to disinfect the blood pressure cuff prior to use on or in between Resident #40, Resident #48 and Resident #42, In an interview on 5/12/2026 at 10:03 AM with MA H, she stated she was frequently in serviced on infection control. She stated she did not recall if the policy mentioned disinfecting the blood pressure cuff between residents. She did not know of any issues that could occur if the blood pressure cuff was not cleaned. In interview on 5/12/2026 at 3:16 PM with RN C she stated she used to be the infection preventionist. She stated that she was frequently in-serviced on infection control and that it included cleaning the blood pressure cuff between residents. She stated that if reusable medical equipment were not wiped down they could transmit infections from resident to resident. In an interview on 5/14/2026 at 12:03 PM with the DON she stated that it was expected that staff disinfected the blood pressure cuff between residents so as not to spread infections. She stated staff were frequently in-serviced on infection control In an interview on 4/16/2026 at 12:36 PM with the ADM he stated that staff are frequently in-serviced on infection control. When asked if the blood pressure cuff should be cleansed between residents he stated, Well it would be hard to dry since it is fabric. He stated that it could spread infection if it had germs on it. Review of facility policy, Cleaning and Disinfection of environmental surfaces revealed, Environmental surfaces will be cleansed and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration bloodborne pathogens standard.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews, and record review the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from Toilet and bathing facilities for 2 (hall 2 and hall 3)of 2 shared resident restrooms reviewed for call lights.1. The facility failed to ensure the hall 2 resident shared restroom call light was accessible from the floor. 2. The facility failed to ensure the hall 3 resident shared restroom call light string was accessible from the shower and was in good repair.These failures could place residents at risk of not being able to call for staff assistance from the floor or shower in the restroom, or in their room, in order to meet their care needs or at risk for injury, pain, hospitalizations.Findings included: In an observation on 05/12/2026 at 11:15 AM of the restroom in hall 2 that was shared amongst residents revealed the call light device to the left of the toilet had no string attached to the metal arm that stuck out approximately half an inch from the wall. In an observation on 05/12/2026 at 12:42 PM of restroom in hall 3 that was shared amongst residents revealed the call light string near the toilet was not reachable from the shower. In an interview on 05/12/2026 at 2:50 PM with RN C, it was revealed that the policy for call lights reflected, residents should be able to reach a call light because they could fall and need assistance. She said that all staff were responsible for making sure the call lights were within reach of each resident. The RN stated she did not know why a call light would not be within reach of a resident. In an additional observation on 05/13/2026 at 10:00 AM of the restroom in hall 2 that was shared amongst residents, revealed the call light device to the left of the toilet still had no string attached to the metal arm that stuck out approximately half an inch from the wall. In an additional observation on 05/14/2026 at 9:21 AM of the restroom in hall 2 that was shared amongst residents, revealed the call light device to the left of the toilet still had no string attached to the metal arm that stuck out approximately an inch from the wall. In an interview on 05/13/2026 at 8:01 AM, LVN D stated she has been trained in resident rights and it was the residents right to get the care they needed while living at this facility. LVN D stated that the facility policy on call lights reflected that call lights were to be within reach of each resident. She stated everyone was responsible for the call light location. She stated that CNAs and nurses each did rounds every 2 hours. She said, Residents are observed at least 1 time per hour. She said she did not know why anyone's call light was not located in a place that they could reach it. She said a resident may not get appropriate care if they can't call for help. In an interview on 05/13/2026 at 12:00 PM, with CNA E, it was revealed that she had been trained on call light placement and call light response times. CNA E stated it was her responsibility to provide direct care for the residents. She stated she worked 6am-6pm and she was responsible for making sure the residents' call lights were within reach of each resident. She stated if she saw a call light on the floor, she was to pick it up and make it accessible for the resident. CNA E said stated she thought a resident could fall or get hurt if they did not have a call light in reach. In an interview on 05/14/2026 9:22 AM with RN A, she stated that approximately 4 residents used hall 2 restroom, and she was aware the call light cord was missing, and the DON had been notified and was getting with the Maintenance Director to replace it. She stated she was not sure when it was removed, or how long the restroom had been without the call light cord but agreed that a resident would not have been able to reach it if they had been on the floor. In an interview on 05/14/2026 at 11:12 AM with the DON, she stated that she had started working on getting the pull cord replaced on 05/14/2026, and she was not sure how long it had been missing for. She stated that when staff noticed it, they should have reported it to maintenance. She stated if the pull string was not there, residents would not be able to reach the light if they were on the floor. In regard to the hall 3 restroom, she stated that they would need to make the string accessible from the shower. In an interview on 05/14/2026 at 1:32 PM with the MTD, he stated he would replace the call light cords in the shared bathrooms when it was reported to him. He stated he was notified on 05/14/2026 that the cord in the hall 2 resident shared (continued on next page)

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	05/14/2026

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

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathroom needed replacement. He stated that he checked his maintenance log every morning when he came into work, but some things were verbalized to him, such as the call light cord from earlier in the day. In an interview on 05/14/2026 at 2:00 PM with the ADM, he stated that he was not sure how long the call light cord was missing from the hall 2 resident shared restroom because he hardly ever went in there unless he was helping the MTD with something. He stated that if a resident was on the floor they would not be able to reach the call light switch in that restroom without the pull cord. He stated he would need to look at the hall 3 resident shared restroom to understand the call light identified issue as he could not recall the exact location of the call light. He stated in regard to call lights in resident rooms he stated that call lights were to be within all residents' reach. He stated staff were trained on call light response times and location of call lights when they were in orientation, after that they conducted in-services about the call light buttons often. He stated he felt that the facility could meet the residents' needs. The ADM stated that if a resident were to fall, they needed to be able to reach the call light button to call for help. He said he would expect his staff to follow proper policy and procedure. Review of the facility's maintenance logs dated May 6-14th, 2026 revealed no mention of the hall 2 call light string or the hall 3 bathroom call light cord. Review of the facility's policy titled ?Answering the Call Light' dated September 2022, reflected, The purpose of this procedure is to ensure timely responses to the resident's requests and needs.Upon admission and periodically as needed, explain and demonstrate use of the call light to the residents. Ask the resident to return the demonstration.Explain to the residents that a call system is also located in his/ her bathroom.Be sure that the call light is plugged in and is always functioning.5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.6. Report all defective call lights to the nurse supervisor promptly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 1 residents reviewed for pharmacy services. (Resident #44)The facility failed to account for controlled substances for Resident #44.This failure could put residents at risk for not having medications administered as ordered by physician.Findings included:Record review of Resident #44's face sheet reflected a [AGE] year-old female admitted [DATE] with diagnosis of Cerebral Infarction (stroke) due to occlusion of small artery, Type II Diabetes Mellitus, Hypercalcemia (high blood calcium), Osteoarthritis of the left knee, history of Transient Ischemic attach (mini-Stroke) without residual effects, Epilepsy (seizures).Review of resident #44's MDS dated [DATE] reflected a BIMS score of 15 indicating no cognitive impairment.Review of Resident #44's current physician's orders reflected an or for Acetaminophen-Codeine Tablet 300-30 MG (Tylenol #3) Give 1 tablet by mouth two times a day for pain.Review of Resident #44's MAR reflected that she had not missed a dose of the prescribed narcotic. In an interview on 05/12/2026 at 2:21 PM with Resident #44, she stated that she got her pain medication as scheduled two times a day. She stated that the medication was effective and she had not missed any doses due to facility being without her Tylenol #3 for a few days. Review of the receipt received from the pharmacy, utilized by the facility, on 05/14/2026 at 8:45 AM. revealed that Tylenol #3 was received on 05/02/2026 and was signed by MA GIn a telephone interview on 5/14/2026 at 11:38 AM with MA G, she stated that she did recall receiving a card of Tylenol #3 on 05/02/2026 and she stated she placed it in the cart containing medications for hall #1. She stated that she ensured there was a controlled medication count sheet placed in the book and the medication card was in the lock box of the cart. She stated she recalled the card being accounted for when she worked on 05/06/2026 and 05/07/2026.In an observation on 5/14/2026 at 11:40 AM revealed all controlled medication was accounted for and medication control count logs were signed ongoing and off going shifts. In an interview on 5/14/2026 at 11:45AM with MA H, she stated that she was working on 5/8/2026 when it was noticed that Resident #44 was out of Tylenol #3. She stated that later on she remembered seeing the card and the narcotic sheet that morning but not for the evening. She stated that the charge nurse and the DON would also have access to the cart at times if needing to give a PRN medication. She stated that they mostly counted narcotics when handing over cart keys for breaks but always when handing over for another shift. She stated that at evening medication pass she noticed there was not Tylenol #3 for Resident #44 and utilized the emergency kit following instructions from the DON and ADM. She stated at the time they thought maybe the pharmacy was low on doses and only provided a portion. She stated she was suspended until drug testing could be completed and her results were negative and she was able to return to work. She stated that following the incident they were in-serviced on abuse/neglect/misappropriation of property and narcotic counts with the new log sheet for counting the total items and the controlled medication sheets so they could ensure nothing went missing.In an interview on 5/14/2026 at 11:59AM with RN A, she stated that there were two sets of keys to each medication cart and that the DON had the spare and the medication aide typically had the other set but if they went on break the charge nurse would cover and hold the keys. She stated that they performed controlled medication counts when handing over the keys to the cart. She stated that she was called 5/8/2026 and asked to come in for a drug test and told she was suspended until the results came in. She stated she did not recall giving any controlled medication on 5/8/2026 or using the control box on the cart. She stated she did not give the medications that often so she did not recall what controlled medications were in the cart (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when counting controlled medications. She stated when she came back with the ok of the ADM she was in-serviced on abuse/neglect/misappropriation of property and narcotic counts with the new log sheet for counting the total items and the controlled medication sheets so they matched.In interview on 5/14/2026 at 12:03 PM with the DON, she stated that while she had access to the medication carts she did not utilize them on 5/8/2026. She stated that they should be counting when handing off cart keys. She stated there were two sets of keys for the 2 medication carts and one set was kept by her for emergencies. She stated that when it was reported on 05/08/2026 that Resident #44 was out of her Tylenol #3 they thought it was either delayed from the pharmacy or they had only given them a partial order as they sometimes did when they did not have enough for a full order on hand. She stated that on Monday 05/11/2026 they followed up with the pharmacy and were told they should have almost a full card, and she found a receipt for delivery and informed the ADM and they immediately checked to ensure all other controls were accounted for and that it did not get misplaced. She stated since she had access she and all others who had access were drug tested and suspended until the results came in. She stated that they had not been able to determine what happened to the card. She stated following the incident all staff were in-serviced on abuse/neglect/misappropriation of property and those that ad access were in-serviced on narcotic count and the new sheet they developed on counting controlled medication count sheets and controlled medication bottles, syringes and cards. In an interview on 5/14/2026 at 12:36PM with the ADM, he stated that on Friday 05/08/2026 late evening the resident was noted to be out of Tylenol #3. He stated there was no control sheet to trigger that a card was missing. He stated they suspected at the time that the pharmacy had not delivered it or the pharmacy owed doses which had happened on occasion. He stated the resident did not miss any doses of her prescribed medication as they utilized the facility's emergency kit. He stated that they attempted to follow up on a reorder on Monday, 05/11/2026 and learned the facility had received a card of Tylenol #3 with a quantity of 60 tablets on 05/02/2026. He stated they estimated that if they had used the card starting that day it would have between 47 and 60 tablets remaining. He stated he watched camera footage and could not see that anyone had removed the medication from the cart. He stated that the employees who had access to the medication cart on the previous shift were all suspended until drug testing was completed. He stated he did not know who signed for the medication when it arrived and was attempting to obtain a copy of the signed receipt from the pharmacy. He stated he and the DON recounted all controlled medications and there were no other discrepancies. He stated they created an additional count sheet that would now include how many controlled items (blister packs, bottles, etc.) and how many controlled medications count sheets there should be. Review of facility policy-controlled substances revised November 2022 it revealed, the facility complies with all laws and regulations, and other requirements related to handling, storage, disposal and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Prevention and Control Act of 1976). The policy states that, the charge nurse on duty maintains the keys to the controlled substance containers. The DON maintains a set of backup keys for all medication storage area including keys to controlled substance containers., Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up.