

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Elgin Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1373 North Avenue C Elgin, TX 78621	
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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 3 residents (Resident #1) reviewed for trauma-informed care. The facility failed to ensure Resident #1 had a care plan that identified possible triggers when Resident #1 had a history of trauma. This failure could place residents at an increased risk for severe psychological distress due to re-traumatization. The findings include:1. Record review of Resident #1's face sheet, dated 07/28/2026, reflected a [AGE] year-old-male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included post-traumatic stress disorder chronic with onset diagnosis on 07/07/2026 (a psychiatric condition that can develop in individuals who have experienced or witnessed a traumatic, terrifying, or life-threatening event. It lingers long after the danger has passed, causing intense, disturbing thoughts and emotions that disrupt daily functioning), impulse disorder (a mental health condition involving a repeated inability to resist harmful urges), and psychotic disorder with hallucinations (a mental health condition where individuals experience a break from reality, causing them to see, hear, smell, taste, or feel things that are not actually there).Record review of Resident #1's Quarterly MDS Assessment, dated 06/30/2026 reflected Resident #1 had a BIMS score of 9 indicating his cognition was moderately impaired. He was assessed to feeling down, depressed, or hopeless. Resident #1 assessed to have delusions (misconceptions or beliefs that are firmly held, contrary to reality). He was assessed to have a diagnosis of psychotic disorder and depression (lasing sadness, low energy, and a loss of interest in life).Record review of Resident #1's Comprehensive Care Plan, completed on 07/07/2026 and revised on 07/10/2026, reflected (problem initiated on 07/10/2026) Resident #1 was at risk for emotional and /or physical symptoms associated with distressing events and an increased inability to cope related to a diagnosis of Post Traumatic Stress Disorder. Resident had a history of incarceration, delusions (a fixed, false belief that a person holds firmly despite clear and obvious evidence that is not true), paranoia (an extreme and irrational mistrust or suspicion of other people, characterized by the belief that others are trying to harm, cheat, or watch you without any real proof), and longstanding mistrust of others. During periods of increased anxiety or perceived threat, resident may become verbally aggressive, make racially derogatory statements towards staff or other residents, refuse care, and exhibit escalating behaviors that may progress to physical aggression. Interventions: Administer psychiatric medications. Establish trust by being nonjudgemental and hones; offer empathy and support. Monitor for increase of paranoia, hallucinations, delusions or changes in mood. Protect other residents by redirecting or separating individuals when necessary. Provide resident with a safe means for expressing feelings, especially those of anger or aggression. Report significant behavioral (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes to the interdisciplinary team and psychiatric providers. Validate the resident's emotions without reinforcing delusional beliefs. Resident #1 did not have a focus area of possible triggers for the PTSD. Interview on 07/28/2026 at 10:05 a.m. Resident #1 stated no one in the facility has asked me about if there was anything that would trigger an episode of PTSD. He stated when he heard loud noises and people talking very loud it affected him and reminded him when he was in jail. Resident #1 stated there was men that thought they were boss of him and he was not going to be bossed by a man anymore. He stated, I become nervous and mad when a man tries to boss me and when there is a lot of noises. He stated, I heard a lot of noises when I was in jail and it reminds me of when I was locked in cell and could not do anything but listen to people yelling and banging on things. Interview with the ADON on 07/28/2026 at 5:05 p.m., the ADON stated the Social Worker was responsible to ensure an assessment was completed on any resident with diagnosis of PTSD. She stated a resident's triggers were expected to be identified during the assessment. The ADON did not elaborate on any of her responses to questions. She stated Resident #1's PTSD specific triggers were not identified on the interventions of his care plan. The ADON did not respond to any further questions about PTSD care plans. In an interview with the Social Worker on 07/28/2026 at 5:15 p.m., the Social Worker stated it was her responsibility to ensure all interventions related to any psychiatric diagnosis was care planned. She stated Resident #1's PTSD was a new diagnosis, and his care plan was expected to reflect his triggers. The Social worker did not respond to any further questions about PTSD and did not elaborate on her answers to questions. She stated she was not aware of the specific triggers of Resident #1. She stated she thought documenting perceived threat was sufficient to indicate his triggers. The Social Worker stated she realized she was not specific enough and the facility staff needed to know Resident #1's triggers. She stated she was going to interview the family and Resident #1 to determine what his triggers were and would revise Resident #1's care plan to reflect his triggers. She stated it would be beneficial to all staff in approaching Resident #1 and what not to do if they were aware of what made him anxious or depressed. She stated it was a possibility with him being incarcerated could be a lot of triggers from this event in his life. In an interview with the MDS Coordinator on 07/28/2026 at 5:30 p.m., she stated Resident #1 should have PTSD triggers identified and documented in his medical record. She stated the Social Worker was responsible for ensuring the PTSD triggers was identified when she did her assessment. The MDS Coordinator stated a resident's Care plan was their Plan of care. The MDS Coordinator did not respond to any further questions about PTSD or explain the purpose of care plans. Record review of the facility's policy on Behavioral Health Sciences, dated 10/24/2022, reflected Is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. Non-pharmacological intervention refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being. Facility staff will implement person-centered care approaches designed to [NAME] the individual goals and needs of each resident, which includes non-pharmacological interventions to help meet behavioral health needs.		