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	05/28/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 3 of 10 residents (Resident #8, Resident #66, and Resident #70) reviewed for ADL care.The facility failed to ensure Resident #8, Resident #66, and Resident #70 did not have long, and dirty fingernails.This failure could place residents at risk of skin tears, infection, and embarrassment.1. Record review of Resident #8's face sheet, dated 05/26/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included dysphagia (trouble swallowing), muscle wasting, lack of coordination, unsteadiness on feet, pain, vomiting, hypertension (high blood pressure), and localized edema (swelling). Record review of Resident #8's quarterly MDS assessment, dated 03/19/2026, reflected a BIMS score of 15, which indicated intact cognitive response. The MDS reflected she required supervision or touching assistance from staff for personal hygiene, which indicated the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity.Record review of Resident #8's care plan, dated 01/13/2026, reflected the following: Focus: ADL self-care performance deficit requires supervision with ADL care. Resident ADL ability fluctuates related to generalized weakness.Goal: Resident will maintain ability to participate with self-care at current level.Interventions: Encourage the resident to participate to the fullest extent possible with each interaction. Encourage the resident to use bell to call for assistance. Praise all efforts at self-care.Observation of Resident #8 on 05/26/2026 at 1:43p.m., revealed she was lying in her bed. Her nails were long and had what appeared to be dirt underneath them.During an interview with Resident #8 on 05/26/2026 at 1:43p.m., she said she had asked staff to cut her nails. She said she did not know when the last time her nails were cut. She said if her nails were cut it would make her feel much better.2. Record review of Resident #66's face sheet dated 05/26/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental function), cellulitis (bacterial infection involving inner layers of the skin), cerebral infarction (long term effects of a stroke), lack of coordination, and difficulty in walking.Record review of Resident #66's quarterly MDS assessment, dated 03/06/2026, reflected he had a BIMS score of 15 which indicated intact cognitive response. The MDS reflected he required supervision or touching assistance from staff for personal hygiene, which indicated the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Record review of Resident #66's care plan, dated 01/18/2026, reflected the following: Focus: [Resident #66] has diabetes mellitus (persistent high blood sugar).Goals: noneInterventions: Podiatry referral as needed and ordered by MD for foot/ nail care.Record review of Physician Orders dated 11/26/2025 stated May be seen by Podiatrist as needed.Record review of Resident 66's podiatrist notes revealed the last time Resident #66 saw the podiatrist was on 03/03/2026.The podiatrist note revealed the residents nails were cut and filed.Observation on 05/26/26 at 2:43 PM of Resident #66, revealed Resident #66 was sitting up in his wheelchair in his room. His fingernails were long and had a brown substance underneath them.During (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
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview with Resident #66 on 05/26/2026 at 1:27p.m., he did not know when staff last cut his fingernails. He said he wanted his fingernails cut and cleaned. He would not say how it make him feel with his fingernails long and dirty.3. Record review of Resident #70's face sheet dated 05/26/2026 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included muscle wasting, muscle weakness, pain in left shoulder, embolism, and thrombosis (blood clots in blood vessels), peripheral vascular disease (abnormal narrowing of arteries), hypertensive heart disease with heart failure (damage to heart and heart failure due to chronic high blood pressure), and heart failure. Record review of Resident #70's quarterly MDS assessment, dated 02/27/2026, reflected a BIMS score of 05, which indicated severe cognitive impairment. [Resident #70] was dependent for personal hygiene which indicated the helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. Record review of Resident #70's care plan, dated 05/13/2026, reflected the following: Focus [Resident #70] have altered cardiovascular status related to congestive heart failure, and hypertension.Goals: [Resident #70] will be free from signs and symptoms of complications of poor circulation.Interventions: Educate on the importance of proper foot care including proper fitting shoes, wash and dry feet thoroughly, inspect feet daily, daily change of hosiery and socks. Refer to podiatrist for nail care.Record review of Resident #70's orders dated 11/20/2025 stated May be seen by Podiatrist as needed. Record review of Resident 70's podiatrist notes revealed the last time Resident #70 saw the podiatrist was on 03/03/2026.Observation on 05/26/2026 at 10:09a.m., revealed Resident #70 lying in bed with her hand in her lap talking to a family member. Her fingernails were long and had a brown substance underneath them.During an interview with Resident #70 on 05/26/2026 at 10:09a.m., she said she had been asking staff to cut her fingernails. She said no one had tried to cut her fingernails and she wanted them to be cut and cleaned. She said she did not know how it made her feel having the long nails.During an interview with CNA C on 05/28/2026 at 11:26a.m., she said she had been trained on ADL. She said the training covered what the staff were supposed to do on a daily basis for the resident such as providing care. She said the policy for nail care was on shower days the staff were to cut the residents' nails and facial hair for females. She said for males staff were to cut the nails and facial hair it they wanted the facial hair cut. She said the CNAs are responsible for cutting the residents' nails and cleaning them unless the resident was diabetic then the nurses were responsible for cutting the residents' nails. She said if the resident's nails were not cut the resident could scratch them self or feel like they are not being taken care of. She said the nurses, ADON and management monitored to ensure staff were cutting and cleaning the residents nails. She said the nurses, ADON and management monitored by observation. She said Resident #8, Resident #66 and Resident #70's nails were not cut because staff did not cut them like they should. During an interview with the ADON on 05/28/2026 at 11:39a.m., she said she had been trained on ADL care. She said the nursing staff were responsible for nail care. She added if the resident had thick nails or toenails that staff were not able to cut nurse was to notify the podiatrist. She said the nurses and CNAs were responsible for providing nail care. She said nail care was supposed to be done weekly or as needed. She said she could not say how the resident would feel about their nails not getting cut but she said she would not feel good. She said the ADON and nursing supervisor should be monitoring to ensure staff were cutting and cleaning the resident's nails. She said the ADON and nursing supervisor monitored by checking the resident's orders for nail care and by observation. She said she did not know why Resident #8, Resident #66 and Resident #70's nails were not cut. During an interview with the DON on 05/28/2026 at 2:59p.m., she said she had been trained on ADLs. She said the policy for nail care was that CNAs should clean and/or cut the resident's nails on shower day. She said if the resident is diabetic the nurse should cut the residents nails. She said the nurses and CNAs were responsible for cutting and cleaning the resident's nails. She said if staff were not cutting or cleaning the resident's nails the resident may feel unclean. She said the nurse and ADON monitored the staff to ensure they were cutting and cleaning the resident's (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nails. She said the nurse and ADON monitored through observations. She said she did not know why Resident#8, Resident #66 and Resident #70's nails were not cut and cleaned. During an interview with the ADM on 05/28/2026 at 1:55p.m., he said he had been trained on ADLs. He said the policy for nail care was staff were to cut and clean the resident's nails on the resident's shower days and as needed. He said the only exception was if the resident was diabetic then the nurse was to do the nail care. He said if the resident's nails were not done the resident could scratch themselves, or their nails could be dirty. He said the nurses and nursing department supervisors monitored to ensure the staff were providing nail care. He said the nurses and nursing department supervisors monitored through weekly assessments. He said he was not sure why Resident #8, Resident #66 and Resident #70's nails were not cut and cleaned. Record review of Activities of Daily Living, Supporting ADL Policy dated 02/2025 revealed Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure CK B wore a hair net on his beard.2. The facility failed to ensure CK B washed his hands when changing tasks.3. The facility failed to ensure DA A washed hands when changing tasks. These deficient practices could place residents at risk for food borne illness. During an observation on initial tour of the kitchen on 05/26/2026 at 9:11 a.m., it was revealed that CK B failed to use a hair net to cover facial hair while preparing puree food. During a kitchen observation on 05/26/2026 at 10:55 a.m., it was revealed that CK B failed to wash hands prior to pureeing ham. CK B failed to wash hands after returning to the food preparation area from loading the pureed ham food canister in the oven. It was observed that CK B failed to wash hands before preparing puree of turnip greens or upon completion of the puree preparation. During an observation in the facility kitchen on 05/26/2026 at 11:45 a.m., it was revealed that DA A wash hands prior to loading lunch trays into the meal cart. DA A delivered a meal cart to the secure unit and she failed to wash hands upon re-entry of the kitchen at 12:10 p.m. At 12:21 p.m., DA A was observed placing covers on the food plates while working on the food line and she failed to wash hands upon entry to the kitchen. During an interview on 05/26/2026 at 9:11 a.m., DM stated she had worked at this facility for 1 year and she has obtained a Manager Food Handler Certificate. DM stated there are a total of 13 kitchen staff including herself (DM) and the RD and each staff member has a current Food Handler Certificate. She stated that the Food Handler certification training includes training on kitchen sanitation and hand sanitation. She stated each staff member had also been in-serviced last week on hand hygiene. She stated staff are trained to use hand hygiene frequently. DM stated it is her expectation that staff will hand sanitize between tasks. During an interview on 05/26/2026 at 9:29 a.m., CK B stated he had been working at this facility for 7 months and he had been trained on proper hand sanitation. CK B stated proper hand sanitation means that all the kitchen staff are supposed to wash hands after touching food. CK B stated that all staff should wash hands to prevent germs from affecting everyone's health. CK B stated all staff are to wear hair restraints on their head to prevent hair from falling into the resident's food. During an interview on 05/26/2026 at 11:45 a.m., DA A stated she had been trained on proper hand hygiene and hand-washing technique. DA A stated the last in-service training was 1 week ago. She stated, we are to wash our hands in the designated hand-washing sink between each task. DA A said, the purpose of handwashing is to prevent cross contamination. During a phone interview on 05/27/2026 at 2:04 p.m., RD revealed that the facility has a contract for Dietary Services with the company she works for. RD stated, she enters the facility 1 time per month. RD stated some of her duties are to work with the DM and to educate the staff on sanitation. She said she will prepare a report showing findings and she will give recommendations to the facility's DM. RD stated she was not aware that kitchen staff were not using proper hand sanitation techniques. She said, staff are required to wash hands and to use proper hand sanitation between tasks. She said that she will make sure that hand sanitizing training is done as soon as possible for the kitchen staff. During an interview on 05/28/2026 at 1:18 p.m., DON stated she has worked at this facility for 6 months and she has been trained in hand sanitation techniques. She stated that staff should use hand sanitation when they enter the kitchen and they should wash their hands again between tasks. She stated gloves should be worn when preparing or cooking food. She stated the purpose of hand hygiene is to prevent foodborne illness. DON stated it is her expectation that all kitchen staff wear proper hair covering for head and facial hair. She stated, Residents could be exposed to illness if proper sanitation is not conducted in the kitchen. DON did not know why [NAME] was not wearing a facial hair restraint. During an interview 05/28/2026 at 1:35 p.m., ADM stated he had training in kitchen sanitation and hand hygiene. He stated, I am the one who does (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in-service training for the staff on hand hygiene. He stated, staff are to wash hands between every change of station. He said the purpose of hand sanitation in the kitchen is to prevent infection and contamination. He said, staff or resident could get sick due to transmission of germs if staff do not follow the hand sanitation policy. ADM stated staff are supposed to wear hair nets, and beard nets. ADM stated DM and myself are responsible for kitchen sanitation. Record Review of Facility's Food Preparation and Service policy, revised November 2022 revealed:Policy StatementFood and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. Policy Interpretation and Implementation General GuidelinesFood preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Food Preparation Area 4. Appropriate measures are used to prevent cross contamination. 5. Handwashing sinks are located near food preparation and clean dish areas and are separate from ware washing sinks. Food Distribution and ServiceFood and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents.8. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. Record Review of Facility's Handwashing/ Hand Hygiene policy, dated October 2023 and updated 01/2025 revealed:Policy statementThis facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and ImplementationAdministrative Practices to Promote Hand HygieneAll personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.5. Environmental measures are being taken to reduce contamination associated with sinks and sink drainage, including:hand washing sinks that are constructed and installed according to health department codes.Indications for Hand Hygiene1. Hand hygiene is indicated:a. immediately before touching a resident Washing Hands1. Wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands.2. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers.3. Rinse hands with water and dry thoroughly with a disposable towel.4. Use towel to turn off the faucet.5. Avoid using hot water because repeated exposure to hot water may increase the risk of dermatitis.Applying Alcohol-Based Hand Rubs1. Apply generous amount of product to palm of hand and rub hands together.2. Cover all surfaces of hands and fingers until hands are dry.3. Rub hands together in the same way as if were using soap and water.4. Allow the sanitizer to dry (This should take around 20 seconds).5. Follow manufacturers' directions for volume of product to use.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure it formulated, adopted, and enforced policies regarding smoking, smoking areas, and smoking safety for 3 of 5 residents (Residents #15, Resident #35, and Resident #44) reviewed for smoking. 1. The facility failed to complete a smoking assessment for Resident #15. 2. The facility failed to complete a smoking assessment for Resident #35. 3. The facility failed to complete a smoking assessment for Resident#44. This failure placed all residents at risk for serious injury, harm, due to staff not knowing if the resident was safe or needed assistance to smoke.Findings included: 1. Record review of Resident #15's face sheet, dated 05/26/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #15 had a diagnosis which included nicotine dependance (chronic addiction in which the brain adapts to regular nicotine exposure causing cravings, withdrawal symptoms, and difficulty quitting), lack of coordination, hypokalemia (low potassium), bipolar (extreme mood swings), and dementia (severe) with other behavior disturbance (memory, thinking, difficulty). Record review of Resident #15's annual MDS, dated [DATE], revealed Resident #15 had a BIMS of 12, which indicated moderate cognitive impairment. The MDS also revealed that current tobacco use was marked as no. Record review of Resident #15's care plan, dated 05/13/2026, reflected the following: Focus: Tobacco use.Goal: Will quit smoking/using tobacco by next review date.Interventions: Assess smoking safety quarterly and as needed. Monitor clothing for burn holes. Provide safe metal containers for extinguishing cigarette butts.Record review of Resident #15's Smoking Assessment on 05/27/2026, revealed Resident #15 did not have a smoking assessment completed. 2. Record review of Resident #35's face sheet, dated 05/26/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #35 had a diagnosis which included lack of coordination, type 2 diabetes mellitus without complications (high blood sugar), muscle wasting, mild intellectual disability (a neurodevelopmental condition characterized by below average intellectual functioning), cognitive communication deficit (problems with communication), hyperlipidemia (high cholesterol), and hypertension (high blood pressure). Record review of Resident #35's annual MDS, dated [DATE], revealed Resident #35 had a BIMS of 0, which indicated severe cognitive impairment. The MDS also revealed that current tobacco use was marked as yes. Record review of Resident #35's care plan, dated 01/07/2026, reflected the following: Focus: The resident is a smoker.Goal: The resident will not suffer injury from unsafe smoking practices through the review date. The resident will not smoke without supervision through the review date.Interventions: Instruct resident about the facility policy on smoking: locations, times, safety concerns. Observe clothing and skin for signs of cigarette burns.Record review of Resident #35's Smoking Assessment on 05/27/2026, revealed Resident #35 did not have a smoking assessment completed. 3. Record review of Resident #44's face sheet, dated 05/26/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #44 had a diagnosis which included respiratory failure, lack of coordination, muscle wasting, muscle weakness, nicotine dependance (chronic addiction in which the brain adapts to regular nicotine exposure causing cravings, withdrawal symptoms, and difficulty quitting), hyperthyroidism (excessive production of thyroid hormones), and anemia (not healthy red blood cells. Record review of Resident #44's admission MDS, dated [DATE], revealed Resident #44 had a BIMS of 15, which indicated intact cognitive response. The MDS also revealed that current tobacco use was marked as yes. Record review of Resident #44's cancelled care plan, dated 05/04/2026, reflected the following: Focus: The resident requires staff supervision when using tobacco products. Goal: I will follow tobacco policy of facility without injuring myself or others.Interventions: I require the facility staff to keep all tobacco and fire-starting materials for safety. My smoking supplies are stored in smoker's box with facility staff to issue to me during supervised smoking times.Record review of Resident #44's Smoking Assessment on 05/27/2026, (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed Resident #44 did not have a smoking assessment completed. Observation of smoking on 05/27/2026 at 09:08a.m., revealed Resident #44 was outside smoking with staff present.During an interview with the ADON on 05/28/2026 at 11:44a.m., she said she had been trained on how to complete the smoking assessment in the computer. She said a smoking assessment should be done on admission and quarterly. She said normally the Social Worker was responsible for doing the smoking assessments, but the facility did not have a full-time social worker. She said the nurses do the smoking assessments on admission. She said she would do the smoking assessment if she was the nurse at the time the resident was admitted . She said if a resident did not have a smoking assessment the resident could be smoking unsafely, or staff would not know if the resident needed a smoking apron. She also said if a staff member was not familiar with the resident the staff member would not know what the resident's needs were when smoking. She said management would monitor to ensure a smoking assessment was completed on all residents who smoked. She said management monitored by going into the system and looking to see if the smoking assessments had been done. She said she did not know why Resident #15, Resident #35 and Resident #44 did not have a smoking assessment completed During an interview with the DON on 05/28/2026 at 1:05p.m., she said she had been trained on completing the smoking assessments. She said the smoking assessment contained information about the resident such as if the resident had to be supervised while smoking or if the resident needed a smoking apron. She said the smoking assessment should be done on admission, quarterly or if the resident had a change in condition. She said the nursing department was responsible for completing the smoking assessment. She said if the resident did not have a smoking assessment the resident could be at risk of burning themselves or their clothing. She said the DON/ADM monitored to ensure the smoking assessments were done. She said the DON/ADM monitored by checking to see if each resident who smoked had a smoking assessment. She said when the DON/ADM checked for the smoking assessment they would also see when the resident was due for another assessment. She said she thought she had done Resident #15, Resident #35 and Resident #44's smoking assessment.During an interview with the ADM on 05/28/2026 at 1:47p.m., he said he had been trained on completing the smoking assessments. He said the policy was to ask the resident if he/she smoked when they were being admitted to the facility. He said if the resident smoked the smoking assessment should be done on admission before the resident started smoking. He said the nurse was responsible for doing the smoking assessment. He said if the resident did not have a smoking assessment the resident could burn themselves. He said the nursing management monitored to ensure the residents had smoking assessments. He said the nursing manager monitored by checking the computer to see if there was a smoking assessment completed. He said he did not know why Resident #15, Resident #35 and Resident #44 did not have a smoking assessment completed. Record review of the Smoking Policy- Residents dated 10/2022 revealed This facility shall establish and maintain safe resident smoking practices. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker or smokeless tobacco user, the evaluation will include current level of tobacco consumption, method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe), desire to quit smoking, if a current smoker; and ability to smoke safely with or without supervision (per a completed Smoking Assessment). The staff shall consult with the Attending Physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Smoking Assessment. A resident's ability to smoke or chew tobacco safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure assessments accurately reflected the resident's status for 2 of 3 residents (Resident #15, and Resident #67) reviewed for accuracy of assessments. The facility failed to ensure Resident #15's annual MDS, dated [DATE], accurately reflected her smoking status. The facility failed to ensure Resident #67's admission MDS, dated [DATE], accurately reflected his smoking status. These failures could place residents at risk of inadequate supervision due to an inaccurate assessment for smoking status.Findings include: 1. Record review of Resident #15's face sheet, dated 05/26/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #15 had a diagnosis which included nicotine dependance (chronic addiction in which the brain adapts to regular nicotine exposure causing cravings, withdrawal symptoms, and difficulty quitting), lack of coordination, hypokalemia (low potassium), bipolar (extreme mood swings), and dementia (severe) with other behavior disturbance (memory, thinking, difficulty). Record review of Resident #15's annual MDS, dated [DATE], revealed Resident #15 had a BIMS of 12, which indicated moderate cognitive impairment. The MDS also revealed that current tobacco use was marked as no. Record review of Resident #15's care plan, dated 05/13/2026, reflected the following: Focus: Tobacco use.Goal: Will quit smoking/using tobacco by next review date.Interventions: Assess smoking safety quarterly and as needed. Monitor clothing for burn holes. Provide safe metal containers for extinguishing cigarette butts.Record review of Resident #15's Smoking Assessment on 05/27/2026, revealed Resident #15 did not have a smoking assessment completed. 2. Record review of Resident #67's face sheet, dated 05/26/2026, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #67 had diagnoses which included parkinsonism (syndrome characterized by tremors and postural instability), signs and symptoms involving cognitive functions and awareness (changes in mental ability including memory loss, concentration and impaired decision making), polyneuropathy (damage affecting the nerves roughly the same area on both sides of the body), and schizophrenia (mental health condition that affects everything from how you think, how you feel and how you behave). Record review of Resident #67's admission MDS, dated [DATE], revealed Resident #67 had a BIMS of 03, which indicated severe cognitive impairment. The MDS also revealed current tobacco use was marked as no. Record review of Resident #67's care plan, dated 01/05/2026, reflected the following: Focus: SmokerGoal: Will have no complications from smoking through next review. Will present no hazards through the next review.Interventions: Assess smoking safety quarterly and as needed. Encourage resident to participate in activities.Record review of Resident #67's Smoking Assessment, dated 03/14/2026, revealed Resident #67 required supervision when smoking. During an interview with the MDS LVN on 05/28/2026 at 12:40p.m., she said she was trained on the basics of the MDS. She said she was responsible for completing the MDS. She said information that was on the MDS were assessments, demographics, BIMS, diet, and smoking status. She said the MDS should be completed when there was a significant change, annually, and quarterly. She said she had fourteen days from admission to complete the MDS. She said there was a question on the MDS about the resident's tobacco use and if the resident was a smoker, it would be checked yes. She said if the resident's smoking status was not coded correctly she did not know how it would affect the resident. She said staff would inform her when a resident was admitted that the resident was a smoker. She said there was a person in corporate that monitored to ensure the MDS was completed correctly. She said the corporate person would access the resident's cart remotely and look at the MDS once in a while. She said she did not know how she missed Resident #15 and Resident #67's smoking status not being correct. During an interview with the ADM on 05/28/2026 at 1:51p.m., he said he had been trained on the MDS. He said the policy for MDS was that MDS should be done on admission, change of condition and every quarter. He said the MDS LVN was responsible for completing the MDS accurately. He said the MDS had the (continued on next page)

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	676295	A. Building B. Wing	05/28/2026

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's smoking status on it. He said if the smoking status was not correct on the MDS the resident would not be able to smoke when they wanted to smoke. He said the DON, ADM and the MDS Regional person monitored to ensure the MDS was correct. He said the DON, ADM and the MDS Regional person monitored by doing IDT meetings weekly on Thursdays to ensure everything was on the MDS. He said he did not know why the Resident #15 and Resident #67's smoking status was not correct on their MDS. Record review of the Smoking Residents list provided on 05/26/2026 revealed Resident #15, and Resident #67 were smokers. Record review of the Comprehensive Assessments Policy dated 02/2025 revealed Comprehensive assessments are conducted to assist in developing person-centered care plans. Significant Correction to Prior Comprehensive Assessment (SCPA) - The SCPA is a comprehensive assessment for an existing resident that must be completed when the IDT determines that a resident's prior comprehensive assessment contains a significant error. It can be performed at any time after the completion of an admission assessment. A significant error is an error in an assessment where the resident's overall clinical status is not accurately represented (example: miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and the error has not been corrected via submission of a more recent assessment. A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for residents that included the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care within 48 hours of the resident's admission for 1 (Resident #44) of 4 residents reviewed for care plans. The facility failed to complete a baseline care plan within 48 hours of Resident#44's re-admission date of 05/02/26. This failure could result in residents not receiving prescribed care while in the facility.Findings included: Record review of Resident #44's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. She was diagnosed with chronic respiratory failure (a long-term condition where the lungs cannot maintain adequate oxygen levels or remove carbon dioxide effectively, often requiring ongoing treatment and oxygen support), muscle wasting and atrophy (muscle weakness), hypothyroidism (underactive thyroid gland, often treated with medication and measured with blood work), anemia (low blood cell count), chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarette smoke and air pollution), , lack of coordination, arthritis, nicotine dependence, systemic inflammatory response syndrome (a clinical condition characterized by an exaggerated inflammatory response of the body to a harmful stressor, which may be infectious (like bacteria or viruses) or non-infectious (such as trauma, burns, surgery, or cancer), and anxiety disorder. Record review of Resident #44's Nursing Home Comprehensive MDS, dated [DATE] reflected that this admission assessment was the first assessment since the most recent admission. Section A reflected an entry date of 05/02/26, and type of entry was a reentry from the original admission date of 03/23/26. Record review of Resident #44's Quarterly MDS, dated [DATE], reflected a BIMS Score of 15, indicating no impaired cognition. Section GG reflected Resident #44 used a manual wheelchair, required setup or clean-up assistance for meals and oral hygiene, and partial/moderate assistance for other activities of daily living. Record review of Resident #44's Inactivation Request MDS, dated [DATE] reflected 3. Inactivate existing record. Record review of Resident #44's Nursing Home Discharge MDS, dated [DATE] reflected in Section A this was an unplanned discharge, which was from 03/23/26 - 04/30/26, and Resident #44 was discharged to Home/Community. Section GG reflected Resident #44 required verbal cues and touch assistance for bed mobility, bed to wheelchair, toilet and shower transfers, and setup or clean-up assistance for her daily living activities. Record review of Resident #44's Discharge Summary reflected a discharge date of 04/30/26 at 6:00 PM, against medical advice, to home in a family vehicle with no home health care services arranged. Resident #44 and her RP did not want to sign the discharge summary. Record review of Resident #44's Care Plan Report dated 05/02/26 reflected Resident #44's focus areas, goals, and interventions/tasks had been initiated on 04/01/26, revised and cancelled on 05/04/26. Record review of Resident #44's Progress Notes dated 04/25/26 reflected, This nurse was notified by another staff nurse LVN that this resident told her she wanted to go home and to pack her stuff and leave AMA. This nurse approached resident's room and asked resident why she was wanting to go home, resident stated, I want to go home, I'm tired of the rules and regulations. Resident #44 was educated on the risks of leaving against medical advice. This nurse notified the DON and Administrator. MD/NP on call notified as well. Observation on 05/26/26 at 10:35 AM revealed Resident #44 sitting in her bed typing on her phone. She appeared clean and well-groomed, and her room was free from odors. Interview on 05/27/26 at 09:35 AM revealed Resident #44 stated she had left the facility against medical advice on 4/30/26. She stated she was tired of all the bullshit in the facility and wanted to live with her family member. She stated she returned to the facility on 5/02/26. During an interview on 05/28/2026 at 12:48 PM the MDS Coordinator stated she had been trained on (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans. She said she was not sure how long she had to do the care plan. She said she was responsible for completing the care plans. She said the care plan had information about the resident such as the resident's smoking status, ADL, medications, and behaviors. She said she monitored to ensure every resident had a care plan. She said she monitored by completing the MDS; the MDS would trigger her to go in and complete a care plan. The MDS Coordinator said Resident #44 left the facility AMA on 04/30/2026. She said Resident #44 changed her mind and returned to the facility on [DATE] She stated she did not realize that she had to do another care plan. During an interview on 05/28/2026 at 1:11 PM. the DON said she had been trained on a care plan. She said that if it was a baseline care plan the facility had 24 hours to complete it. She said the IDT team and the MDS was responsible for the care plan. She said if there was not a care plan it could put the resident at risk of not getting the proper care the resident needed. She said the DON, ADM, and MDS regional monitored to ensure the care plans were done. She said they monitored their dashboard in the electronic medical records. She said Resident #44 did not have a care plan because when the resident left on 03/31/2026 her profile was deleted on the nursing side. During an interview on 05/28/2026 at 1:28 PM the ADM stated he had been the Administrator at this facility since November 2025. He stated he had been trained in care plans, which covered doing an initial care plan that included resident medications, preferences, family involvement, what time they like to get up, go to bed, what they like and dislike eating, and discuss this information with the IDT. The ADM stated he was a nurse and received training on care plans since 2010 and had additionally received training with the regional department when taking the job as Administrator. He stated the Policy and Procedure on Care Plans included conducting an initial care plan on admission within 48 hours, change of condition, and quarterly care plans. The IDT, the resident and family/RP were to be involved in the care plan process. The MDS nurse and the Social Worker were responsible for Care Plans. He further stated since they currently do not have a Social Worker, the MDS nurse was responsible. The ADM stated the Care Plan had important information about the residents' care, behaviors, how they eat, and patient care. The initial care plan should be completed within 48 hours. The initial care plan not being completed on time could affect the residents by staff not knowing know to provide care. N, The Regional MDS and I are responsible for monitoring the completion of the initial care plan, and on Thursdays the IDT holds a meeting that includes the DON with MDS nurse. He stated Resident #44 did not have a care plan. He stated Resident #44 went left the facility and went home AMA (against medical advice) and found that she could not take care of herself. Resident #44 had been discharged for 72 hours. Her family member could not take care of her, and after 72 hours Resident #44 started calling the DON. The ADM stated he had not been aware that when a resident left the facility AMA that the facility had to do a whole admission that included the initial care plan if the resident returned to the facility. Review of the facility's Policy & Procedures on Care Plans, Comprehensive Person-Centered, dated March 2022, reflected, Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to:a. participate in the planning process.b. identify individuals or roles to be included.c. request meetings.d. request revisions to the care plan.e. participate in establishing the expected goals and outcomes of care.f. participate in determining the type, amount, (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequency, and duration of care.g. receive the services and/or items included in the plan of care; andh. see the care plan and sign it after significant changes are made.5. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences.6. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.7. The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes.b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including:(1) services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.(2) any specialized services to be provided as a result of PASARR recommendations; and(3) which professional services are responsible for each element of care.c. includes the resident's stated goals upon admission and desired outcomes.d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for problem areas and conditions. 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are:a. provided by qualified persons.b. culturally competent; andc. trauma informed.9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.12. The interdisciplinary team reviews and updates the care plan:a. when there has been a significant change in the resident's condition.b. when the desired outcome is not met.c. when the resident has been readmitted to the facility from a hospital stay; andd. at least quarterly, in conjunction with the required quarterly MDS assessment.13. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.