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	04/18/2026

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 - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 7 residents (Resident #1 and, Resident #5) reviewed for care plans. The facility failed to ensure the comprehensive care plan for Resident #1 addressed a fall, preferences, and discharge planning. The facility failed to ensure the staff developed the comprehensive care plan goals and interventions from the comprehensive assessment for Resident #5 to address nutrition, dental, pressure ulcer, communication, ADL function/rehabilitation potential, and discharge planning. This failure could place the residents at risk of inadequate care and services.Findings included: Record review of Resident #1's face sheet dated 4/18/2026 revealed a [AGE] year-old female with an admission date of03/13/2026. Her diagnoses included Alzheimer's Disease (a brain disorder that slowly destroys a person's memory and thinking skills), Dementia (loss of mental ability that interferes with daily life), chronic kidney disease, stage 3 (mild to moderate kidney damage affecting the kidney's not filtering waste from your blood), Depression (persistent sadness impacting daily life), anxiety disorder (persistent, excessive fear that interferes with daily life). Record review of Resident #1's MDS dated [DATE] in the CAA summary indicated that falls was a triggered area and that it was addressed in the care plan.Record review of Resident #1's comprehensive care plan undated and reviewed on 4/18/2026 revealed no evidence that falls was addressed in the care plan.Record review of Resident #1's comprehensive care plan undated and reviewed on 4/18/2026 revealed no evidence of documented discharge plans or discharge assessment. Records review of Resident #1's Event nurse's note dated 3/18/26 indicated a fall occurred with no injury. Record review of Resident #5's face sheet dated 4/18/2026 revealed a [AGE] year-old male with an admission date of 03/07/2026. His diagnoses included Acute kidney failure (rapid loss of kidney function to filter waste from the blood), Wernicke's Encephalopathy (acute neurological condition of intense swelling of the brain), severe protein calorie malnutrition (inadequate intake of protein and calories), Hypertensive heart and chronic kidney disease with heart failure and stage one through stage 4 chronic kidney disease (Complex cardiorenal syndrome where high blood pressure causes both heart dysfunction and progressive kidney damage), depression (persistent sadness affecting daily life), anxiety disorder (persistent worry and fear affecting daily life), dementia (loss of mental ability affecting daily life), Gastro esophageal reflux disease without esophagitis (Stomach acid frequently flows back into the esophagus causing heartburn, chest pain and regurgitation), calculus of gallbladder without cholecystitis without obstruction (gallstones without inflammation or blocked bile ducts), Occlusion and stenosis of bilateral carotid arteries (plaque buildup narrows or blocks both main neck arteries restricting blood flow to the brain). Record review of Resident #5's MDS dated [DATE] indicated a BIMS of 15 (cognitively intact).Record review of Resident #5's MDS dated [DATE] in the CAA summary indicated that communication, ADL functional/rehabilitation potential, nutritional status, dental care, and pressure ulcer were triggered (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	areas. The CAA summary further indicated that these areas were addressed in the care plan.Record review of Resident #5's comprehensive care plan undated and reviewed on 4/18/2026 revealed no evidence that communication, ADL functional/rehabilitation potential, nutritional status, dental care, and pressure ulcer were addressed in the care plan.Record review of Resident #5's comprehensive care plan undated and reviewed on 4/18/2026 revealed no evidence of documented discharge plans or discharge assessment. Record review of Resident #5's progress notes reviewed on 4/18/26 indicated he had a dental appointment scheduled and his dietary preferences were noted. In an interview on 4/17/26 at 5:28 p.m. with Resident #5, he stated that his needs were met. He stated he did his own showers and toileting, and he did not have any sores. Resident #5 stated he can get where he wanted to go on his own in his wheelchair. Resident #5 was able to express his wants and needs with clear communication. In an interview on 4/18/2026 at 12:25 p.m. with ADON-B, she revealed that it was the responsibility of MDS-A to complete the MDS assessment and initial comprehensive care plans after the MDS assessment was completed. ADON-B stated she was not sure who was responsible for including the discharge planning information in the care plan. ADON-B stated a negative effect from fall risk not being in the care plan may prevent the falls from being addressed if interventions were not in the care plan. She stated that Resident #1's falls were due to her behavior and the facility worked hard on minimizing the risk. ADON-B stated that the residents were all getting their needs met. In an interview on 4/18/26 at 4:48 p.m. with MDS-A, she stated she was responsible for the MDS assessment and completing the initial comprehensive care plans. MDS-A stated she was not aware of the care plans for Resident #1 and Resident #5 missing CAA triggered areas. She stated a negative impact from the information not being documented in the care plan could mean the residents' needs would not be person-centered or not be met. MDS-A stated she felt that had not happened in this case and the facility was meeting the residents' needs. In an interview on 4/18/26 at 5:20 p.m. with DON-C, she stated that MDS-A was responsible for initial and comprehensive care plans. DON-C stated MDS-A was available and responsible for the care plans created for Resident #1 and Resident #5. DON-C stated that Resident #1 was a fall risk and it should have been in the care plan. She stated Resident #1 had no injury from her falls. A negative effect of the CAA triggers not being addressed in the care plan could break communication between all departments but felt facility staff knew the residents and met their needs. In an interview on 4/18/26 at 6:42 p.m. with ADM-D, she stated that MDS-A was responsible for the MDS assessment and comprehensive care plans. ADM-D stated the department heads rely on MDS-A to update changes to the care plan. ADM-D stated a negative effect could have been that Resident #1 could have fallen and broken something. She stated the documentation could avoid immediate issues. Record Review of the Comprehensive Care Planning policy undated reflected The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Comprehensive care plans may include, but are not limited to resident Kardex records, baseline care plans, and task listings. The comprehensive care plan will describe the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and. The residents' goals for admission and desired outcomes. The resident's preference and potential for future discharge. The facility documents on whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. Discharge plans and the comprehensive care plan, as appropriate. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. If a Care Area Assessment (CAA) is triggered, the facility will further assess the resident to (continued on next page)

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