STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676267	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brodie Ranch Nursing and Rehabilitation Center	2101 Frate Barker Rd Austin, TX 78748

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for 3 of 5 residents (Residents #11, #73 and 103) reviewed for accidents.1. The facility failed to prevent Resident #11 from sustaining a head injury requiring lacerations during an unwitnessed fall on 04/15/2026.2. The facility failed to conduct a smoking safety evaluation for Residents #73 and 103 prior to survey entrance on 05/19/2026.The facility failed to address smoking in the care plan for Resident #73.These failures placed residents at risk of smoking-related and fall-related injuries. 1.Review of Resident #11s face sheet, dated 05/21/26, revealed an [AGE] year-old female admitted [DATE]. She had diagnoses which included dementia (severe cognitive decline in memory, thinking, reasoning), Alzheimer's disease (progressive disease that destroys memory and other important mental function), unsteadiness on feet, lack of coordination, and heart disease.Review of Resident #11's quarterly MDS assessment, dated 04/21/2026, revealed Resident #11 had a BIMS score of 03 indicating severe cognitive impairment. The MDS also revealed the resident had one fall since admission (the incident on 04/15/2026). The MDS also revealed that Resident #11 was dependent on staff for transfers and bed mobility.Review of Resident #11's care plan, updated 04/16/2026, revealed, [Resident #11] had an actual fall with injury on 04/15/2026. Interventions were, Ensure resident is not left unsupervised in the room while in wheelchair. If the resident feels tired encourage her to rest in bed, as tolerated. The care plan also stated [Resident#11] is at risk of falls related to poor safety awareness, impaired mobility, weakness, Alzheimer's disease, dementia. The interventions was be sure the call light is within reach and encourage to use it to call for assistance when needed. Keep needed items, water, in reach. The care plan also revealed there was no falls prior to the fall on 04/16/2026. Review of Resident #11's progress notes, dated 04/15/2026 at 11:00 a.m. by LPN G, stated, Resident was observed lying on the floor, face lying on the left side, and area was bleeding from the left side in room. Wheelchair was behind resident. 911 called. Assessment done. Vital signs taken. Resident able to move extremities and talking in Spanish as usual. Dressing applied to area on left side of head. Vital signs taken. Laceration noted on left side of head and on left cheekbone. Son was called and notified and stated to send resident to the hospital. The progress notes revealed there were no documentation of any other falls for Resident #11. Review of Resident #11's skin assessment, dated 04/15/2026, revealed, Laceration to left side of face with skin glue on it, side of head with 4 staples, bruising to left arm upper and lower, abrasion to left lower leg, swelling and bruising to left eye. During an interview with LPN G on 05/21/2026 at 1:48 p.m., she said she was the nurse on duty when Resident #11 was injured on 04/15/2026. She said Resident #11 had an unwitnessed fall and could not tell the staff what happened. She said the policy was to send the resident out for observation when the resident had an injury. She said Resident #11 returned from the hospital with a glue substance on her cheek and four staples in her head. She said Resident #11 did not say what happened. She said Resident #11 only spoke Spanish. She said she reported Resident #11's injury to the DON and the ADM. She said the DON was responsible for reporting the incident to Health and Human Services. She said the (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 4 of 4 residents (Resident #10, Resident #12, Resident #55, and Resident #84) reviewed for resident rights. The facility failed to ensure that HS knocked on the doors of Resident #12, Resident #55, and Resident #84 when entering their rooms. The facility failed to ensure the privacy of Residents #12, #55, and #84 by not knocking before entering. The facility failed to ensure Resident #10 was dressed in his own clothing on 05/19/2026, 05/20/2026, and 05/21/2026. These failures placed residents at risk of poor self-esteem and feeling that their privacy was invaded. Based on observation, interview, and record review, the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 3 of 3 residents (Resident #10, Resident #12, Resident #55, and Resident #84) reviewed for resident rights. The facility failed to ensure that HS knocked on the doors of Resident #12, Resident #55, and Resident #84 when entering their rooms. The facility failed to ensure the privacy of Residents #12, #55, and #84 by not knocking before entering. The facility failed to ensure Resident #10 was dressed in his own clothing on 05/19/2026, 05/20/2026, and 05/21/2026. These failures could place residents at risk of poor self-esteem and feeling that their privacy was invaded. Findings included: 1. Record review of Resident #12's face sheet, dated 05/21/2026, revealed a [AGE] year-old female admitted [DATE]. Resident #12 had diagnoses that included: Type 2 Diabetes with Neuropathy, Chronic Obstructive Pulmonary Disease (lung disease), and unspecified heart disease. Record review of Resident #12's admission MDS assessment, dated 03/18/2026, revealed Resident #12 did not have a BIMS score listed. Record review of Resident #12's care plan, dated 04/29/2026, did not reflect anything about privacy or knocking on the resident's door. Record review of Resident #55's face sheet, dated 05/19/2026, revealed a [AGE] year-old male, admitted [DATE] and readmitted [DATE]. Resident #55 had diagnoses that included: Legal Blindness, Type 2 Diabetes, and Chronic Obstructive Pulmonary Disease (heart disease). Record review of Resident #55's admission MDS assessment, dated 03/19/2026, revealed Resident #12 had a BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #55's care plan, dated 04/13/2026, did not reflect anything about privacy or knocking on the resident's door. Record review of Resident #84's face sheet, dated 0/19/2026, revealed a [AGE] year-old male admitted [DATE]. Resident #84 had diagnoses that included: Type 2 Diabetes, chronic Obstructive Pulmonary Disease (heart disease), and kidney disease. Record review of Resident #84's admission MDS assessment, dated 05/06/2026, revealed Resident #84 had a BIMS score of 12, which indicated moderate cognitive impairment. Record review of Resident #84's care plan, dated 05/13/2026, did not reflect anything about privacy or knocking on the resident's door. During an observation on 05/19/2026 at 10:25 A.M., of HSWhen she was delivering clothes to residents in rooms [ROOM NUMBERS], she did not knock on the door to let the resident know that she was entering the room. During an interview on 05/19/2026 at 10:40 A.M., the HS stated if there's no one in the room, she doesn't knock on the door. The HS stated all staff were supposed to knock and notify residents before entering the room. The HS stated residents could be receiving care, and that if they don't knock, they could walk in on them. The HS stated it was a privacy issue when they did not knock before entering. The HS stated she received training on residents' privacy and that her most recent training was a month ago during a huddle before the shift started. During an interview on 05/21/2026 at 2:10 PM, the DON stated all staff should be knocking on residents' rooms before entering. The DON stated staff should knock on the door even if no one was in the room. The DON stated she had not seen any staff (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not knocking on the residents' doors. The DON stated if she saw staff not knocking on the door, she would pull them aside and remind them to knock. The DON stated that she could not remember when they had in-service training on privacy. The DON stated that the Assistant Director of Nursing conducted the training. The DON stated she was unaware of any negative outcomes for residents if staff did not knock on the door. During an interview on 05/21/2026 at 2:17 PM, the ADM stated all staff should knock on the door before going into a resident's room. The ADM stated if the staff's hands were full, they should announce their entry to the room. The ADM stated he had not seen any staff not knocking on doors and, if he did, he would correct the staff and provide in-service training. The ADM stated that if staff did not knock on the door, it could startle the residents and would not create a homelike environment. The ADM stated that they recently had in-service training on privacy on 5-18-2026. 2. Record review of the undated face sheet for Resident #10 reflected a [AGE] year-old male admitted [DATE]. His diagnoses included depression, cognitive communication deficit (problems with communication due to impaired cognition), muscle weakness, post-traumatic stress disorder, age-related physical debility, and chronic pain. Record review of the care plan for Resident #10, dated 04/20/2026, reflected the following: FOCUSADL Self Care Performance Deficit r/t age related physical debility, chronic pain syndrome, depression, muscle weaknessGOALWill maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene through the review date. Record review of the admission MDS assessment for Resident #10, dated 04/22/2026, reflected a BIMS score of 05, indicating a severe cognitive impairment. It also reflected he required substantial/maximal assistance in upper body dressing and was completely dependent on staff for lower body dressing. Record review of the dressing task for Resident #10, from 05/07/2026 to 05/21/2026, reflected he was dressed at 8:49 AM by CNA E and 17:03 PM on 05/19/2026 and 8:25 A.M. and 9:59 PM. Record review of OT notes for Resident #10, dated 05/20/2026, reflected the following: Patient demonstrates UB dressing tasks with Max a with cues for proper body mechanics and sequencing. Patient requires total a for LB dressing tasks with cues for log rolling and bridging. The note was signed by OT F at 5:46 PM on 05/20/2026. During observations on 05/19/2026 at 10:30 A.M. and 2:42 PM, Resident #10 was lying in his bed wearing a hospital gown. During an observation and interview on 05/20/2026 at 9:59 A.M., Resident #10 was lying in his bed with a hospital gown on. He stated he would like to put on his own shirt and pants, but he had not spoken with anyone about it. He stated no staff offered to help him change into his own shirt and pants. He stated he had shirts and pants in his drawer and closet. Observation revealed there were seven t-shirts hanging in his closet and four pairs of pants in his drawer. During an observation and interview on 05/21/2026 at 9:25 A.M., Resident #10 was lying in bed wearing a hospital gown. He stated the staff finally got him dressed in his own clothes the afternoon before but had not offered to help him dress that day. He stated they got him back in the hospital gown before he went to sleep the night before. During an observation on 05/21/2026 at 12:19 PM, Resident #10 was lying in bed in a hospital gown. During an interview on 05/21/2026 at 12:20 PM, CNA E stated she had worked on Resident #10's hall on 05/20/2026. She stated she had signed the dressing task in the POC system for the morning, but she could not remember if she dressed him in his own clothes. She stated when she saw him in the afternoon that day, he was in his clothes. She stated she did not know how he got dressed in his clothes. She stated she was not sure if she had asked him if he wanted to get dressed in his own clothes that morning when she documented that she had dressed him. She stated she was trained to offer to help residents dress in their own clothes, and she did not know why she did not assist Resident #10 on 05/20/2026.^ During an interview on 05/21/2026 at 12:29 PM, OT G stated she assisted Resident #10 in getting dressed on 05/20/2026 as part of his occupational therapy exercises. She stated she thought it was just before lunch that she helped him dress in his own clothes. She stated she would have expected residents to be assisted by CNAs in dressing in their own clothes by lunchtime, but sometimes residents refused to change. During an interview on 05/21/2026 at 3:28 PM, LPN F stated residents were supposed to be offered help dressing in regular (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for one of eight residents (Resident #11) reviewed for ??.The facility failed to report to Health and Human Services an injury of unknown origin that occurred on 04/15/2026 when Resident #11 had an unwitnessed fall with injury and could not tell staff what happened. This failure could place residents at risk of abuse, neglect, pain, and diminished quality of life.Findings included: Record review of Resident #11s face sheet, dated 01/05/26, revealed an [AGE] year-old female admitted [DATE]. She had diagnoses which included dementia (severe cognitive decline in memory, thinking, reasoning), Alzheimer's disease (progressive disease that destroys memory and other important mental function), unsteadiness on feet, lack of coordination, and heart disease. Record review of Resident #11's quarterly MDS assessment, dated 04/21/2026, revealed Resident #11 had a BIMS score of 03 indicating severe cognitive impairment. The MDS also revealed the resident had one fall since admission (the incident on 04/15/2026). The MDS also revealed that Resident #11 was dependent on staff for transfers. Record review of Resident #11's care plan, updated 04/16/2026, revealed, [Resident #11] had an actual fall with injury on 04/15/2026. Interventions were, Ensure resident is not left unsupervised in the room while in wheelchair. If the resident feels tired encourage her to rest in bed, as tolerated. The care plan also stated [Resident#11] is at risk of falls related to poor safety awareness, impaired mobility, weakness, Alzheimer's disease, dementia. The interventions was be sure the call light is within reach and encourage to use it to call for assistance when needed. Keep needed items, water, in reach. Record review of Resident #11's progress notes, dated 04/15/2026 at 11:00 a.m. by LPN G, stated, Resident was observed lying on the floor, face lying on the left side, and area was bleeding from the left side in room. Wheelchair was behind resident. 911 called. Assessment done. Vital signs taken. Resident able to move extremities and talking in Spanish as usual. Dressing applied toarea on left side of head. Vital signs taken. Laceration noted on left side of head and on left cheekbone. Son was called and notified and stated to send resident to the hospital. Record review of Resident #11's skin assessment, dated 04/15/2026, revealed, Laceration to left side of face with skin glue on it, side of head with 4 staples, bruising to left arm upper and lower, abrasion to left lower leg, swelling and bruising to left eye. During an interview with LPN G on 05/21/2026 at 1:48 p.m., she said she was the nurse on duty when Resident #11 was injured on 04/15/2026. She said Resident #11 had an unwitnessed fall and could not tell the staff what happened. She said the policy was to send the resident out for observation when the resident had an injury. She said Resident #11 returned from the hospital with a glue substance on her cheek and four staples in her head. She said Resident #11 did not say what happened. She said Resident #11 only spoke Spanish. She said she reported Resident #11's injury to the DON and the ADM. She said the DON was responsible for reporting the incident to Health and Human Services. She said the facility had a two-hour window to report. During an interview with the DON on 05/21/2026 at 1:53pm., she said she remembered the incident with Resident #11 on 04/15/2026. She said Resident #11 fell and hit her head. She said it was an unwitnessed fall. She said the resident could not tell the staff what happened. She said the policy for injury of unknown origin was the DON and ADM would talk about the incident and determine if it (continued on next page)

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	676267	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brodie Ranch Nursing and Rehabilitation Center	2101 Frate Barker Rd Austin, TX 78748

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to be reported. She said the way she was laying on the floor was clear she had a fall. She said she knew she was supposed to report an injury of unknown origin, but the DON and ADM knew it was from a fall. She could not say how the DON and ADM knew the resident fell. She said she did not know how not reporting an injury of unknown origin could affect the residents. The DON then said Resident #11 had a roommate, but she could not say for sure the roommate saw Resident #11 fall. She said the DON and ADM knew Resident #11 fell so that was why they did not report the incident. During an interview with the ADM on 05/21/2026 at 2:00 p.m., he said he was responsible for reporting incidents to Health and Human Services. He said he was aware of a fall Resident #11 had on 04/15/2025 where she was sent out to the hospital. He said Resident #11 had an unwitnessed fall. He said the resident could not tell staff what happened. He said the nurse determined Resident #11 had a fall He said he would not consider Resident #11's incident an injury of unknown origin because he said Resident #11 had a history of falls. He said the DON talked to the roommate. He said he did not know if the roommate Resident #11 fell. He said he was supposed to report an injury of unknown origin within two hours. He said if there was an injury of unknown origin there could be an ongoing harm. He said he did not report Resident #11's incident because he did not find it suspicious and said the incident did not fit the criteria of injury of unknown origin. Record review of the facility policy titled, Abuse: Prevention of and Prohibition Against, dated 10/2022, revealed, Because some cases of abuse are not directly observed, understanding resident outcomes of abuse can assist in identifying whether abuse is occurring or has occurred. Possible indicators of abuse include, but are not limited to: Bruises, skin tears and injuries of unknown source; Extensive injuries; Injuries in an unusual location; Occurrences, patterns, and trends that may constitute abuse; Allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 2 (Residents #113 and 87) of 6 residents reviewed for PASARR.The facility failed to perform a new PASRR assessment on Resident #113 when he was newly diagnosed with bipolar disorder.The facility failed to refer Resident #87 for a level II PASRR evaluation despite her qualifying diagnosis of paranoid personality disorder.This failure could place residents at risk of not receiving the services and support needed.Findings Included: Record review of Resident #113's face sheet, dated 05/21/26, revealed a [AGE] year-old male admitted [DATE] with diagnoses that included chronic pain syndrome, need for assistance with personal care, vitamin D deficiency, cognitive communication deficit, major depressive disorder and bipolar disorder.Record review of Resident #113's annual MDS assessment, dated 03/13/26, revealed a BIMS score of 11 which indicated he had moderately impaired cognition. The MDS also indicated Bipolar Disorder and Depression were included in his active diagnoses. Record review of Resident#113's care plan completed on 03/30/26 revealed there was no care plan for Bipolar disorder or depression.Record review of Resident# 113's diagnoses revealed he had a diagnosis of bipolar disorder newly identified on 08/25/25.Record review of Resident #113's PASRR Level 1 assessment indicated that it was conducted on 10/08/20199, at which time the resident was noted to be negative for mental illness. Further record review indicated no subsequent PASRR assessments were performed following the diagnosis of bipolar disorder on 08/25/25.Record review of the undated face sheet for Resident #87 reflected a [AGE] year-old female admitted [DATE]. Her diagnoses included paranoid personality disorder (fear) , generalized anxiety disorder, and dementia.Record review of the care plan for Resident #87, dated 10/02/2025, reflected the following: FOCUS(Resident #87) is at risk for impaired cognitive function or impaired thought processes related to personality disorderGOALWill maintain current level of cognitive function through the review date.INTERVENTIONSAdminister medications as ordered.Engage in simple, structured activities that avoid overly demanding tasks.Give step by step instructions one at a time as needed to support cognitive function.Keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.Record review of the admission MDS assessment for Resident #87, dated 03/20/2026, reflected that she could or would not participate in the BIMS assessment, indicating severe cognitive impairment. It also reflected that she had verbal behaviors 1-3 times rejection of care behavior every day during the two-week review period. Record review of the PASRR level I evaluation for Resident #87, dated 10/01/2025, reflected she had a primary diagnosis of dementia and had no diagnosis of mental illness.During an observation and interview on 05/19/2026 at 9:44 A.M., Resident #87 was sitting in a dining chair in the corner of her room. She stated she knew someone was killing the children and putting poison in their breakfast cereal. She did not respond to efforts to redirect the interview.During an interview on 05/19/2026 at 2:03 PM, the LG for Resident #87 stated she had never thought about PASRR services for Resident #87 and thought they might be good for her.During an interview on 05/21/26 at 2:20 PM, the MDSN stated she was responsible for conducting PASRR assessments but was unable to locate a PASRR screening following Resident #113's new diagnosis. She stated she inadvertently missed PASRR assessment. The MDSN said that the absence of a new PASRR assessment due to the qualifying diagnosis could result in Resident#113 not receiving additional services to which he might be entitled. The MDSN stated she was new to the position and had also not review Resident #87's chart to see if she needed a PASRR referral.During a telephone interview on 05/21/26 at 3:10 pm, the NP stated she was not aware of Resident #113's bipolar diagnosis from 08/25/25. She reported she knew the resident well and observed no signs or (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms consistent with bipolar disorder. The NP stated she was unaware of any medications the resident was taking for bipolar disorder and indicated she needed to verify whether the diagnosis was incorrect or if the resident missed treatment. She further stated that, given the current condition of Resident #113, she would not prescribe psychiatric medication for bipolar disorder, as there were no behavioral concerns with him at present.During an interview on 05/21/26 at 3:45 pm, the DON stated the MDSN should have identified residents with newly qualifying criteria that would necessitate a PASRR assessment by conducting appropriate screenings. The DON said that the impact of this negligence on Resident #113 was minimal, as he was receiving other psychiatric interventions. She stated she was unsure of the potential benefits Resident #113 might have missed if he tested positive for PASRR following his recent diagnosis.Record review of facility policy, dated 01/2022, titled, PASRR, reflected the following: Policy: The facility will designate an individual to follow up on ALL residents have received a PASRR Level I screening. If Facility serves a resident with a positive PASRR Level I screening, the facility MUST have obtained A PASRR Level II evaluation from the Local Authority or have a documented attempts to follow up with the Local Authority to obtain the PASRR Level II evaluation.Procedure: Nursing Individual MUST:A. Coordinate with referring entities to ensure that any person seeking admission to a Medicaid-Certified NF received a PASRR Level I screening for an intellectual disability (ID), related condition (DD) also know as developmental disability or mental illness (MI) prior t or upon admissionB. Coordinate with the local Intellectual/ Development Disability and/or Local Mental Health Authority (Local Authority) to ensure a PASRR Level II Evaluation is conducted when an individual ?s PASRR Level I screening indicates the individual may have an ID, DD, or MI.C. Coordinate with the local authority to ensure that the individual is properly assessed for any specialized services recommended in the Level II evaluation as being needed when a determination of ID, DD, or MI is made. (Under 40 TAC Chapter 19, the NF is responsible for assessing the individual for PT, (Occupational Therapy), and ST needs and for Durable Medical Equipment.D. Convene the IDT meeting within 14 days.E. Provide nursing facility specialized services agreed to in the IDT meeting within 30 days after IDT meeting.F. Coordinate and cooperate with the LIDDA/LMHA Service Planning Team

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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 observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 11 residents (Resident #73) reviewed for comprehensive care plans. The facility failed to ensure Resident #73 was care planned for smoking and for compromised oral/dental status. This failure placed residents at risk of accident injury and not having nutritional needs met. Record review of the undated face sheet for Resident #73 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included type two diabetes mellitus (a disease that affects how the body uses blood sugar), chronic obstructive pulmonary disease (a long-term lung condition that causes airflow blockage and breathing difficulties), emphysema (a long-term lung condition that causes airflow blockage and breathing difficulties), muscle weakness, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit (problems with communication due to impaired cognition), dementia, schizoaffective disorder (combination of schizophrenia and a mood disorder), and post-traumatic stress disorder. Record review of the admission MDS for Resident #73, dated 12/29/2025, reflected a BIMS score of 10, indicating a moderate cognitive impairment. It also reflected he did not use tobacco. Record review of the care plan for Resident #73, dated 05/20/2026 (the day after the recertification began), reflected the following: FOCUS(Resident #73) uses TobaccoGOALResident will Adhere to the Tobacco/Smoking Policies of the FacilityINTERVENTIONS-Educate Resident / Family on risks & health effects of tobacco use-Provide education regarding the adverse effects of smoking-Provide support to Resident The care plan also reflected the following, dated 01/07/2026 FOCUSHas nutritional problem or potential nutritional problemGOALWill maintain adequate nutritional status as evidenced by maintaining weight with no s/sx of malnutrition through review date.INTERVENTIONS-Honor resident rights to make personal dietary choices and provide dietary education as needed-Meals in dining room if resident is in agreement Observation and interview on 05/19/2026 at 9:50 AM revealed Resident #73 lying in his bed. He stated he only had a few teeth, and he really wanted dentures so he could eat better. He showed his mouth, and there were only three teeth visible on the top row. He stated that he smoked and had never been injured or felt unsafe smoking in the facility. Observation on 05/19/2026 at 1:00 PM revealed Resident #73 was seated in a chair in the outdoor smoking area and was smoking a cigarette. He was able to smoke without any obvious hazard to his person. The area was supervised by four staff members. During an interview on 05/21/2026 at 3:28 PM, LPN F stated she sometimes conducted admission assessments but not often, as her hall was the long-term hall. She stated she had not seen a smoking safety assessment on every single admission checklist and did not know how the smoking evaluation got added to the admission assessments. She stated the residents who did smoke were supposed to have a smoking safety evaluation. During an interview on 05/21/2026 at 4:13 PM, the MDSN stated the admitting charge nurse should have done the smoking safety evaluation. She stated they had a morning meeting and that was where they discussed new residents who smoked. She stated she did not think there was a process in place for a resident who entered the facility as a nonsmoker but decided to start smoking after they entered. She stated if a resident had a problem with their teeth, it should have been care planned under nutrition. She stated she did not have any role in completing Resident #73's admission assessments and paperwork, because she had only started in her role about three weeks prior. She stated a potential negative impact of not having care areas added tot eh care plan was the issue might not make it on the POC, and then the aides might not know they had to provide care. During an interview on 05/21/2026 at 4:49 PM , the ADM stated he expected a smoking safety (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment to be completed for all smokers within 72 hours of admission. He stated if smoking was observed by staff after admission, he thought the care plan should be updated. He stated there was not a particular person whose role it was to update that information. He stated he did not know how they monitored for compliance with smoking safety evaluations and care planning. He stated the potential negative impact of not having smoking on the care plan was burns and the potential negative impact of not having dental status on the care plan was weight loss. Record review of facility policy, dated 04/2025 and titled, Comprehensive Resident Centered Care Plan, reflected the following: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist residents in obtaining routine dental care for 1 of 11 residents (Resident #73) reviewed for dental needs. The facility failed to offer Resident #73 dental services or refer him to be seen by a dentist. This failure placed residents at risk of pain and poor nutrition.Review of the undated face sheet for Resident #73 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included type two diabetes mellitus (a disease that affects how the body uses blood sugar), chronic obstructive pulmonary disease (a long-term lung condition that causes airflow blockage and breathing difficulties), emphysema (a long-term lung condition that causes airflow blockage and breathing difficulties), muscle weakness, abnormalities of gait and mobility, lack of coordination, cognitive communication deficit (problems with communication due to impaired cognition), dementia, schizoaffective disorder (combination of schizophrenia and a mood disorder), and post-traumatic stress disorder. Review of the admission MDS for Resident #73 dated 12/29/2025 reflected a BIMS score of 10, indicating a moderate cognitive impairment. It also reflected that he had abnormal mouth tissue (ulcers, masses, oral lesions), obvious or likely cavity or broken natural teeth, and inflamed or bleeding gums or loose natural teeth. Review of the care plan for Resident #73 dated 01/07/2026 reflected the following: FOCUSHas nutritional problem or potential nutritional problemGOALWill maintain adequate nutritional status as evidenced by maintaining weight with no s/sx of malnutrition through review date.INTERVENTIONS-Honor resident rights to make personal dietary choices and provide dietary education as needed-Meals in dining room if resident is in agreement. Review of documents in Resident #73's clinical record from December 2026 to 05/20/2026 reflected nothing related to dental services. Observation and interview on 05/19/2026 at 9:50 AM revealed Resident #73 lying in his bed. He stated he only had a few teeth, and he really wanted dentures so he could eat better. He showed his mouth, and there were only three teeth visible on the top row. He said he wanted to see a dentist but had not seen one since he admitted to the facility. During an interview on 05/20/2026 at 1:15 PM, the ADM stated the SW was out on leave, but he would obtain the information about whether Resident # 73was referred for dental services. He came back a few minutes later and said Resident #73 had not been referred for dental services and had not seen the dentists since his arrival at the facility. The ADM stated he was referring Resident #73 to the dentist because Resident #73 was entitled to be referred to the dentist. He stated he did not know if anyone had followed up for consent from Resident #73 after trying a week ago to obtain them. He stated Resident #73 was relatively easy to locate. During an interview on 05/20/2026 at 4:49 PM, the ADM stated it was his expectation that residents who needed dental care would be referred to the dentist. He stated the failure to refer a resident to the dentist could result in nutritional problems or unaddressed pain. Review of an email received from the ADM on 05/21/2026 at 9:26 AM reflected the following: For (Resident #73), they attempted to have him sign the consent forms last week to begin dental treatments, but he was unavailable. I've spoken to the provider, and they said they would be able to get him on their schedule once consents are signed. Review of the facility policy dated 04/2025 and titled Dental Services reflected the following: It is the policy of this Facility to ensure that its residents who require dental services on a routine or emergency basis have access to such services without barrier. It is likewise the policy of the Facility to repair or replace the dentures of a resident except in those situations where the loss or damage directly results from the action of an alert and oriented resident who is responsible for his/her own medical decisions.For Medicaid residents, the Facility will provide all emergency dental services and those routine dental services to the extent covered under the Medicaid state plan. The Facility will inform the resident of the deduction for the incurred medical expense available under the Medicaid state plan and will assist the resident in applying for the deduction.In order to comply with the Facility's obligations as set forth in 42 CFR Section 483.55, the Facility will: Provide, or obtain (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from an outside resource, routine, and emergency dental services for each resident. Assist the resident as necessary or requested to make appointments for dental services or arrange for transportation to and from dental services locations. Promptly, and within three days, refer a resident with lost or damaged partial or full dentures, and/or documented the extenuating circumstances that led to a delay. Document what the Facility did to ensure that a resident with missing or damaged partial or full dentures could still eat and drink adequately while awaiting dental services. Not charge a resident for the loss or damage of partial or full dentures determined to, by Facility policy, to be the Facility's responsibility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 1of 3 residents (Resident #125) reviewed for incontinence care. The facility failed to ensure that :CNA C and CNA D handled personal care items with clean gloves while providing incontinent care for Resident #125. This failure could place the residents at the facility at risk of transmission of disease and infection.Findings included: Record review of Resident #125's face sheet, dated 05/20/26, reflected Resident #125 was admitted to the facility on [DATE]. Resident #125 was a [AGE] year-old female, diagnosed with type 2 diabetes, chronic kidney disease, muscle weakness, lack of coordination, cognitive communication deficit and major depressive disorder.Record review of Resident #125's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating her cognition was intact. The MDS indicated that the Resident was dependent on one or more staff for personal hygiene. Record review of Resident #125's care plan dated 05/05/25 revealed she had ADL self-care performance deficit . The intervention was providing required ADL care. During an observation on 05/19/26 at 1:40 pm, CNA C and CNA D provided incontinent care to Resident #125. Both CNAs entered the resident's room, washed their hands, and donned disposable gloves. CNA C removed the soiled brief and cleaned Resident #125's front and back using wet wipes. However, she did so without changing her gloves after direct contact with feces, and she handled the wet wipe packet with the contaminated gloves. This action resulted in the contamination of the wipe packet. Subsequently, CNA C stored the contaminated packet, along with remaining wipes and other incontinent care items for Resident #125, in the drawer for future use.During an interview on 05/19/26 at 2:10 PM , CNA C requested a walk-through of the peri-care performed by her and CNA D to identify her errors. She stated that she should have changed her gloves at appropriate intervals and should not have handled the wet wipe packet with soiled gloves. CNA C expressed concern that her improper practices could facilitate the spread of infections. She noted that she had attended an in-service session a few weeks prior, which covered incontinent care and infection control protocols. She stated that she was nervous during the incident and inadvertently forgot to change her gloves before handling the wet wipe packet.In an interview on 05/19/26 at 1:55 pm , CNA D stated that she observed CNA C touching the wet wipe packet with contaminated gloves. She wanted to correct her but refrained from doing so in the presence of the HHSC surveyor, fearing it might be perceived as a violation of the survey process. CNA D stated that changing contaminated gloves before handling clean items was mandatory to prevent cross-contamination. She also stated that she attended a peri-care in-service a few weeks earlier with CNA C.During an interview on 05/21/26 at 3:45 PM, the DON stated that CNA C should not have handled the wet wipe packet with soiled gloves. She stated that both CNA C and CNA D were supposed to dispose of the contaminated wet wipe packet immediately rather than saving it for future use. The DON concluded that CNA C's improper practices increased the risk of disease transmission through contamination.Record review of facility policy Infection Control revised in March,2025 reflected : Policy:It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. Procedure: Standard Precautions are infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions, and excretions (except sweat) may contain transmissible infectious agents. Standard Precautions include:Proper selection and use of PPE, such as gowns, gloves, facemasks, respirators, and eye protection:Use and type of PPE is based on the predicted staff interaction with residents and the potential for exposure to blood, body fluids, or pathogens (e.g., gloves are worn when contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment are anticipated).