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	06/26/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status in either life-threatening condition of clinical complications for one of eight residents (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1's FM was notified when he hit another resident on 6/25/2026. This failure could place 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 include: Record review of Resident #1's face sheet, dated 6/26/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Epilepsy (seizure disorder), Dementia (decline in mental ability), high blood pressure, anxiety disorder, and major depressive disorder. Record review of Resident #1's admission MDS, dated [DATE], reflected he had a BIMS of 2, which indicated severe cognitive impairment. Record review of Resident #1's care plan, dated 6/26/2026, reflected a focus: Resident exhibits physically aggressive behaviors, including hitting staff and other residents, placing self and others at risk for injury with the intervention: Monitor the resident closely for signs of agitation or escalating behaviors. Identify and document potential triggers. Record review of Resident #1's progress notes, dated 6/25/26 to 6/26/26, reflected no entry that Resident #1's FM was contacted about the incident on 6/25/2026. During an interview on 6/26/2026 at 12:15 PM, the DON stated she was not aware of the incident with Resident #1 until today and was not aware of any previous incidents with Resident #1 and other residents. She stated she reviewed the progress notes and did not see any note that indicated Resident #1's FM was informed about the incident. She stated Nurse B should have called the family about the incident, so they were aware of the change in behavior. She stated her concern with the FM not being called was they would not be informed of changes in the resident's behaviors and their needs may not be met. During an interview on 6/26/2026 at 12:26 PM, Nurse B stated she worked the day shift yesterday, on 6/25/2026 on the memory care unit and observed Resident #1 hit another resident on the back of the neck about 1:30 PM. She stated she separated the residents and redirected Resident #1 out of the area. She stated she assessed both residents for injuries, and none were noted. She stated it was her first day on the unit, she was busy passing medications, and she did not call the FM because she had not known she was supposed to do that. During an interview on 6/262026 at 2:23 PM, the FM for Resident #1 stated she was not aware of the incident involving Resident #1 hitting another resident until she was called today. She stated it bothered her that no one called her to tell her what happened. The FM also stated if they did not call her about this incident, she was worried there may have been other issues they had not called her to discuss. During an interview on 6/26/2026 at 4:37 PM, the ADM stated he had just found out about the incident where Resident #1 hit another resident. He stated he was not aware Nurse B did not call the FM to let them know about the incident. He stated nursing staff was supposed to call the family immediately when there was a change in behavior with a resident, as it was their right to be informed. Record review of the facility's policy Resident Rights, (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised February 2021, reflected: Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:o. be notified of his or her medical condition and of any changes in his or her condition;p. be informed of, and participate in, his or her care planning and treatment.

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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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately but not later than 2 hours after the allegation was made, if the events that caused the allegation involved serious bodily injury, to the Administrator of the facility and other officials including to the State Survey Agency in accordance with State and law through established procedures for one of eight (Resident #1) residents reviewed for abuse and neglect. Nursing facility staff failed to report to the Administrator that Resident #1 was observed hitting another resident on 6/25/2026 at 1:30 pm. This failure could place residents at risk of not being protected from abuse, neglect, or exploitation.Findings include: Record review of Resident #1's face sheet, dated 6/26/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Epilepsy (seizure disorder), Dementia (decline in mental ability), high blood pressure, anxiety disorder, and major depressive disorder. Record review of Resident #1's admission MDS, dated [DATE], reflected he had a BIMS of 2, which indicated severe cognitive impairment. Record review of Resident #1's care plan, dated 6/26/2026, reflected a focus: Resident exhibits physically aggressive behaviors, including hitting staff and other residents, placing self and others at risk for injury with the intervention: Monitor the resident closely for signs of agitation or escalating behaviors. Identify and document potential triggers. During an interview on 6/26/2026 at 10:08 AM, CNA A stated she worked yesterday, 6/25/2026, during the day on the memory care unit. She stated she was picking up lunch trays around 1:30 PM and observed Resident #1 hit another resident. She stated Nurse A was standing right there and observed the incident. She stated she and Nurse B separated the residents and removed Resident #1 from the area. She stated she had been working on the unit for about three weeks and had never seen Resident #1 become aggressive with any of the residents. CNA A stated she received training on abuse and neglect and would consider one resident hitting another as physical abuse. She stated she should have reported it immediately to the ADM but figured since Nurse B had observed it also, Nurse B would report it to the ADM. She stated she was not aware Nurse B did not report it to the ADM. During an interview on 6/26/2026 at 12:15 PM, the DON stated she was not aware of the incident with Resident #1 until today and was not aware of any previous incidents with Resident #1 and other residents. She stated neither Nurse B or CNA A reported the incident when it happened on 6/25/2026. She stated all staff were trained to report any instances of abuse or neglect immediately to the ADM, who was the abuse coordinator. The DON stated one resident hitting another could be considered physical abuse. She stated her concern with events not being reported would be the needs of the residents may not be met. During an interview on 6/26/2026 at 12:26 PM, Nurse B stated she worked the day shift yesterday, on 6/25/2026 on the memory care unit and observed Resident #1 hit another resident on the back of the neck about 1:30 PM. She stated she separated the residents and redirected Resident #1 out of the area. She stated she assessed both residents for injuries, and none were noted. She stated it was her first day on the unit, she was busy passing medications, and she didn't think to report it to the ADM who was also the abuse coordinator. She stated she had been trained in reporting any instances of abuse or neglect immediately to the ADM and she would consider one resident hitting another as physical abuse. She stated when abuse happened I should report it right there and then. She stated not immediately reporting instances of abuse or neglect could cause it to happen again, a resident could get injured, or they could go on to other residents. During an interview on 6/26/2026 at 4:37 PM, the ADM stated he had just found out about the incident where Resident #1 hit another resident. He stated he reported the incident to the state agency and was informed neither resident was injured. He stated by incidents not being reported, he had serious concerns about (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' safety. He stated he needed to know if something was wrong so they could take care of the residents. Record review of the facility's policy Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, reflected: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 3. ?Immediately' is defined as:a. within two hours of an allegation involving abuse or result in serious bodily injury; orb. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.