STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676148	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peach Tree Place	315 W Anderson St Weatherford, TX 76086

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the resident/resident representative and consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status for one (Resident #1) of four residents reviewed for resident rights. The facility failed to ensure LVN A and LVN E communicated to the physician and POA a change in Resident #1's behavioral status that led to a change in his treatment regimen.The facility failed to ensure that RN NB communicated to the physician and the POA a change in Resident#6's health status that led to a change in his treatment regimen. This failure could place residents at risk of unmet physical and psychosocial needs, physical harm and a decrease in quality of life. The findings included: The findings included: Record review of Resident # 1's face sheet dated 8/24/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: major depressive disorder, (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life that can lead to a range of behavioral symptoms), anxiety disorder (a nervous disorder that significantly impairs daily life by causing constant, debilitating fear and worry that make every day activities difficult to complete), unspecified dementia without behavioral disturbance (a condition characterized by progressive and persistent loss of intellectual functioning with impaired memory and abstract thinking and personality change resulting from organic disease of the brain), and Alzheimer's Disease . Record review of Resident #1's Quarterly MDS, dated [DATE] revealed in Section C that he had a BIMS score of 05 which indicated severe cognitive impairment. Section E behavior indicated no psychosis, no presence of physical behavioral symptoms directed toward others, no presence of verbal behavioral symptoms directed toward others, and he had no behaviors such as wandering, pacing, or rummaging. Section N indicated the resident did not take an antipsychotic or an antidepressant since admission, re-entry or the last OBRA assessment. Record review of Resident #1's active physician orders dated 8/20/25, reflected Resident #1 had an order dated 10/17/24 which reflected: Admit to secure unit due to history of elopement with exit seeking behavior. There was no order for physical restraints. There was a one-time order for Haldol 5 mg/ml 1 time only for 1 day. Record review of the Resident #1's MAR dated 08/2025 reflected that Haldol 5mg was administered at 6:49 PM on 8/17/25. Record review of Resident #1's Skin Assessments revealed:effective 8/17/25 and signed by the ADON on 8/18/25 reflected a 2-centimeter x 2-centimeter skin tear of Resident #1's Left pinky finger and a 2-centimeter x 2- centimeter to his left upper arm.effective 8/19/25 and signed by the ADON on 8/19/25 reflected a 2-centimeter x 2-centimeter skin tear of Resident #1's Right ring finger and a 2-centimeter x 2-centimeter to his left upper arm. Record review of Residents #1's Nurse's Progress Notes revealed: Author: LVN EEffective Date: 08/17/2025 3:30 PM Type: Nursing NoteNote Text: Resident was being combative with staff and was escorted back to room, Resident started throwing things at the window in his room and broke his window, Police and EMS was called to deescalate the situation. Will continue to monitor, Hospice gave new orders for Haldol 5mg/1ml. Resident has been given Haldol 5mg/1ml, POA notified. Interventions: 1 on 1 monitoring, directed to the resident's room to decrease stimulation, assess for pain. Record review of Resident #1's care plan last dated revised on 8/18/25 included: Focus: The resident has a behavior problem - will become aggressive with staff and residents pushing and hitting. Purposely places himself on the floor. Interventions: Caregivers to provide for positive interaction, attention, stop and talk with him as they pass by (1/3/24); Hospice to evaluate medication list with psych. (3/17/25); If resident becomes aggressive towards another resident remove him from the situation. Take him to a quiet area to talk. Resident likes to talk, walk outside and sit on the couch in the lobby (4/22/25); Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from the situation and take to an alternate place location as needed (12/5/23); Resident enjoys prayers. When resident is combative ask him if he needs to pray (3/13/25); When resident has increased confusion and or combativeness call his granddaughter and let him speak to her (3/13/25) Focus: Resident is at risk of feelings of isolation due to being on a secure unit because of high risk of elopement Revised 5/4/25.Interventions: Admit to secure unit per Dr orders.Assist and monitor resident for off unit activities if possible.Involve resident in secure unit activities.Notify physician and family of changes. Focus: The resident has a history of trauma that may have a negative impact. Created 8/11/25 by DON and interventions initiated on 8/11/25. Interventions: Monitor for escalating anxiety, depression, or suicidal thought and report immediately to the nurse, physician, and

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Peach Tree Place	315 W Anderson St Weatherford, TX 76086

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect the resident's right to be free from abuse and neglect for 1 of 7 residents (Resident #1) reviewed for abuse and neglect. The facility failed to protect Resident #1 from abuse when four facility staff (LVN A, RN B, NA C and Laundry Staff D) grabbed Resident #1 and forcibly carried him by his extremities and dragged him on the floor to his room. The staff placed Resident #1 in his room and held the door closed so that he could not leave his room. An Immediate Jeopardy was identified on 8/25/25. The IJ template was provided to the facility on 8/25/25 at 5:07 PM While the IJ was removed on 8/26/25, the facility remained out of compliance at a scope of isolated, and a severity level of no actual harm, due to the facility's need to evaluate the effectiveness of their corrective actions. This failure could place residents at risk of physical injury, psychological trauma, and severe emotional distress. Findings include: Record review of Resident # 1's face sheet dated 8/24/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: major depressive disorder, (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life that can lead to a range of behavioral symptoms), anxiety disorder (a nervous disorder that significantly impairs daily life by causing constant, debilitating fear and worry that make every day activities difficult to complete), unspecified dementia without behavioral disturbance (a condition characterized by progressive and persistent loss of intellectual functioning with impaired memory and abstract thinking and personality change resulting from organic disease of the brain). Record review of Resident #1's Quarterly MDS, dated [DATE] revealed in Section C that he had a BIMS score of 5 which indicated severe cognitive impairment. Section E behavior indicated no psychosis, no presence of physical behavioral symptoms directed toward others, no presence of verbal behavioral symptoms directed toward others, and he had no behaviors such as wandering, pacing, or rummaging. Section N indicated the resident did not take an antipsychotic or an antidepressant since admission, re-entry or the last OBRA assessment. Record review of a skin assessment dated effective 8/17/25 and signed by the ADON on 8/18/25 reflected a 2-centimeter x 2-centimeter skin tear of Resident #1's Left pinky finger and a 2-centimeter x 2- centimeter skin tear to his left upper arm. Record review of Resident #1's skin assessment dated effective 8/19/25 and signed by the ADON on 8/19/25 reflected a 2-centimeter x 2-centimeter skin tear of Resident #1's Right ring finger and a 2-centimeter x 2- centimeter skin tear to his left upper arm. Record review of Resident #1's active physician orders dated 8/20/25 reflected Resident #1 had an order dated 10/17/24 which reflected: Admit to secure unit due to history of elopement with exit seeking behavior. admit date [DATE], and an order dated 9/9/23 : Admit to Hospice, and order dated 8/19/25 cleanse skin tear to left arm with normal saline and pat dry . Apply steri strips, cover with xeroform gauze and a padded dressing. Wrap with Kerlix daily and prn. There was no order for physical restraints. There was a one-time order for Haldol 5 mg/ml 1 time only for 1 day ordered on 8/17/25 by the Hospice physician. Record review of the MAR dated 8/1/25 reflected that Haldol 5mg was administered at 6:49 PM on 8/17/25. Record Review of Resident #1's Care Plan dated revised 8/18/25 reflected Focus: Resident has an actual impairment of skin integrity . Intervention : use caution during transfers and bed mobility to avoid striking arms, hands, and legs against any sharp or hard surface (dated initiated 8/18/25). Record review of Resident #1's care plan last dated revised on 8/18/25 included: Focus: The resident has a behavior problem - will become aggressive with staff and residents pushing and hitting. Purposely places himself on the floor. Interventions: Caregivers to provide for positive interaction, attention, stop and talk with him as they pass by (1/3/24); Hospice to evaluate medication list with psych. (3/17/25); If a resident becomes aggressive towards another resident remove him from the situation. Take him to a quiet area to talk. Resident likes to talk, walk outside and sit on the couch in the lobby (4/22/25); Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from the situation and take to an alternate location as needed (12/5/23); Resident enjoys prayers. When resident is combative ask him if he needs to pray (3/13/25); When resident has increased confusion and or combativeness call his family member and let him speak to her (3/13/25) Focus: Resident is at risk of feelings of isolation due to being on a secure unit because of high risk of elopement Revised 5/24/25.Interventions: Admit to secure unit per Dr orders.Assist and monitor resident for off unit activities if possibleInvolve resident in secure unit activitiesNotify physician and family of changes Focus: The resident has a history of trauma that may have a negative impact. Created 8/11/25 by DON and

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	676148	A. Building B. Wing	09/19/2025

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Peach Tree Place	315 W Anderson St Weatherford, TX 76086

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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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

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	676148	A. Building B. Wing	09/19/2025

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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 0603 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect the resident's right to be free from involuntary seclusion for 1 of 7 residents (Resident #1) reviewed for involuntary seclusion. The facility failed to ensure LVN A, RN B, N/A C, and Laundry Staff D did not isolate Resident #1 as a method of addressing his behaviors. The staff placed Resident #1 in his room and held the door closed by the doorknob so that he could not leave his room as he struggled to get the door open and leave the room. An Immediate Jeopardy was identified on 8/25/25. The IJ template was provided to the facility on 8/25/25 at 5:07 PM While the IJ was removed on 8/26/25, the facility remained out of compliance at a scope of isolated, and a severity level of no actual harm, due to the facility's need to evaluate the effectiveness of their corrective actions. This failure affected Resident #1 and could place residents with behavior healthcare needs at risk of injury and isolation, leading to a decreased quality of life, severe emotional distress and trauma leading to distrust of staff. Findings include: Record review of Resident # 1's face sheet dated 8/24/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: major depressive disorder, (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life that can lead to a range of behavioral symptoms), anxiety disorder (a nervous disorder that significantly impairs daily life by causing constant, debilitating fear and worry that make every day activities difficult to complete), unspecified dementia without behavioral disturbance (a condition characterized by progressive and persistent loss of intellectual functioning with impaired memory and abstract thinking and personality change resulting from organic disease of the brain), and Alzheimer's Disease. Record review of Resident #1's Quarterly MDS, dated [DATE] revealed in Section C that he had a BIMS score of 5 which indicated severe cognitive impairment. Section E behavior indicated no psychosis, no presence of physical behavioral symptoms directed toward others, no presence of verbal behavioral symptoms directed toward others, and he had no behaviors such as wandering, pacing, or rummaging. Section N indicated the resident did not take an antipsychotic or an antidepressant since admission, re-entry or the last OBRA assessment. Record review of Resident #1's active physician orders dated 8/20/25 reflected Resident #1 had an order dated 10/17/24 which reflected: Admit to secure unit due to history of elopement with exit seeking behavior. There was no order for physical restraints . There was a one-time order for Haldol 5 mg/ml 1 time only for 1 day ordered on 8/17/25 by the Hospice physician. There was an order dated 8/19/25 cleanse skin tear to left arm with normal saline and pat dry . Apply steri strips, cover with xeroform gauze and a padded dressing. Wrap with Kerlix daily and prn. Record review of the MAR dated 8/1/25 reflected that Haldol 5mg was administered at 6:49 PM on 8/17/25. Record review of Resident #1's care plan last revised on 8/18/25 included: Focus The resident has a behavior problem - will become aggressive with staff and residents pushing and hitting. Purposely places himself on the floor. Interventions: Caregivers to provide for positive interaction, attention, stop and talk with him as they pass by initiated 1/3/24. Hospice to evaluate medication list with psych initiated 3/17/25. If resident becomes aggressive towards another resident remove him from the situation. Take him to a quiet area to talk. Resident likes to talk, walk outside and sit on the couch in the lobby initiated 4/22/25. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from the situation and take to an alternate place location as needed initiated 12/5/23. Resident enjoys prayers. When resident is combative ask him if he needs to pray (3/13/25); When resident has increased confusion and or combativeness call his family member and let him speak to her initiated 3/13/25.Focus: Resident is at risk of feelings of isolation due to being on a secure unit because of high risk of elopement Revised 5/24/25. Interventions: Admit to secure unit per Dr orders.Assist and monitor resident for off unit activities if possibleInvolve resident in secure unit activitiesNotify physician and family of changes Focus: The resident has a history of trauma that may have a negative impact. Created 8/11/25 by DON and interventions initiated on 8/11/25.Interventions: Monitor for escalating anxiety, depression, or suicidal thought and report immediately to the nurse, physician, and mental health provider. Perform the following de-escalation techniques (there were no de-escalation techniques listed). An observation of the electronic monitoring system video dated 8/17/25, showed these events: At 2:20 PM Resident #1 began showing behaviors which included: wandering into other resident's rooms, taking items from other resident's rooms, dropping clothing items in the hallway, and pulling a bedside table down the hallway. At 2:44 PM Resident #1 went into another

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	676148	A. Building B. Wing	09/19/2025

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Peach Tree Place	315 W Anderson St Weatherford, TX 76086

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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to protect the resident's right to be free from physical or chemical restraints imposed for purposes of discipline or convenience, and that are not required to treat the resident's medical symptoms for 1 of 7 residents (Resident #1) reviewed for physical restraint/chemical restraints. The facility failed to protect Resident #1 from physical restraint when LVN A, RN B, N/A C, and Laundry Staff D grabbed Resident #1 by his arms and legs which restricted his movement and dragged the resident across the floor and carried him by holding onto his arms and legs down to his room. The staff placed Resident #1 in his room and held the door closed so that he could not leave his room. An Immediate Jeopardy was identified on 8/25/25. The IJ template was provided to the facility on 8/25/25 at 5:07 PM While the IJ was removed on 8/26/25, the facility remained out of compliance at a scope of isolated, and a severity level of no actual harm, due to the facility's need to evaluate the effectiveness of their corrective actions. This failure could place residents at risk of physical injury, psychological trauma, and severe emotional distress.Findings include:An observation on 8/20/25 of the electronic monitoring system video dated 8/17/25, showed these events: At 2:20 PM Resident #1 began showing behaviors which included: wandering into other residents rooms, taking items from other residents rooms, dropping clothing items in the hallway, and pulling a bedside table down the hallway. At 2:44 PM resident number one went into another residents' room and took a small fan out of that room and carried it down the hallway. Resident #1 became agitated when housekeeping staff took the fan away from him. At 2:53 PM resident number one walked out of his room with a bedside table. Resident #1 pushed the bed side table forcefully into Rn B and hit her in the shins of both legs. RN B and NA C walk away towards the nurses station and resident number one walk after them. 2:55 PM incident number one started running toward N/A C down the hallway towards the nurses station with a call light cord which resembled an outdoor extension cord in his hand it had an approximately 1. 5-inch metal prong on one end and the other end was plastic with a red call button on the end in his hand. N/A C started running away from Resident #1 toward the nurses station. Resident #1 swung the call light cord while he ran toward the nurses station following staff. He bumped into laundry staff member D as he ran, and she held her hands up in the air. Resident #1 continued to run and chase the staff and was swinging the cord . Resident number one tripped on a chair and fell to the floor. There were four other residents in the vicinity. Rn B motioned with her hand to two unidentified residents that were sitting in the row of chairs at the nurses station to go down the hallway away from resident #1. The two residents walked away. N/A C removed another resident away from resident #1 down the other hallway. An unidentified 4th resident stood back and watched. Laundry staff D held onto the cord and sat in a nearby chair as resident #1 held the cord and sat on the floor. Rn B and LVN A walked around Resident#1 as he tried to kick laundry staff D. RN B and LVN A grabbed resident number one by the arms and twisted his body to lay on his back. They pulled him approximately 5 feet on the floor. Resident #1 tried kicking and resisting staff as the laundry staff got up and hung on to the cord and walked beside them down the hall as they continued to drag him. Resident #1 continued to kick with both feet to resist the staff. LVN A moved to his right leg as he tried to kick her. N/A C held on to his left arm. Resident #1 kicked with both feet as LVN A move to his left leg and laundry staff grabbed his right leg. The 4 Staff picked him up off the floor by his extremities with no support to his back or midsection and carried resident number one to his room. Staff carried him into the room ran out of the room and closed the door of his room. During a telephone interview with N/A C on 8/18/25 at 4:20 PM via phone regarding another incident NA C stated she worked 6 AM to 6 PM on 8/17/25 and an incident had occurred with resident #1 between 2:00 PM and 4 PM when the Nurse had to call the police due to Resident #1's aggressive behaviors. She stated he broke the window glass in his room and the police were called. She stated the staff, and the police had to restrain him by holding him down. She stated she was only involved in this incident. During an interview on 8/19/25 at 9:24 AM RN B stated on Sunday, 08/17/ 2025, Resident #1 was sitting in chair near the nurses station. She stated Resident # 1 suddenly became violent toward other residents that were near him and attempted to strike them. She stated she tried to assist him to a standing position and called for help. She stated she tried to guide him to his room, he was resistant. She stated he tried to strike at her with his fists. She stated other staff members responded, and they continued to attempt to make their way to take him down the hall while he continued to attempt to break lose, and kick, and punch the staff. She stated Resident #1 did manage to break free and grabbed a bedside table, picked it up, and

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

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to implement policies and procedures for reporting when the administrator and the State Survey Agency were not notified immediately notified of abuse on 8/17/25 when 4 facility staff (LVN A, RN B, NA C, and Laundry attendant D) grabbed Resident #1 and forcibly carried him by his extremities to his room. The staff placed Resident #1 in his room and held the door closed so that he could not leave his room. The abuse was not reported to the administrator until 8/19/25. This failure could place residents at risk of physical injury, psychological trauma, and severe emotional distress.An Immediate Jeopardy was identified on 9/12/25. The IJ template was provided to the facility on 9/12/25 at 5:07 PM While the IJ was removed on 9/14/25, the facility remained out of compliance at a scope of isolated, and a severity level of actual harm, due to the facility's need to evaluate the effectiveness of their corrective actions. Findings include: A record review of the facility policy Abuse/Neglect, dated as revised 9/9/24, revealed the following [in part]: Policy Statement: Reporting any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse neglect or exploitation must report this to the Don, administrator, state, and our adult Protective Services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated. Employees must report all allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury and unknown source to the facility administrator. The facility administrator or designee will report to HSC all incidents that meet the criteria of provider letter 2024-14 dated 8/29/24. A record review of Provider Letter No. 2024-14, dated 8/29/24 revealed the following [in part]: 1. Abuse: A NF must report incidents a nursing facility must report to CII the following types of incidents in accordance with applicable state and federal requirements: abuse, neglect, exploitation, due to unusual circumstances, a missing resident misappropriation drug theft, suspicious injuries of unknown sources, fire emergency situations that pose a threat to resident health and safety, communicable disease, situations that are an unusual or abnormal event that possess a threat to resident health and safety. Record review of Resident # 1's face sheet dated 8/24/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: major depressive disorder, (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life that can lead to a range of behavioral symptoms), anxiety disorder (a nervous disorder that significantly impairs daily life by causing constant, debilitating fear and worry that make every day activities difficult to complete), unspecified dementia without behavioral disturbance (a condition characterized by progressive and persistent loss of intellectual functioning with impaired memory and abstract thinking and personality change resulting from organic disease of the brain). Record review of Resident #1's Quarterly MDS, dated [DATE] revealed in Section C that he had a BIMS score of 5 which indicated severe cognitive impairment. Section E behavior indicated no psychosis, no presence of physical behavioral symptoms directed toward others, no presence of verbal behavioral symptoms directed toward others, and he had no behaviors such as wandering, pacing, or rummaging. Record review of Residents #1's nursing progress note Author: LVN EEffective Date: 08/17/2025 3:30 PM Type: Nursing NoteNote Text: Resident was being combative with staff and was escorted back to room, Resident started throwing things at the window in his room and broke his window, Police and EMS was called to deescalate the situation. Will continue to monitor, Hospice gave new orders for Haldol 5mg/1ml. Resident has been given Haldol 5mg/1ml, POA notified. Interventions: 1 on 1 monitoring, Directed to the resident's room to decrease stimulation, Assess for pain. Record review of the Incident Investigation Worksheet, dated 8/19/25, revealed the following [in part]: It was reported to the DON on 8/17/25 that Resident #1 threw a drawer through his window. During the course of investigation, it was discovered on 8/19/25 that the resident had previously thrown an over bed table out of a room at the staff and that the staff carried Resident #1 to his room, put him in his room and held the door closed. The staff members were suspended pending investigation. Inservice on abuse/neglect. Family notified; physician notified. An observation on 8/19/25 at 12:24 PM of the electronic monitoring system video dated 8/17/25, showed these events: -At 2:20 PM Resident #1 began showing behaviors which included: wandering into other residents' rooms, taking items from other residents rooms, dropping clothing items in the hallway, and pulling a bedside table down the hallway. -At 2:44 PM Resident #1 went into another residents' room and took a small fan out of that room and carried it down the hallway. Resident #1 became

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676148	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peach Tree Place	315 W Anderson St Weatherford, TX 76086

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment which were to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being for 1 of 7 residents (Resident #1) reviewed for comprehensive care plans. The facility failed to implement de-escalation techniques listed on the care plan were not implemented when 4 facility staff , (LVN A RN B, NA C and Laundry staff D) grabbed Resident #1 and forcibly carried him by his extremities to his room. The staff placed Resident #1 in his room and forcibly held the door closed so that he could not leave his room. An Immediate Jeopardy was identified on 9/12/25. The IJ template was provided to the facility on 9/12/25 at 5:07 PM While the IJ was removed on 9/14/25, the facility remained out of compliance at a scope of isolated, and a severity level of actual harm, due to the facility's need to evaluate the effectiveness of their corrective actions. These deficient practices could place residents at risk of not receiving the necessary care or services and having personalized plans developed to address their needs and maintain their highest level of well-being mentally and physically. Findings include: Record review of Resident # 1's face sheet dated 8/24/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses: major depressive disorder, (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life that can lead to a range of behavioral symptoms), anxiety disorder (a nervous disorder that significantly impairs daily life by causing constant, debilitating fear and worry that make every day activities difficult to complete), unspecified dementia without behavioral disturbance (a condition characterized by progressive and persistent loss of intellectual functioning with impaired memory and abstract thinking and personality change resulting from organic disease of the brain). Record review of Resident #1's Quarterly MDS, dated [DATE] revealed in Section C that he had a BIMS score of 5 which indicated severe cognitive impairment. Section E behavior indicated no psychosis, no presence of physical behavioral symptoms directed toward others, no presence of verbal behavioral symptoms directed toward others, and he had no behaviors such as wandering, pacing, or rummaging. Section N indicated the resident did not take an antipsychotic or an antidepressant since admission, re-entry or the last OBRA assessment. Record review of Resident #1's care plan last revised on 8/18/25 included: Focus The resident has a behavior problem - will become aggressive with staff and residents pushing and hitting. Purposely places himself on the floor. Interventions: Caregivers to provide for positive interaction, attention, stop and talk with him as they pass by initiated 1/3/24. Hospice to evaluate medication list with psych initiated 3/17/25. If resident becomes aggressive towards another resident remove him from the situation. Take him to a quiet area to talk. Resident likes to talk, walk outside and sit on the couch in the lobby initiated 4/22/25. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from the situation and take to an alternate place location as needed initiated 12/5/23. Resident enjoys prayers. When resident is combative ask him if he needs to pray (3/13/25); When resident has increased confusion and or combativeness call his granddaughter and let him speak to her initiated 3/13/25. Focus: Resident is at risk of feelings of isolation due to being on a secure unit because of high risk of elopement Revised 5/`4/25.Interventions: Admit to secure unit per Dr orders.Assist and monitor resident for off unit activities if possible.Involve resident in secure unit activities.Notify physician and family of changes. Focus: The resident has a history of trauma that may have a negative impact. Created 8/11/25 by DON and interventions initiated on 8/11/25.Interventions: Monitor for escalating anxiety, depression, or suicidal thought and report immediately to the nurse, physician, and mental health provider.Perform the following de-escalation techniques (there were no de-escalation techniques listed for staff to implement). An observation on 8/19/25 at 12:24 PM of the electronic monitoring system video dated 8/17/25, showed these events: -At 2:20 PM Resident #1 began showing behaviors which included: wandering into other residents' rooms, taking items from other residents rooms, dropping clothing items in the hallway, and pulling a bedside table down the hallway. -At 2:44 PM Resident #1 went into another residents' room and took a small fan out of that room and carried it down the hallway, Resident #1 became agitated when housekeeping staff took the fan away from him. -At 2:53 PM Resident #1 walked out of his room with a bedside table and pushed the bed

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record reviews and interviews the facility failed to develop implement and maintain an effective training program for all new and existing staff individuals providing services under a contractual management and volunteers consistent with their expected roles for 2 of 12 employees (LVN A and RN B) reviewed for required training. The facility failed to ensure LVN A and RN B had annual dementia and restraint reduction training. This failure could place residents at risk of receiving care from individuals who have not been properly trained. Findings include: Record review of employee training files reflected LVN A was hired 3/1/24 and her last dementia training was dated 3/15/24 . There was no evidence of restraint reduction training in her file other than a copy of a restraint reduction policy that was signed on 10/13/24. Record review of RN B's Employee files reflected the date of hire as 1/16/25. Ungraded dementia test dated 1/16/25. No restraints training. During an interview on 8/23/25 at 1:30 PM, LVN A stated Everyone that works in that building has had training for dementia and behaviors. We have in-services. We were supposed to do an in-person course not too long ago on behaviors and dementia, but it got cancelled. We have all our courses online now, and that is where the dementia and behavior is located. At the beginning of the month, Admin staff will go over stuff before we get our check. The old ADM did it before. The HR lady that quit has also done it before. It's just verbal and then you sign it at the end. They read it and there has been other ones we read, and sign stated she doesn't remember dates. LVN A did not answer when her last training was on behaviors and dementia. During an interview on 8/23/25 at 0:00, RN B she stated: I don't recall any training on dealing with behaviors. They say no restraints or nothing like that, and I absolutely support that. The interim administrator stated in an interview on 8/23/25 at 2:00 PM, the staff was responsible to complete their own training online. She stated each employee knows how to sign in and the trainings are assigned by the program for them to do. She stated the company had recently changed training programs which made it more difficult to keep up with the employee's progress. The administrator stated the facility was currently without an HR person, she recently resigned. She stated she would look for a training policy, a policy was not provided by the time of exit.