STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676295	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Nursing & Rehabilitation	3210 W Hwy 22 Corsicana, TX 75110

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44671 Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations were thoroughly investigated and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the allegation was verified appropriate corrective action was taken for one of three residents (Resident #1) reviewed for abuse and neglect . The facility failed to report, on 02/01/2025, the results of an investigation of an allegation of Abuse and Neglect involving Resident #1 when she had an unwitnessed fall on 01/27/2025. This failure could place residents at risk for continued abuse or neglect without appropriate corrective actions being taken. Findings included: Record review of Resident #1's face sheet, dated 02/07/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included primary generalized osteoarthritis(multiple joints affected without a known underlying cause), Dysphagia(difficulty swallowing food), and primary hypertension(high blood pressure with no single cause). Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS of ten (10), which indicated Resident #1 had moderate cognitive impairment. Record review of TULIP, dated 02/07/2024, reflected no five day submitted by the facility. The unwitnessed fall occurred on 01/27/2025 and the five day should have been submitted 02/01/2025. During an interview on 02/07/2024 at 11:00 AM, the DON stated she had submitted the facility self-report to the state on 01/27/2025 when Resident # 1 had an unwitnessed fall and was sent out to the hospital. The DON stated she was not responsible for sending the five day to the state. The DON stated the the interim ADM was responsible to send the completed five day to the state. The DON stated it was expected for the completed five day to be sent within five days so the state would see the proper steps taken for Resident #1's unwitnessed fall. The DON stated the five day completion show the completed in services for staff and interventions in place. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676295	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Nursing & Rehabilitation	3210 W Hwy 22 Corsicana, TX 75110

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/07/2024 at 5:34 PM, the interim DON stated it was her responsibility and expectation to send the completed 5 days to the state by 02/01/2025. The interim DON stated that there was no facility policy on the five day and that the facility followed the state regulations on the five-day completions. The interim DON stated the completed five day showed the steps taken to ensure the incident would not happen again. The interim DON stated the 5 day was completed but was not sent to the state. The interim DON stated it was a communication breakdown and she thought that the DON had sent it in to the state. The interim DON sated she should had followed up with the DON to make sure the 5 day was sent to the state. Record review of the facility policy Recognizing Signs and Symptoms of Abuse/Neglect revised April 2021 reflected Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor of to the Director Of Nursing Services immediately.