STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676276	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewest Rehabilitation and Skilled Care	2450 Bickers St Dallas, TX 75212

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 9 (Residents #2, #3, #4, #5, #6, #7, #8, #9, #10) of 14 reviewed for Abuse.The facility failed to protect Residents #2, #3, #4, #5, #6, #7, #8, #9, #10 from physical and verbal abuse by another resident.An IJ was identified on 4-16-2026. The IJ template was provided to the facility on 4-16-2026 at 3:40 PM. While the IJ was removed on 4-17-2026, the facility remained out of compliance at a scope of pattern and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective measures. This failure placed residents at risk of subsequent abuse resulting in potential mental anguish, emotional distress, and physical harm. Findings included:Record review of Resident #1's admission Record, dated 4-15-2026, revealed a [AGE] year-old female with an original admission date of 4-26-2021 and a readmission date of 11-4-2025. Resident #1 had a primary diagnosis of dementia with psychotic disturbance (the presence of delusions or hallucinations in individuals with a diagnosed neurodegenerative [chronic loss of function in nerve cells] disorder) and secondary diagnoses of homicidal ideations (thoughts, fantasies, or plans about killing another person), paranoid schizophrenia (a chronic mental health disorder, characterized by intense, irrational delusions and hallucinations-often auditory centered on persecution or conspiracy), dementia with other behavioral disturbance (involves non-cognitive symptoms like agitation, aggression, depression, wandering, or social disinhibition) schizoaffective disorder (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions, disorganized speech) with major mood disorder, such as depression or bipolar mania), psychosis not due to a substance or known physiological condition, and insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early, leading to daytime fatigue, irritability, and poor concentration). Review of Resident #1's Quarterly MDS dated [DATE], revealed Resident #1 re-entered the facility from an inpatient psychiatric facility with a BIMS score of 8 which indicated being mildly cognitively impaired. The D Mood section indicated Resident #1 often felt socially isolated. Section E Behavior section indicated Resident #1 rejected evaluation and care daily. Review of Resident #1's most recent Care Plan with an initial date of 5-24-2022 and revised on 2-9-2026 revealed she was physically aggressive to staff and residents having a pair of scissors being at risk for potential for harming herself and others. Resident #1 has attempted to use metal utensils to harm staff. On 10-7-2025 Resident #1 hit another resident, 10-8-2025 Resident #1 was physically aggressive to another resident, 1-21-2026 Resident #1 was physically aggressive toward another resident. Resident #1 was at risk for delirium initiated on 4-24-2022 stating the devil will tell her to do things, Resident #1 was resistive to care by refusing to take medications revised on 4-5-2023, Resident #1 had potential to be verbally aggressive yelling at staff because of ineffective coping skills revised on 5-19-2021, Resident #1 was physically aggressive to staff and residents because of poor impulse control by locking herself in other resident's bathroom revised on 6-20-2023, Resident #1 had aggressive behavior problems striking Residents initiated on 9-29-2024, Resident #1 was care planned to receive antipsychotic medication (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	for mood & behavior management revised on 7-24-2022.Review of a Resident #1's Psychiatric Subsequent assessment dated [DATE], reflected a history of being confrontational, not compliant with medications, bizarre behavior, having schizoaffective disorder having a history of depression, symptoms of psychosis including auditory hallucinations, visual hallucinations, delusions, Alzheimer's disease with major depressive disorder, and paranoid schizophrenia. Current psychotropic medications included: Depakote Sprinkle, Trazodone, and Haldol injections. Resident #1 frequently refused medications and lag draws. Review of Resident #1's progress nurse notes reflected the following:1-23-2025 at 1:58 PM - Resident just came back from [mental] hospital stay due to negative behaviors. Resident had been making threats and taking things from other residents .5-8-2025 at 1:15 PM - Psychiatric service asked to see resident due to increase of behaviors. Resident yelling and screaming out loud at staff with any attempts to redirect her .5-13-2025 - 3:59 PM - .resident's refusal of valproic acid lab draw. Lab personnel will try again in the next round of blood draw.5-15-2025 - 4:00 PM - Psych in facility and due to resident's increased behaviors .5-28-2025 at 3:0016 AM - Resident #1 had a fall. Neighborhood portable x-ray personnel [were] in this facility for resident's ordered skull series x-ray. resident refused stating Get out, I told you I am a missionary; I don't go over what other people go through . The above skull series x-ray not performed at this time. resident refused.7-30-2025 at 7:47 PM - Resident stated she doesn't take meds nurse notified.7-31-2025 at 7:41 PM - [Resident] stated she doesn't take medication nurse notified.8-2-2025 at 12:20 PM - I am calling about [Resident #1] . Noncompliant with taking medications. This started on 07/28/2025. Since this started has stayed the same. The following makes this condition worse refusing medications . Resident noted to have behaviors of refusing meds and is hard to redirect . Resident noted to have more pacing in and out of room and verbal aggressiveness towards staff. Informed that resident has been refusing her medication saying she is not sick .8-5-2025 at 7:25 PM - Resident stated she doesn't take medications that nothing is wrong with her because she is a missionary.8-19-2025 at 1:40 PM - Patient noted with increased agitation yelling at another resident and noted to have verbal outburst when discussing boundaries and behaviors. Patient gets upset and yells at staff. Patient can be redirected at times but requires constant redirection.8-19-2025 at 1:40 PM - Resident #1 in the dining room and reported to be verbally aggressive with table mate .8-21-2025 at 12:03 PM - Resident #1 is noted to have increased agitation with anxiety, yells at staff, pacing and follows staff .8-25-2025 at 12:20 PM - Resident #1 is noted to have agitation and yells at staff, pacing .8-26-2025 at 1:25 PM - Resident #1 has been verbally aggressive with staff, yells out when redirected, then paces to her room .8-28-2025 at 5:20 PM - Resident #1 pacing and follows 1 staff and yells out with agitation when staff redirects her that she has to work. Tells staff. Shut up, you don't do nothing! .8-31-2025 at 3:52 PM - Resident #1 was observed entering another resident's room (313A) and removing clothing items from the closet . the resident became verbally and physically agitated. She raised her voice and yelled, stating, Y'all work for the devil and when God tells me to leave then I'll leave or when she tells me to leave then I will, but the rest of y'all can go to hell.9-5-2025 at 11:11 AM - Social Worker Note: and changing clothes multiple times per day. Resident #1 is currently being followed by [mental health professional]. She has also been noted to bother other residents and cross personal boundaries .10-7-2025 at 2:45 PM - ADON A witnessed resident from RM [ROOM NUMBER]A hit resident [Resident#6] on her left shoulder while passing by outside dining room across by nurse's station . [Resident #1] was verbally aggressive when asked why she hit the other and walked away to her room, refused assessment .10-8-2025 at 8:28 AM - NP notified . Patient noted to have physical aggressive behavior toward residents and staff. Refuses all medications and assistance from staff. While supervising the patient as a one on one, patient struck staff. Patient unable to be redirected; screaming and using profanity toward staff. Patient chasing staff member through dining room trying to strike at her. Patient redirected by staff x several attempts. Patient goes into her room and after 1-2 mins return to hallway yelling and screaming at staff and other patients trying to hit staff while screaming in their face .Police and 911 called .10-8-2025 at 9:01 AM - (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Resident #1 to be transferred to Psychiatric ER Hospital because of altered mental state with aggression and physical aggression .10-8-2025 at 10:45 AM - While supervising patient as a one on one, patient chased staff away, struck staff to her back. Patient unable to be redirected; screaming and using profanity toward staff. Patient chasing staff member through dining room trying to strike at her again. Patient redirected by staff x several attempts. Patient goes into her room and after 1-2 mins return to hallway yelling and screaming at staff and other patients trying to hit staff while screaming in their face .10-8-2025 at 11:01 AM - ADON A stated Patient needs cannot be met, facility attempts to meet the resident needs, and the service available are refused by patient x several attempts. Patient is a danger to the health and safety of other residents and individuals if failure to transfer or discharge is not implemented. Patient was transferred to [Psychiatric Hospital] at this time accompanied by police and non-emergency services .10-17-2025 at 8:25 AM - Resident #1 with verbal aggression, aide with nurse checking on her and yelled out to get out of her room, banged door behind them .10-21-2025 at 2:46 PM - Resident #1 pacing around. Continues on 1 on 1. Came to the nurse station and told this nurse that will not pray for the writer anymore shouting and spit, then left away from the nursing station .10-22-2025 at 10:30 PM - Police arrived at the facility at about 10pm to transport resident to [Psychiatric Hospital], visited the resident in her room. They walked out. One of the officers returned and told this nurse that they were not taking her because they did not have a mental warrant .11-27-2025 at 12:40 PM - Resident #1 refused all her morning meds and vitals, x 2 attempts with different nurse, resident replied, I am not taking those meds, i don't have any sickness to take them, i will follow what God told me . Resident #1 continued to be non-compliant with taking medications intermittently till 4-2026.1-19-2026 at 9:30 AM - Resident #1 is physically aggressive to a staff member, resident was being redirected from interfering with another patient's care. Yells out when redirected, has been non-compliant with taking her meds, verbally aggressive when redirected .1-21-2026 at 2:35 PM - Resident #1 became verbally hostile towards staff, pacing and yells back and calls staff fools when asked not to assist other residents .1-21-2026 at 4:29 PM - Resident #1 hit another resident and was seen walking from the hallway. Writer asked resident what happened, called writer ugly fool .1-22-2026 at 6:29 AM - Resident #1 would come out of room at times, early in the morning resident went down 400 hall and became verbally aggressive when being redirected off the hall, resident then went down the hall yelling and walked into dining room, then went in her bedroom and slammed the door 2 times.4-2-2026 at 5:43 PM - Resident #1 hit Resident #2 in the dining room. Resident #1 was asked what happened but told this nurse to go away .Record review of Resident #1's EMR assessment section, revealed 9 Internal Investigation Reports where Resident #1 abused other Residents. These reports are the following:7-30-2024 - Resident #1 slapped Resident #3 on her hand twice as Resident #3 was touching her [NAME] Box. 9-29-2024 - Resident #1 hit Resident #4 with a closed fist on Resident #4's right arm. Resident #4 said Resident #1 also hit two other Residents that day. 10-15-2024 - Resident #1 spit on Resident #5 and hit Resident #5 in the face.12-17-2024 - Resident #1 slapped Resident #5 on the face. 10-7-2025 - ADON A saw Resident #1 hit Resident #6 who was non-verbal. 10-8-2025 - Resident #1 hit Resident #7 unprovoked. Resident #7's progress notes revealed she was hit in the face by Resident #1, and it made her cry. Resident #7 was noted to be non-verbal and ADL dependent. 1-21-2026 - Resident #1 hit Resident #8 on her arm and was verbally abusive.4-1-2026 - Resident #1 hit Resident #2 with a closed fist.In an observation and interview on 4-15-2026 at 3:05 PM, Resident #1 was observed to be in a private room and ambulating by walking. Resident #1 said she touched Resident #2's arm but denied hitting her. Resident #1 said I do not take medicine because I am not sick! I'm a missionary and God protects me. God told me to stop taking medicine. In an observation and interview on 4-15-2026 at 3:19 PM, Resident #2 said Resident #1 tried to push Resident #2 in her wheelchair against her will when she told Resident #1 to stop. That is when Resident #1 punched Resident #2 in the arm. Resident #2 said she did not feel safe around Resident #1 and no Residents in the facility should feel safe around Resident #1. In an observation and interview on 4-15-2026 at 3:28 PM, Resident #8 said Resident #1 came into her (continued on next page)

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After the incident the Staffing Coordinator was one-on-one supervision for Resident #1 outside Resident #1's room. However, Resident #1 came charging out of her room toward the Staffing Coordinator in a threatening manner yelling I don't need no one to sit with me, you're going to hell. The Staffing Coordinator said Resident #1 started punching her with a closed fist in a downward pounding motion. The Staffing Coordinator then ran down the hallway, into the dining room, and then into the TV room when the IA intervened and blocked Resident #1 from attacking her. The Staffing Coordinator said Resident #1 seems to target Caucasian people.In an interview on 4-16-2026 at 11:15 AM, the Interim Administrator (Director of Operations of Momentum Skilled Services) said he had filled in as a temporary Administrator at the facility from September 2025 through 12-5-2025 and came back to the facility on 4-1-2026. The IA said the facility's procedure for dealing with aggressive behavior Resident #1 had was to have a psychologist do an assessment and have her medications reviewed to see if changes need to be made. The IA said the facility had problems with Resident #1 refusing to take medications. The IA said the other problem the facility had with Resident #1 was getting her moved to another type of facility because her social security funds ran out to pay for Medicaid. He stated no facility will take Resident #1 if she did not have insurance or money. The IA said, the facility had successfully handled Residents like Resident #1 in the past and he felt they could successfully handle Resident #1. The IA said the risk to other residents if the facility did not successfully manage Resident #1's behaviors was There can be all kinds of risk. What specific risk I cannot tell you. The IA said all residents had the right to feel free from abuse in their own homes. After showing, from the facility's own EMR, 9 separate times Resident #1 abused other residents, the IA said he didn't know why those residents were not protected because he was not here during the time those incidents occurred. The IA said the regular DON resigned on 4-7-2026. In an interview on 4-16-2026 at 11:45 AM, ADON B said she had worked at the facility for 7 years and had been an ADON for 1 year. ADON B said ADON A resigned yesterday 4-15-2026. ADON B said the procedure the facility followed when Resident #1 starts being aggressive was to do in-service training on abuse, follow standing orders, order psychiatric services, and follow what they recommend. ADON B did not believe the facility was adequately equipped to manage Resident #1's aggressive behaviors. ADON B said there has always been roundtable discussions as to whether Resident #1 should reside at the facility. She had always been told it was a money problem. Resident #1 would be sent to a psychiatric hospital, her guardian would then tell the facility if you will take Resident #1 back, I will get her discharged in 2 weeks. ADON B said however, discharge never occurred. ADON B said in 2-2026, she witnessed Resident #1 hit Resident #8, then hit the Staffing Coordinator and chase her throughout the facility. ADON B said she was assaulted by Resident #1 2 years ago when Resident #1 grabbed her close to her throat, broke a necklace around her throat, and scratched her chest. ADON B showed scars on her chest Resident #1 left from the attack. ADON B said the risk to other residents if the facility could not manage aggressive behaviors was harm to residents. ADON B said residents had a right to be free from abuse, had a right to feel safe in their own home, and felt the facility was not equipped to handle someone like Resident #1. ADON B said the last time in-service training on abuse was given at the facility was on 4-6-2026. In an interview on 4-16-2026 at 12:30 PM, the Corporate DON (CD) said the facility DON resigned the previous week. The CD said it depends on what type of aggressive behavior a resident exhibited to determine what action was needed. CD said if the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	combative or verbally aggressive behaviors with staff, and observations of all six of those residents revealed no concerns about these residents having aggressive or abusive behaviors toward other residents. Between 1:38 PM and 7:30 PM on 4-17-2026 staff covering all shifts and departments were interviewed about types of abuse, identifying possible abuse, procedures for de-escalating resident behaviors and managing resident to resident aggressive behaviors, reporting concerns related to possible abuse and neglect, and what to do if they felt administrative staff did not address reported issues. The following staff were interviewed, and all were found to be knowledgeable about the above procedures: ADON B, CMA C, CNA D, CNA E, LVN F, LVN G, CMA H (Staffing Coordinator), LVN I, CNA J, CNA K, LVN L, LVN M, CNA N, CNA O, CNA P, Dietary Manager, Cook, LVN Q, CNA R, CNA S, CNA T, CNA U, CNA V, LVN W, LVN X. An interview on 4-17-2026 at 6:00 PM, revealed the Corporate DON said the IJ was called because Resident #1 has put others at risk because other residents have rights. The DON said staff were in-serviced on de-escalating, resident rights, abuse and neglect with validation on how to report abuse, when, who to and what HHSC phone # is, and nursing did a change in condition one. How to initiate on the compliance hotline with corporate. Did a power point (PP) on who can cause abuse, who is at risk for abuse, details and examples. The DON said she and the IA would oversee monitoring, no changes to the abuse policy occurred, and the Abuse Coordinator was the IA. If the IA was not available, the Corporate DON would be the person staff would report abuse to. The Corporate DON said the facility would determine if it could manage certain behaviors by using an Artificial Intelligence (AI) software program that flags certain behaviors like aggression and restraints. The Corporate DON said the facility would ensure the safety of residents by removing stimulation that causes misbehaviors and will discharge residents whose behavior cannot be managed. An interview on 5-17-2026 at 6:30 PM, the IA said he believes the IJ was called because Resident #1's past events/behaviors and her medical condition. The IA said the in-services were on abuse/neglect, resident rights, de-escalating strategies, a power point presentation was given on abuse, and the corporate compliance phone line number. The IA and Corporate DON stated they would oversee the monitoring to ensure compliance with the POR. The IA said there were no changes to the facility's policies and procedures, he was the Abuse Coordinator, and a designee would be appointed if he was unavailable. The IA said the facility will use an AI software program that will alert red flags of certain types of behaviors that would be inappropriate for the facility to admit. This would help protect residents in the future and if residents who were already admitted don't get along with roommates, they would be moved. The IA said the nursing staff would oversee monitoring of resident's behaviors because they have behavior sheets to monitor medications. The CNAs would monitor combative behaviors and report them to the nurses. Review of the facility's EMRs for six residents (Residents #13, #14, #15, #16, #17, #18) who had combative behaviors or verbal aggression toward staff was reviewed, and no concerns related to abuse of residents were found. Review of the Plan of Removal documentation reflected:1. The Social Worker will discharge residents in a timely manner who have verbal or physical behaviors that cannot be managed2. A corporate compliance hotline phone # was given to staff to report when the facility administration fails in completing duties.3. Residents that portray aggressive or violent behaviors towards residents will immediately be put on 1:1 supervision until the facility can properly discharge them. 4. The facility referrals will be reviewed by the Interdisciplinary Team through the AI software program to ensure a proper discharge can be made and not accept residents who are not appropriate for the facility. An IJ was identified on 4-16-2026 at 3:40 PM. While the IJ was removed on 4-17-2026, the facility remained out of compliance at a scope of pattern and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective measures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676276	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewest Rehabilitation and Skilled Care	2450 Bickers St Dallas, TX 75212

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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 - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, 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, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for 3 of 8 Residents (Residents #6, #7, #8) reviewed for abuse and neglect. The facility failed to report to the Texas Health and Human Services Commission alleged abuse that occurred when Resident #1 physically and verbally abused Resident #6 on 10-7-2025, physically abuse Resident #7 on 10-8-2026, and physically and verbally abused Resident #8 on 1-21-2026. These failures could place residents at risk of abuse, neglect, pain, psychosocial harm, and a diminished quality of life. Findings included:Record review of Resident #1's Face Sheet, dated 4-15-2026, reflected a [AGE] year-old female with an original admission date of 4-26-2021 and a readmission date of 11-4-2025. Resident #1 had a primary diagnosis of dementia with psychotic disturbance (the presence of delusions or hallucinations in individuals with a diagnosed neurodegenerative [chronic loss of function in nerve cells] disorder) and secondary diagnoses of homicidal ideations (thoughts, fantasies, or plans about killing another person), paranoid schizophrenia (a chronic mental health disorder, characterized by intense, irrational delusions and hallucinations-often auditory centered on persecution or conspiracy), dementia with other behavioral disturbance (involves non-cognitive symptoms like agitation, aggression, depression, wandering, or social disinhibition) schizoaffective disorder (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions, disorganized speech) with major mood disorder, such as depression or bipolar mania), psychosis not due to a substance or known physiological condition, and insomnia (a common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early, leading to daytime fatigue, irritability, and poor concentration). Review of Resident #1's Quarterly MDS dated [DATE], revealed Resident #1 re-entered the facility from an inpatient psychiatric facility with a BIMS score of 8 which indicated being mildly cognitively impaired. The D Mood section indicated Resident #1 often felt socially isolated. Section E Behavior section indicated Resident #1 rejected evaluation and care daily. Review of Resident #1's most recent Care Plan with an initial date of 5-24-2022 and revised on 2-9-2026 revealed she was physically aggressive to staff and residents having a pair of scissors being at risk for potential for harming herself and others. Resident #1 has attempted to use metal utensils to harm staff. On 10-7-2025 Resident #1 hit another resident, 10-8-2025 Resident #1 was physically aggressive to another resident, 1-21-2026 Resident #1 was physically aggressive toward another resident. Resident #1 was at risk for delirium initiated on 4-24-2022 stating the devil will tell her to do things, Resident #1 was resistive to care by refusing to take medications revised on 4-5-2023, Resident #1 had potential to be verbally aggressive yelling at staff because of ineffective coping skills revised on 5-19-2021, Resident #1 was physically aggressive to staff and residents because of poor impulse control by locking herself in other resident's bathroom revised on 6-20-2023, Resident #1 had aggressive behavior problems striking Residents initiated on 9-29-2024, Resident #1 was care planned to receive antipsychotic medication for mood & behavior management revised on 7-24-2022.Review of Resident #1's progress nurse notes reflected the following:10-7-2025 at 2:45 PM - ADON A witnessed resident from RM [ROOM NUMBER]A hit resident [Resident#6] on her left shoulder while passing by outside dining room across by nurse's station . [Resident #1] was verbally aggressive when asked why she hit the other and walked away to her room, refused assessment .10-8-2025 at 8:28 AM - NP notified . Patient noted to have physical aggressive behavior toward (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents and staff. Refuses all medications and assistance from staff. While supervising the patient as a one on one, patient struck staff. Patient unable to be redirected; screaming and using profanity toward staff. Patient chasing staff member through dining room trying to strike at her. Patient redirected by staff x several attempts. Patient goes into her room and after 1-2 mins return to hallway yelling and screaming at staff and other patients trying to hit staff while screaming in their face .Police and 911 called .10-8-2025 at 9:01 AM - Resident #1 to be transferred to Psychiatric ER Hospital because of altered mental state with aggression and physical aggression .10-8-2025 at 10:45 AM - While supervising patient as a one on one, patient chased staff away, struck staff to her back. Patient unable to be redirected; screaming and using profanity toward staff. Patient chasing staff member through dining room trying to strike at her again. Patient redirected by staff x several attempts. Patient goes into her room and after 1-2 mins return to hallway yelling and screaming at staff and other patients trying to hit staff while screaming in their face .10-8-2025 at 11:01 AM - ADON A stated Patient needs cannot be met, facility attempts to meet the resident needs, and the service available are refused by patient x several attempts. Patient is a danger to the health and safety of other residents and individuals if failure to transfer or discharge is not implemented. Patient was transferred to [Psychiatric Hospital] at this time accompanied by police and non-emergency services .1-21-2026 at 2:35 PM - Resident #1 became verbally hostile towards staff, pacing and yells back and calls staff fools when asked not to assist other residents .1-21-2026 at 4:29 PM - Resident #1 hit another resident and was seen walking from the hallway. Writer asked resident what happened, called writer ugly fool .Record review of Resident #1's EMR assessment section, revealed the facility filled out Internal Investigation Reports where Resident #1 abused Resident #6, #7, and #8. The reports stated: 10-7-2025 - ADON A saw Resident #1 hit Resident #6 who was non-verbal. 10-8-2025 - Resident #1 hit Resident #7 unprovoked. Resident #7's progress notes revealed she was hit in the face by Resident #1, and it made her cry. Resident #7 was noted to be non-verbal and ADL dependent. 1-21-2026 - Resident #1 hit Resident #8 on her arm and was verbally abusive.Record review of Resident #1's progress notes dated 10-7-2025 and 10-8-2025 revealed the Administrator and DON were notified of the incidents of Resident #1 striking Resident #6 and Resident #7. Record review of Resident #8's progress notes dated 1-21-2026 at 4:20 PM, revealed the DON was notified of Resident #1 striking Resident #8. Resident #6, #7, and #8's face sheet, care plan, MDS, and orders were not obtained. Record review of Resident #7's progress notes revealed Resident #7 died on 2-12-2026 from unrelated causes. In an interview and observation on 4-15-2026 at 3:05 PM, Resident #1 was observed in a private room ambulating on her own. Resident #1 denied hitting anyone and said she would be in jail if she hit anyone. In an interview and observation on 4-15-2026 at 3:28 PM, Resident #8 was observed to be in her room and said Resident #1 came into her room when she was asleep, hit her with a closed fist in her chest, and yelled your people and you are all going to hell and your kids are stupid. Resident #8 said Resident #1 still comes into her room and did not feel safe around her. In an interview and observation on 4-16-2026 at 5:53 PM, Resident #6 was observed to be lying in her bed, awake, and unresponsive to questions. In an interview on 4-16-2026 at 11:15 AM, the IA stated he was the Interim Administrator for the facility from [DATE] through [DATE]. The IA said he returned to the facility as the Interim Administrator on 4-1-2026. In an interview on 4-17-2026 at 6:30 PM, the IA said he did not know why abuse was not reported to Texas Health and Human Services Commission (THHSC) regarding Resident #6 and #7 in [DATE] and Resident #8 in [DATE]. The IA said the risk for not reporting abuse would be the abuse will continue happening. The IA said he expected abuse to be reported immediately. Record review of Resident #6's progress notes failed to show any documentation or assessment that she had been hit by Resident #1. Review of (THHSC) Long Term Provider Letter #PL 2024-14 (Replaces PL 2019-17), titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC), Provider Type: Nursing Facilities (NF), dated [DATE], stated: A NF must report to CII (Complaint and Incident Intake) the following types of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incidents, in accordance with applicable state and federal requirements: Abuse, Neglect . Immediately, but not later than two hours after the incident occurs or is suspected.Review of TULIP (Texas Unified Licensure Information Portal) revealed no reports being filed from the facility for allegations of abuse or neglect concerning Residents #6, #7, or #8 during [DATE] or [DATE].