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	10/03/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify the resident's representative of the change] in the resident's physical, mental, or psychosocial status for one (Resident #1) of seven residents reviewed for resident rights. The facility failed to ensure Resident #1's RP was notified when she was found lying in bed with Resident #2 on 9/18/2025. This failure placed residents at risk of a decreased quality of life and risk of not having their responsible party represent them in medical and care decisions.Findings included: 1. Review of Resident #1's face sheet, dated 9/26/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including d[dementia (group of brain disorders that cause progressive cognitive decline), anemia (low blood iron level), insomnia (problems falling and staying asleep), hypokalemia (low blood levels of potassium), and acute respiratory failure. Review of Resident #1's admission MDS assessment, dated 9/5/2025, reflected that she had a BIMS score of 4 suggesting severe cognitive impairment. Review of Resident #1's MDS assessment (type not noted), dated 9/12/2025, reflected a BIMS score of 3 suggesting severe cognitive impairment. Review of Resident #1's progress notes, dated 9/18/2025, reflected no mention of Resident #1 found in bed with Resident #2 and no mention that her RP was notified of the incident on 9/18/2025. Review of Resident #1's care plan dated 9/26/2025 (the only care plan in the EMR) on 9/26/2025, reflected the focus area initiated on 9/11/2025: I reside in the Secure/ Memory unit and am at risk for injury from wandering in an un-safe environment R/T DX of dementia AEB impaired safety awareness. I am at risk for injury from others while residing in secure/ memory unit D/T altered cognition with interventions, Administer meds per order, monitor labs- report abnormals to MD. Ensure family/ MD aware of behaviors and/or any increase in behaviors noted, Keep environment free of possible hazards. 2. Review of Resident #2's face sheet, dated 9/26/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including dementia (group of brain disorders that cause progressive cognitive decline), Parkinson's disease (progressive neurological disorder that affect movement, balance and coordination), hypotension (low blood pressure), anxiety disorder and benign prostatic hyperplasia (BPH - enlarged prostate gland). Review of Resident #2's MDS screen in the EMR on 9/26/2025 and 10/3/2025 reflected there was no MDS assessment. Review of Resident #2 progress note, dated 9/18/2025, at 2:30 pm by LVN C reflected, In a female room lying in bed with another female. This is not either resident room. Lying on top of the blanket and fully clothed. He had his hand on her leg. This nurse assisted him to his chair and told him that he cannot lay in the bed with anyone. Redirected this resident to his room. Review of Resident #2's care plan, dated 9/26/2025, reflected no entries prior to 9/22/2025 and there were no entries related to his sexual behaviors.The following focus was initiated on 9/25/32025: I have memory loss/dementia r/t dementia, difficulty making decisions, disease process, impaired decision making, neurological symptoms.With interventions initiated on 9/25/2025 and revised on 9/26/2025: Cue, reorient and supervise or assist me as needed. Discuss concerns about confusion, disease process, transition issues, andcommunity placement with all team members. Observe for and report to the nurse any changes in cognitive function, specificallychanges in: decision-making ability, memory, recall and general awareness, difficulty, expressing self, difficulty understanding others, level of consciousness, and mentalstatus. Review of Resident #2's care plan, dated 09/26/2025 reflected the following focus: I have episodes of adverse behavior(s): Sexually inappropriate behavior (has held hands and attempted to kiss others, shows preference to one resident);Interventions:Anticipate behavior(s) and redirect when in close proximity to others that mightinvoke aggression.Ensure family/MD/aware of behaviors and/or any increase in behaviors noted.Ensure staff is aware of physical/sexual behaviors and interventions.Redirect/remove when approaching/being approached by particular female residentMonitor and chart behaviors q shift and report to MD.Resident will be placed one to one until IDT determines one to one is no longer inneed. During an interview on 9/26/2025 at 3:10 pm, LVN C stated she found Resident #1 and Resident #2 lying in bed together on 9/18/2025. She stated the residents were lying side by side on top of the covers, fully clothed and Resident #2 had his hand on Resident #1's leg. She stated Resident #2 wasn't trying to engage in anything. She stated she had no suspicion of ANE because she did not see him try to grab at nothing or try to touch [Resident #1] in an inappropriate way - he did not seem malicious or vicious at that time[. She stated she was easily able to redirect him from the situation and denied seeing Resident #1 and Resident #2 in bed together prior to that. She stated she did not] report the incident as ANE because they weren't naked

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents had the right to be free from abuse and neglect for three residents (Resident #1, Resident #2 and Resident #4) of seven reviewed for abuse. The facility failed to:1) Ensure Resident #1 did not engage in sexual activity with Resident #2 on 9/24/2025.2) Ensure Resident #2 did not engage in inappropriate behavior on 9/18/2025, 9/19/2025 and 9/24/2025.3) Ensure CNA D did not grab Resident #4's wrist forcefully and shake her arm in the presence of therapy staff on 9/3/2025. On 9/26/2025 at 6:40 pm an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/3/2025, the facility remained at a level of actual no actual harm at a scope of pattern that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of abuse, injury, and psychosocial harm. Findings included: 1. Review of Resident #1's face sheet, dated 9/26/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dementia (group of brain disorders that cause progressive cognitive decline), anemia (low blood iron level), insomnia (problems falling and staying asleep), hypokalemia (low blood levels of potassium), and acute respiratory failure. Review of Resident #1's admission MDS assessment, dated 9/5/2025, reflected she had a BIMS score of 4 suggesting severe cognitive impairment. Review of Resident #1's progress notes for the date of 9/18/2025, reflected no mention of her being found in bed with Resident # 1 on 9/18/2025 Review of Resident #1 's progress note dated 9/25/2025 at 4:14 am, by LVN E reflected: CNA reported that this resident was lying in bed with female resident [Resident #1] sitting on top of him with both of their pants off. CNA told residents to stop and redirected the female resident into the dining room. Review of Resident #1's care plan dated 9/26/2025 (the only care plan in the EMR) on 9/26/2025 , reflected the focus area initiated on 9/11/2025: I reside in the Secure/ Memory unit and am at risk for injury from wandering in an un- safe environment R/T DX of dementia AEB impaired safety awareness. I am at risk for injury from others while residing in secure/ memory unit D/T altered cognition with interventions to Administer meds[per order, monitor labs- report abnormals to MD. Ensure family/ MD aware of behaviors and/or any increase in behaviors noted, Keep environment free of possible hazards. 2. Review of Resident #2's face sheet, dated 9/26/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including dementia (group of brain disorders that cause progressive cognitive decline), Parkinson's disease (progressive neurological disorder that affect movement, balance and coordination), hypotension (low blood pressure), anxiety disorder and benign prostatic hyperplasia (BPH - enlarged prostate gland). Review of Resident #2's MDS screen in the EMR on 9/26/2025 and 10/3/2025 reflected there was no MDS assessment. Review of Resident #2's progress note, dated 9/18/2025 at 2:30 pm, by LVN C, reflected: In a female room lying in bed with another female. This is not either resident room. Lying on top of the blanket and fully clothed. He had his hand on her leg. This nurse assisted him to his chair and told him that he cannot lay in the bed with anyone. Redirected this resident to his room. Review of Resident #2's progress note, dated 9/25/2025 at 4:14 am, by LVN E, reflected: CNA reported that this resident was lying in bed with female resident sitting on top of him with both of their pants off. CNA told residents to stop and redirected the female resident into the dining room. During an interview on 9/26/2025 at 2:39 pm, CNA B stated she worked Wednesday night on 9/24/25 and about 7:30 pm she discovered Resident #1 and Resident #2 in Resident #2's room. Resident #2 was sitting in his wheelchair and was naked from the waist down with Resident #1 on top of him also naked from the waist down and they were engaged in sexual activity. She stated she separated and redirected residents and took female resident across the hall to her room and helped her put her clothes back on. She called LVN E, the charge nurse, and told her what happened. She stated she had not thought it was abuse at the time because both residents had dementia and did not really know what they were doing. She had no suspicion of ANE because the residents were confused. She stated she did not call ADM because she reported it to LVN E and thought LVN E would call and report this to ADM. She stated she was trained on ANE and all incidents of ANE were to be reported immediately to the ADM. She stated- she did not do that and now she realizes it was ANE and should have been reported. She thought because they were confused it could not be ANE. During an interview on 9/26/2025 at 3:10 pm, LVN C stated she found Resident #1 and Resident #2 lying in bed together on 9/18/2025. She stated the residents were lying side by side on top of the covers, fully clothed and Resident #2 had his hand on Resident #1's leg. She stated Resident #2 wasn't trying to engage

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to be free from misappropriation of property and exploitation for 1 of 6 (Resident #5) reviewed for misappropriation and exploitation, in that: The facility failed to ensure Resident #5 was free from exploitation when the BOM took Resident #5's net spend credit card and used the card for personal use. The BOM used Resident #5's credit card and withdrew funds totaling $3700. This failure could place residents at risk of financial hardships and a decrease in resident's quality of life.Findings included: Record review of Resident #5's admission record dated 10/02/25 documented a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #5 had diagnoses included major depressive disorder (sadness), cognitive communication deficit (inability to communicate effective), and hypertension (high blood pressure). Record review of Resident #5's Quarterly MDS assessment, dated 09/23/25, revealed the resident had a BIMS score of 0 indicating the resident had severe cognitive impairment. Record review of Resident #5's care plan, dated 09/29/25, revealed Resident #5 was care planned for visually impaired and required secure storage of personal items/medications in a lock box to ensure safety and prevent misuse or loss. An attempted interview with the BOM was made 10/02/25 at 4:30pm, 10/03/25 at 11:49am, and 10/03/25 at 3.37pm. A voice message was left and the BOM did not return call prior to facility exit 10/03/25. An interview with the Marketing Director on 10/01/25 at 10:44am stated on 09/15/25 Resident # 5's RP came to the facility to pick up Resident #5's wallet and the RP noticed there was a credit card missing. The Marketing Director stated she was a witness with the BOM to count out the large amount of cash that was in Resident #5's wallet. Resident #5's RP told the BOM there was a card missing and the BOM asked what card. The Marketing Director stated it was alerted to staff that Resident #5's card may have been misplaced and to be on the lookout. Resident #5's RP stated there was no activity on the card because they had not received any alerts on the card. The Marketing Director stated the next day, 09/16/25,she was speaking with the BOM over the phone and she asked her what was going on because she had given short responses. The Marketing Director stated the BOM asked her if they could meet and they met around 6:08pm. The Marketing Director stated when she opened the BOM's car door she was sobbing and told her she “fucked up” with Resident #5's money and she took Resident #5's card. The Marketing Director stated the BOM stated she received a fraud notification claim and she Resident #5's card. The Marketing Director stated the BOM initially told her she used $2,000 then she went to $3,000 and told her she could not get the money back to Resident #5. The Marketing Director asked what she used Resident #5's card for and she stated on things she could not get back. The BOM stated once she started using the card she could not stop and she had set up a pin for the card. The Marketing Director stated the BOM stated she would be shown on camera using Resident #5's card at locations and she gave her the office key as she was not going back to work because the police would be there. The Marketing Director stated the next morning 09/17/25 around 9:00am when she went to work she reported the incident to the ADM. The Marketing Director stated she did not report to the ADM immediately after it happened because she was trying to process what the BOM told her. The Marketing Director stated it was expected for her to contact the ADM immediately after the BOM confessed to taking Resident #5's credit card and used it for her personal use. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #5 on 10/02/25 at 4:00pm stated his RP told him someone had taken his card out of his wallet and spent $3,700. Resident #5 stated he did not know who took his card and used it but the person who used the card had paid the $3,700 back to him. Resident #5 stated his RP did not tell him who used his credit card but he was upset about it Resident #5 stated he spoke with police and did not press charges because he received the money back. An interview with Resident #5's RP on 10/02/25 at 4:49pm stated she was told by the ADM the BOM took Resident #5's card out of his wallet and spent $3,700. Resident #5's RP stated the wallet was locked up in the business office when Resident #5 was in the hospital. Resident #5's RP stated when Resident #5 returned from the hospital on [DATE] he told his RP that his wallet was in the business office. Resident #5's RP stated she went to the business office to retrieve the wallet from the BOM. Resident #5's RP stated the BOM and another unidentified woman counted the money out to her that was in Resident #5's wallet. Resident #5's RP stated that she had noticed a credit card was missing. Resident #5's RP stated they had not received any card alerts that Resident #5 had used the card. Resident #5 ‘s RP stated when the account was checked it was a total of $3,700 that was used. Resident #5's RP stated Resident #5 did not want to press charges because he received the money back. Resident #5 stated if it was up to her she would have pressed charges on the BOM. Resident #5's RP stated Resident #5 in his right mind, and he had received the $3700 back and did not want to file charges. Resident #5's RP stated the check for $3,700 was written out to her An interview with the SW on 10/03/25 at 12:06pm stated she was not aware of the incident with the BOM using Resident #5's credit card. The SW stated that she did not know the exact date she found out, but it was after the incident had occurred when she and the ADM went to Resident #5's room to return the credit card along with a cashier's check. The SW stated it was expected for the BOM to have not used Resident #5's credit card for her personal use. The SW stated the negative outcome of the BOM using Resident #5's credit card would cause financial hardship to the resident. An interview with the interim DON on 10/03/25 at 12:20pm stated she was not made aware that the BOM had used Resident #5's credit card for her personal use until 09/17/25. The interim DON stated the negative outcome would be loss of control of Resident #5's credit card that would affect Resident #5 emotionally. An interview with the ADM on 10/03/25 at 12:40pm stated she did not find out until 09/17/25 around 10:30am that the BOM confessed to the Marketing Director that she had taken Resident #5's credit card and spent $3700 for her personal use. The ADM stated on 09/15/25 Resident's #5's RP reported the credit card missing from Resident #5's wallet. The ADM stated it was expected that the Marketing Director's reported to her immediately when the BOM confessed of taking and using Resident #5's card. The ADM stated the Marketing Director met with the BOM the evening on 09/16/25 and she had confessed to the Marketing Director that she had taken the card and used the card for personal use. The ADM stated the police were called out to the facility on [DATE] and the resident did not want to press charges because the $3700 was returned back to him . The ADM stated the police did not make any reports due to Resident #5 not wanting to press charges with the credit card being used. The Adm stated the negative outcome with the incident would cause debt to Resident #5 and could effect Resident #5 emotionally and financially. The ADM stated it was expected for the BOM not have took Resident #5's credit card and used it for her personal use. Review of the BOM's personnel file reflected she was terminated on 09/17/25. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of cashier's check pay to the order of Resident #5's RP with remitter BOM in the amount of $3700 dated 09/18/25. Review of facility's investigation dated 09/18/25 reflected a thorough investigation was completed, and the allegation of misappropriation was confirmed. Review of facility's policy, dated April 2021, titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program reflected: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff. b. other residents. c. consultants. d. volunteers. e. staff from other agencies. f. family members. g. legal representatives. h. friends. i. visitors; and/or j. any other individual. Develop and implement policies and protocols to prevent and identify theft, exploitation, or misappropriation of property”.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents had the right to be free from abuse and neglect for three residents (Resident #1, Resident #2 and Resident #4) of seven reviewed for abuse. The facility failed to:1) Ensure Resident #1 did not engage in sexual activity with Resident #2 on 9/24/2025.2) Ensure Resident #2 did not engage in inappropriate behavior on 9/18/2025, 9/19/2025 and 9/24/2025.3) Ensure CNA D did not grab Resident #4's wrist forcefully and shake her arm in the presence of therapy staff on 9/3/2025. On 9/26/2025 at 6:40 pm an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 10/3/2025, the facility remained at a level of actual no actual harm at a scope of pattern that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of abuse, injury, and psychosocial harm. Findings included: 1. Review of Resident #1's face sheet, dated 9/26/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dementia (group of brain disorders that cause progressive cognitive decline), anemia (low blood iron level), insomnia (problems falling and staying asleep), hypokalemia (low blood levels of potassium), and acute respiratory failure. Review of Resident #1's admission MDS assessment, dated 9/5/2025, reflected she had a BIMS score of 4 suggesting severe cognitive impairment. Review of Resident #1's progress notes for the date of 9/18/2025, reflected no mention of her being found in bed with Resident #1 on 9/18/2025 Review of Resident #1 's progress note dated 9/25/2025 at 4:14 am, by LVN E reflected: CNA reported that this resident was lying in bed with female resident [Resident #1] sitting on top of him with both of their pants off. CNA told residents to stop and redirected the female resident into the dining room. Review of Resident #1's care plan dated 9/26/2025 (the only care plan in the EMR) on 9/26/2025, reflected the focus area initiated on 9/11/2025: I reside in the Secure/ Memory unit and am at risk for injury from wandering in an un- safe environment R/T DX of dementia AEB impaired safety awareness. I am at risk for injury from others while residing in secure/ memory unit D/T altered cognition with interventions to Administer meds per order, monitor labs- report abnormals to MD. Ensure family/ MD aware of behaviors and/or any increase in behaviors noted, Keep environment free of possible hazards. 2. Review of Resident #2's face sheet, dated 9/26/2025, reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including dementia (group of brain disorders that cause progressive cognitive decline), Parkison's disease (progressive neurological disorder that affect movement, balance and coordination), hypotension (low blood pressure), anxiety disorder and benign prostatic hyperplasia (BPH - enlarged prostate gland). Review of Resident #2's MDS screen in the EMR on 9/26/2025 and 10/3/2025 reflected there was no MDS assessment. Review of Resident #2's progress note, dated 9/18/2025 at 2:30 pm, by LVN C, reflected: In a female room lying in bed with another female. This is not either resident room. Lying on top of the blanket and fully clothed. He had his hand on her leg. This nurse assisted him to his chair and told him that he cannot lay in the bed with anyone. Redirected this resident to his room. Review of Resident #2's progress note, dated 9/25/2025 at 4:14 am, by LVN E, reflected: CNA reported that this resident was lying in bed with female resident sitting on top of him with both of their pants off. CNA told residents to stop and redirected the female resident into the dining room. During an interview on 9/26/2025 at 2:39 pm, CNA B stated she worked Wednesday night on 9/24/25 and about 7:30 pm she discovered Resident #1 and Resident #2 in Resident #2's room. Resident #2 was sitting in his wheelchair and was naked from the waist down with Resident #1 on top of him also naked from the waist down and they were engaged in sexual activity. She stated she separated and redirected residents and took female resident across the hall to her room and helped her put her clothes back on. She called LVN E, the charge nurse, and told her what happened. She stated she had not thought it was abuse at the time because both residents had dementia and did not really know what they were doing. She had no suspicion of ANE because the residents were confused. She stated she did not call ADM because she reported it to LVN E and thought LVN E would call and report this to ADM. She stated she was trained on ANE and all incidents of ANE were to be reported immediately to the ADM. She stated- she did not do that and now she realizes it was ANE and should have been reported. She thought because they were confused it could not be ANE. During an interview on 9/26/2025 at 3:10 pm, LVN C stated she found Resident #1 and Resident #2 lying in bed together on 9/18/2025. She stated the residents were lying side by side on top of the covers, fully clothed and Resident #2 had his hand on Resident #1's leg. She stated Resident #2 wasn't trying to engage

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	676295	A. Building B. Wing	10/03/2025

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, 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 not later than 24 hours if the events that cause the allegation do not involve abuse to the Administrator for 3 of 7 residents (Resident #1, Resident #2, Resident #5) reviewed for Abuse and Neglect.[KS1] [LP2] The facility staff failed to immediately report abuse and neglect to the Administrator when: 1) Resident #1 was observed engaging in sexual activity with Resident #2 on 9/24/2025.2) Resident #2 was observed engaging in inappropriate behavior with Resident #1 on 9/18/2025 and 9/24/2025.An Immediate Jeopardy (IJ) was identified on 9/29/2025. The IJ template was provided to the facility on 9/29/2025 at 2:00 pm. While the IJ was removed on 10/3/2025, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not IJ and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.3) The BOM confessed to the Marketing Director that she had taken Resident #5's credit card and spent $3700 for personal useThis failure placed residents at risk of not being protected from abuse, neglect, or exploitation. Findings included: 1.) Resident #1 Review of Resident #1's face sheet dated 9/26/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Dementia (group of brain disorders that cause progressive cognitive decline), Anemia (low blood iron level), Insomnia (problems falling and staying asleep), Hypokalemia (low blood levels of potassium), and acute respiratory failure. Review of Resident #1's admission MDS assessment dated [DATE] reflected she had a BIMS score of 4 suggesting severe cognitive impairment. Review of the behavior section revealed no behaviors were noted. Review of Resident #1's progress notes on 9/18/2025, reflected no mention of her being found in bed with Resident #2 on 9/18/2025. Review of Resident #1's progress notes dated 9/25/2025 at 4:14 am by LVN E reflected: CNA reported that this resident was lying in bed with female resident [Resident #1] sitting on top of him with both of their pants off. CNA told residents to stop and redirected the female resident into the dining room. Review of Resident #1's care plan (the only care plan in the EMR) on 9/26/2025, reflected the focus area initiated on 9/11/2025:I reside in the Secure/ Memory unit and am at risk for injury from wandering in an un- safe environment R/T DX of dementia AEB impaired safety awareness. I am at risk for injury from others while residing in secure/ memory unit D/T altered cognition.with interventions Administer meds per order, monitor labs- report abnormals to MD. Ensure family/ MD aware of behaviors and/or any increase in behaviors noted, Keep environment free of possible hazards. 2.) Resident #2 Review of Resident #2's face sheet dated 9/26/2025 reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Dementia (group of brain disorders that cause progressive cognitive decline), Parkinson's disease (progressive neurological disorder that affects movement, balance and coordination), hypotension (low blood pressure), anxiety disorder and Benign Prostatic Hyperplasia (BPH - enlarged prostate gland). Review of Resident #2's MDS screen in the EMR on 9/26/2025 and 10/3/2025 reflected there was no MDS assessment. Review of Resident #2's progress note dated 9/18/2025 at 2:30 pm by LVN C reflected: In a female room lying in bed with another female. This is not either resident room. Lying on top of the blanket and fully clothed. He had his hand on her leg. This nurse assisted him to his chair and told him that he cannot lay in the bed with anyone. Redirected this resident to his room. Review of Resident #2's progress note dated 9/25/2025 at 4:14 am by LVN E reflected: CNA reported that this resident was lying in bed with female resident sitting on top of him with both of their pants off. CNA told residents to stop and redirected the female resident into the dining room. During an interview on 9/26/2025 at 2:39 pm, CNA B stated she was working Wednesday night on 9/24/25 and about 7:30 pm she discovered Resident #1 and Resident #2 in Resident #2's room. Resident #2 was sitting in his wheelchair and was naked from the waist down with Resident #1 on top of him also naked from the waist down and they were engaged in sexual activity. She stated she separated and redirected residents and took the female resident across the hall to her room and helped her put her clothes back on. She called LVN E, the charge nurse, and told her what happened. She stated she had not thought it was abuse at the time because both residents had dementia and did not really know what they were doing. She had no suspicion of ANE because the residents were confused. She stated she did not call the ADM because she reported it to LVN E and thought she would. She

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct an initial comprehensive, accurate, standardized reproducible assessment of the resident's functional capacity within 14 days of admission for 1 (Resident #2) of 7 residents reviewed for Comprehensive Assessments being completed timely. The facility failed to complete a comprehensive assessment for Resident #2 within 14 days of admission. This failure placed newly admitted residents at risk of not having care and treatment needs assessed to ensure necessary care and services were provided to meet these needs.Findings included: Review of Resident #2's face sheet dated 9/26/2025 reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Dementia (group of brain disorders that cause progressive cognitive decline), Parkinson's disease (progressive neurological disorder that affects movement, balance and coordination), hypotension (low blood pressure), anxiety disorder and Benign Prostatic Hyperplasia (BPH - enlarged prostate gland). Review of Resident #2's MDS screen in the EMR on 9/26/2025 and 10/3/2025 reflected there was no MDS assessment. During an interview on 10/3/2025 at 4:17 pm, the MDS Coordinator stated Resident #2 did not have an MDS assessment done yet. She stated she was running late in getting assessments done. She further stated the facility has 14 days from admission to complete MDS assessments and Resident #2's did not get done. She stated she was the one responsible for making sure they got done. She stated she initially thought Resident #2 was respite because he was admitted on hospice services. During an interview on 10/3/2025 at 4:30 pm, the ADM stated she was unaware the MDS assessments were late and not getting done and unaware that Resident #2 did not have any MDS assessments done since his admission. She stated the MDS coordinator reported up to regional MDS staff but that at the local level the MDS coordinator reported directly to the ADM. She stated her expectation was that the MDS coordinator will complete MDS assessments on time per the facility policy. Review of Facility Policy Comprehensive Assessments with revision date February 2025 reflected: Comprehensive assessments are conducted to assist in developing person-centered care plans.1. Comprehensive assessments are conducted in accordance with criteria and time frames established in the Resident Assessment Instrument (RAI) User Manual.2. admission Assessment -The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:a. this is the resident's first time in this facility, ORb. the resident has been admitted to this facility and was discharged return not anticipated, ORc. the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for 3 of 7 residents (Resident #1, Resident #2, Resident #3) reviewed for care plans. The facility failed to update Resident #1's care plan after she was seen in bed with Resident #2 on 9/18/2025[KS1] [LP2] and after a sexual activity incident on 9/24/2025. The facility failed to update Resident #2's care plan after inappropriate behaviors were noted on 9/18/2025, 9/19/2025 and 9/24/2025.[KS3] [LP4] The facility failed to care plan interventions to routinely monitor Resident #3 when an initial elopement assessment was completed 06/03/24[KS5] [LP6] . This failure placed residents at risk of not having their individualized needs met, a delay in services, and not receiving adequate care to meet their needs.Findings included: Resident #1 Review of Resident #1's face sheet dated 9/26/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Dementia (group of brain disorders that cause progressive cognitive decline), Anemia (low blood iron level), Insomnia (problems falling and staying asleep), Hypokalemia (low blood levels of potassium), and acute respiratory failure. Review[KS7] [LP8] of Resident #1's admission MDS assessment dated [DATE] reflected she had a BIMS score of 4 suggesting severe cognitive impairment. No behaviors were noted in the behavior section of the MDS. Review of Resident #1's progress notes on 9/18/2025, reflected no mention of her being found in bed with Resident #2 on 9/18/2025[KS9] [LP10] Review of Resident #1's progress notes dated 9/25/2025 at 4:14 am by LVN E reflected: CNA reported that this resident was lying in bed with female resident sitting on top of him with both of their pants off. CNA told residents to stop and redirected the female resident into the dining room. Review of Resident #1's care plan (the only care plan in the EMR) on 9/26/2025, reflected the focus area initiated on 9/11/2025: I reside in the Secure/ Memory unit and am at risk for injury from wandering in an un- safe environment R/T DX of dementia AEB impaired safety awareness. I am at risk for injury from others while residing in secure/ memory unit D/T altered cognition.with interventions Administer meds per order, monitor labs- report abnormals to MD. Ensure family/ MD aware of behaviors and/or any increase in behaviors noted, Keep environment free of possible hazards. Resident #2 Review of Resident #2's face sheet dated 9/26/2025 reflected an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including Dementia (group of brain disorders that cause progressive cognitive decline), Parkinson's disease (progressive neurological disorder that affects movement, balance and coordination), hypotension (low blood pressure), anxiety disorder and Benign Prostatic Hyperplasia (BPH - enlarged prostate gland). Review of Resident #2's MDS screen in the EMR on 9/26/2025 and 10/3/2025 reflected there was no MDS assessment. Review of Resident #2's progress note dated 9/18/2025 at 2:30 pm by LVN C reflected: In a female room lying in bed with another female. This is not either resident room. Lying on top of the blanket and fully clothed. He had his hand on her leg. This nurse assisted him to his chair and told him that he cannot lay in the bed with anyone. Redirected this resident to his room. Review of Resident #2's progress note dated 9/19/2025 at 8:27 am by LVN K reflected: resident was noted to be kissing a female resident on her hand. resident was redirected by this nurse redirection was successful. Review of Resident #2's progress note dated 9/19/2025 at 8:44 am by LVN K reflected: resident was noted kissing a female resident in the mouth by this nurse, resident was separated from female resident. and redirected. Review of Resident #2's progress note dated 9/25/2025 at 4:14 am by LVN E reflected: CNA reported that this resident was lying in bed with female resident [Resident #1] sitting on top of him with both of their pants off. CNA told residents to stop and redirected the female resident into the dining room. Review of Resident #2's care plan dated 9/26/2025 reflected no entries initiated prior to 9/22/2025 and there were no entries related to his sexual behaviors.The following focus that was initiated on 9/25/2025: I have memory loss/dementia r/t dementia, difficulty making decisions, disease process, Impaired decision making, neurological symptoms. With interventions initiated on 9/25/2025 and revised on 9/26/2025: Cue, reorient and supervise or assist me as needed. Discuss concerns about confusion, disease process, transition issues, andcommunity placement with all team members. Observe for and report to the nurse any changes in cognitive function, specificallychanges in: decision-making ability, memory, recall and general awareness, difficulty, expressing self, difficulty understanding others, level of consciousness, and mentalstatus. Review of Resident #2's care plan on 10/3/2025 reflected the following focus and intervention initiated on 9/26/2025: I have episodes of

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 interview and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision to prevent accidents for 1 of 6 residents (Resident #3) reviewed for accidents and hazards.The facility failed to ensure Resident #3 did not elope from the facility on 09/10/25. The noncompliance was identified as PNC (past noncompliance). The Immediate Jeopardy (IJ) began on 09/10/25 and ended on 09/15/25. The facility had corrected the noncompliance before the survey began. This deficient practice placed residents at risk for falls, injuries, and hospitalization.Based on interview and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision to prevent accidents for 1 of 6 residents (Resident #3) reviewed for accidents and hazards. The facility failed to ensure Resident #3 did not elope from the facility on 09/10/25. The noncompliance was identified as PNC (past noncompliance). The Immediate Jeopardy (IJ) began on 09/10/25 and ended on 09/15/25. The facility had corrected the noncompliance before the survey began. This deficient practice placed residents at risk for falls, injuries, and hospitalization. Findings included: Record review of Resident #3's admission recorded dated 10/02/25 documented an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses including: unspecified dementia (loss of memory, language, problem solving and other thinking abilities), muscle weakness (lack of physical or muscle strength), and history of falling. Record review of Resident #3's Quarterly MDS assessment, dated 09/02/25, revealed the resident had a BIMS score of 3 indicating the resident had severe cognitive impairment. Record review of Resident #3's care plan, dated 09/29/25, revealed Resident #3 was care planned for impaired cognitive function/dementia or impaired thought processes r/t dementia, at risk for falls r/t confusion, cognitive impairment, gait/balance problems, and unaware of safety needs. Resident #3's care plan did not reflect to routinely monitor the resident. Review of an initial “Elopement Risk Assessment” dated 06/03/24, reflected Resident #3 was not at risk for elopement and care plan interventions of routinely monitor resident. Review of elopement incident report dated 09/10/25 at 6:10pm written by LVN C reflected “This nurse received a phone call that there was a possible resident of ours walking down the highway. This nurse went outside and resident was walking up with a male person. A lady in a car told me that she is bringing one of our residents back that was off the property. This nurse walked with the resident back into the facility. The resident sat down in the front lobby and was given some water to drink. Vital signs stable. Keeping the resident within sight at this time. No injuries observed at the time of the incident.” (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #3's nursing progress note dated 09/10/25 written by LVN Cat 6:17pm reflected “This nurse received a phone call of a possible resident outside. This nurse went outside and there was a male walking up the sidewalk with the resident. The lady in the car stated that our resident was walking outside and they are bringing her back. This nurse notified the ADON while we are walking back into the facility because she is here at this time. Assisted the resident back in the facility and gave her some water. VS stable 167/52(blood pressure) 98(oxygen) 97.2(temperature) 98(pulse) O2 sat. She denies any pain and said that she did not fall while she was out. States that she just wanted to get away. She has no control over anything and needed to get away. This nurse was directed to send her back to the secure until to room [ROOM NUMBER] at this time. Notified the responsible party that she would be moving back there and what room she would be in. He states that he will be calling tomorrow and speaking with management”. In an interview with the former DON on 09/29/25 at 2:59pm, she stated she had received a call from the ADON on 09/10/25 around 6:00pm and could not recall the exact time that Resident # 3 was found outside at the road to the right of the facility by someone that passed by in their car. LVN C assessed Resident #3 with no injuries and Resident #3 was placed on the secured unit. The former DON stated there was no camera footage of Resident #3 when she had exited the facility as the cameras did not work. The former DON was advised by the ADON that Resident #3 went out of the facility when a visitor was holding the door open for CNA B to come into the facility. The former DON stated that CNA B did not recognize Resident #3 because she had worked the secured unit. CNA B stated Resident #3 did not reside on the secure unit. The former DON stated CNA B thought that Resident #3 was a visitor because she was dressed like a visitor and had a purse . The former DON stated it was expected for CNA B to recognize Resident #3, and the incident could have resulted in Resident #3 possibly being hit by a car while outside the facility. The former DON stated immediately after the incident on 09/10/25 the facility was trained on the missing resident policy, what to do when a resident elope, and to prevent elopement. In an interview with LVN C on 09/29/25 at 3:14pm, she stated on 09/10/25 she had received a call around 6:00pm during shift change from a lady whom she did not know to let her know there was an elderly person out at the road. LVN C stated at the same time the ADON was on the line with another facility in the area asking if they had a resident that was missing. LVN C stated when she got off the phone she and the ADON immediately went outside the facility. LVN C stated a lady was sitting in a blue car and a young man was bringing Resident #3 to the facility door. LVN C stated Resident # 3 was not outside the facility more than five minutes. LVN C stated she asked Resident #3 where she was going, and Resident #3 told her she just needed a break. LVN C gave Resident #3 some water and assessed her for any injuries, and none were noted. Resident # 3 was placed on the secured unit. LVN C stated anything could have happened to Resident #3 that could have caused harm while outside the facility. LVN C stated inservice on preventing elopement was completed after the incident on what to do in case of elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA B on 09/29/25 at 4:08pm, she stated on 9/10/25 after 6:00PM (the exact time could not be recalled), as she was coming in the facility, a visitor that was leaving out of the facility had held the door open as she was coming in to work. CNA B stated shortly after she was on the secured unit an unidentified staff member had stated to her that Resident #3 went out of the facility earlier. CNA B stated she asked the unidentified person what did Resident #3 look like, and the unidentified person said the resident was dressed up and had a purse. CNA B then stated to the unidentified staff member “Oh My Gosh Resident #3 was coming out of the facility as she was coming into the facility”. CNA B stated Resident #3 did not look like a facility resident. CNA B stated she did not know Resident #3 was a facility resident because she had a dressy colorful dress on, and had a purse, with big hair. CNA B stated she had never seen Resident #3 as she worked the secured unit. CNA B stated that she will take the blame for not recognizing it was Resident #3 coming out of the facility as she was coming in. CNA B expressed she was very sorry for that. CNA B received elopement training to prevent elopement after the incident over elopement procedures and the protocol to follow when there is an elopement. In an attempted interview with Resident #3 on 09/30/25 at 3:22pm, Resident #3 was sitting in the secured unit at the dining table, and she was not able to say if she was safe or not. Resident # 3 was not able to elaborate on if she had left the facility or how she got outside when she was found in the road. Resident #3 she was not able to recall the elopement incident, and she stated she was here and said she did not know. In an interview with Resident #3's RP on 10/01/25 at 9:25am he stated that he received a call on 9/10/2025 around 6:00pm that evening from a female (name unknown) at the facility advised that Resident #3 had been found outside at the road walking on the highway. Resident #3's RP stated the facility never told him how Resident #3 was let out of the facility. Resident #3's RP stated he had a problem with Resident #3 being let out of the facility and that Resident #3 was let out of the facility by staff. Resident #3's RP was very concerned because Resident #3 had dementia and that someone had let Resident #3 out and there was no way Resident #3 could have pushed that heavy door leading to the outside open. Resident #3's RP stated Resident #3 would not have known to return back to the facility if she was not found outside the facility. Resident #3's RP stated the Highway is a very busy highway and anything could have happened (possibly hit by a car) with Resident #3 being on the Highway if no one had found her. Resident #3's RP stated the problem he had was the facility door was not secured, and Resident #3 was able to get out of the facility. Resident #3's RP stated that residents could be able to walk out with employees because no staff was at the front area watching the door. Resident #3's RP stated he wanted the security to the door to be enforced for the safety of all the residents and to ensure this incident would not ever happen again. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the ADON on 10/01/25 at 11:55am she stated she was on the phone around 6:00pm (could not recall the exact time) on 09/10/25 talking with another facility in the area, and they were asking if they had a resident that was missing. The ADON stated while she was on the phone speaking with the other facility LVN C was on the line with the people that had Resident #3 outside the facility. The ADON stated once she and LVN C both got off the phone they went outside to the parking lot of the facility. The ADON stated there was a lady that was sitting in a blue car and a male gentleman was escorting Resident #3 back to the door of the facility. The ADON stated Resident #3 was back inside the facility by 6:15 pm. The ADON stated that Resident #3 may have gotten out of the facility with visitors. The ADON stated that Resident #3 dressed up every day and would not be recognized as a resident. The ADON stated when Resident # 3 was brought back inside the facility, Resident #3 sat in a chair, and was given water. The ADON stated that Resident #3 told LVN C that she just needed a break. The ADON stated Resident #3 was fully assessed by LVN C with no injuries and escorted Resident #3 to the secured unit. The ADON stated that Resident #3 was very confused and when she went out of the facility would not have known to come back into the facility. The ADON stated the speed limit in front of the facility was 55 miles per hour and the worst thing that could have happened was Resident #3 could have gotten run over by a car. The ADON stated immediately after the elopement incident elopement training was conducted on the protocol, procedure of elopement, and to monitor residents. In an interview with the ADM and interim DON on 10/01/25 at 5:30 pm they stated that when the state surveyor came in on 09/26/25 the elopement was completed. The ADM and Interim DON stated an elopement assessment was completed on all residents, the elopement book was updated and staff were in serviced on the location to find it. Inservice on the missing resident policy procedures (what to do) was completed with all staff. Care plans were updated for all residents that were elopement risks. The sign on the front door, dining area, and any door staff exit through was placed for all resident's safety. An assessment was completed on Resident #3 and the care plan was updated. Resident #3 was moved to the secure unit and staff statements and witness statements were conducted. A root cause analysis was completed by the interim DON along with a complete report of the elopement incident. An interview with the interim DON on 10/03/25 at 12:20pm reflected that Resident #3 was not recognized by CNA B when a visitor was holding the door open for her when she came to work on 9/10/25 which resulted in Resident #3 exiting the facility. The interim DON stated this could have resulted in potential harm if Resident #3 had a fall while outside the facility. The interim DON stated it was expected for staff to make sure Resident #3 was safe. An interview with the ADM on 10/03/25 at 12:40pm stated that Resident # 3 was let out by CNA B who did not recognize she was a resident on 09/10/25 around 6:00pm. The ADM stated that Resident #3 could have experienced a negative outcome with harm if she was hit by a car on the busy highway. The ADM stated it was expected Resident #3's admit assessment completed on 06/03/24 to be followed. The ADM stated Resident #3 was not an elopement risk at the initial assessment but required care plan to be routinely monitored. Review of the facility's “Safety and Supervision of Resident” policy, dated 2001, revealed “Our facility strives to make the environment as free from accident hazards as possible, Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Policy Interpretation and Implementation (continued on next page)

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	10/03/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Oriented Approach to Safety 1. Our facility-oriented approach to safety addresses risks for groups of residents. Resident Risks and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: e. unsafe wandering…” Review of the facility's “Wandering and Elopements” policy, dated 2001, revealed “The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.” This noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 09/10/25 and ended on 09/15/25. The facility had corrected the noncompliance before the survey began. The facility took the following actions to correct the non-compliance: - Review of Wandering/Elopement Assessment was conducted on all residents was completed on 09/10/25. - Review of Inservice on missing resident policy and protocol to follow was completed on 09/10/25. - Review of Elopement book and Inservice on where the book is located was completed on 09/10/25. - Review of Care plans updated on all residents that are an elopement risk was completed on 09/10/25. - Review of Signage on door in front door and any door staff exit through to make sure residents are not able to exit facility was observed on 09/10/25. - Review of Assessment on Resident #3, Reviewed Resident #3's updated care plan, moved to the secure unit on 09/10/25. - Review of Staff statements/witness statements about the elopement incident was completed on 09/11/25. - Review of Root cause analysis was completed on the elopement was completed by DON on 09/11/25 - Review of Complete incident report on the elopement was completed on 09/15/25