STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676359	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Retirement Community	4100 Moores LN Texarkana, TX 75503

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 care plan to meet the medical, nursing, mental and psychosocial needs for 1 of 8 residents (Resident #1) reviewed for care plans.1. The facility failed to implement Resident #1's care plan by not explaining care and procedures while performing care and not stopping when resident was resistant to care and said quit.2. The facility failed to update Resident #1's care plan transfer status from a mechanical lift transfer to current transfer needs, behaviors, and potential devices needed.These failures could place residents at risk of a decline in physical or functional well-being, not receiving necessary care or services, and not having personalized plans developed to address their needs. Findings included:Record review of Resident #1's face sheet dated 5/12/26 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including Parkinsonism (disorder that causes movement problems), dementia (decline in cognitive abilities such as memory, reasoning, language, and behaviors that interfere with ADLs), hypertension (high blood pressure), and anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear or worry).Record review of Resident #1s quarterly MDS assessment dated [DATE] indicated she was usually understood and sometimes understood others. The MDS indicated she had a BIMS of 00, which indicated she had severe cognitive impairment. The MDS indicated Resident #1 had fluctuating inattention and disorganized thinking. The MDS did not indicate Resident #1 had behavioral symptoms. The MDS indicated Resident #1 used a wheelchair for mobility. The MDS indicated Resident #1 required substantial/maximal assistance dressing her lower body, going from lying to sitting on side of the bed, sit to stand, and chair/bed to chair transfers. The MDS indicated Resident #1 required moderate assistance rolling side to side. The MDS indicated Resident #1 had non-Alzheimer's dementia.Record review of Resident #1's undated care plan indicated the following:*Resident #1 was dependent on staff for meeting emotional, intellectual, physical, and social needs with interventions including all staff to converse with Elder while performing care.* Resident #1 was at risk for physical aggressiveness when ADL care was provided without apparent cause with interventions to determine her mood prior to initiating verbal or physical contact and if resident was resistive, stop, make sure she was safe, allow her time to calm and try again later.* Resident #1 had impaired cognitive and communication function related to dementia with interventions including explaining care and procedures, do not rush, allow her time to ask questions. * Resident #1 had restorative nursing care with interventions including perform safe bed, wheelchair and/or shower transfers.*Resident #1 had potential for pain related complaints of back, leg, and shoulder pain with interventions including per [relative] using mechanical lifts for transfers.Record review of video footage dated 5/02/26 beginning at 4:16 PM, started with Resident #1 lying in bed with her pants at approximately knee level. CNA A raised the bed up some and laid the resident flat in bed, there was no verbal communication from CNA A to let resident know what she was doing. CNA A started to pull Resident #1's pants up and grabbed under Resident #1's right hip and back of her right arm and pushed the resident onto her left side away from CNA A and Resident #1 said Oh and then continued talking (this (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor was unable to understand what Resident #1 said). CNA A tried to pull up Resident #1's pants some more and allowed resident to come back onto her back. CNA A grabbed under Resident #1's left arm, then elbow and left hip and pulled resident toward her while trying to pull up resident's pants as Resident #1 said quit then resident yelled Quit louder and continued to talk (this surveyor was unable to understand what Resident #1 said) and CNA A continued to try to pull Resident #1's pants up and did not communicate with Resident #1 as she continued care. CNA A pushed Resident #1 back onto her left side with her left hand in the middle of Resident #1's back and finished pulling up her pants with her right hand. CNA A then moved the wheelchair and positioned it at the end side of bed. CNA A asked Resident #1's RP #1 if he wanted her to get Resident #1 into her chair and he said yes. CNA A then grabbed Resident #1 under her knees and pulled her legs off the edge of the bed and then put her left hand behind Resident #1's neck and pulled her up toward a sitting position. The video ended at 4:18 PM.Record review of video footage of a second video that was not dated but was a continuation of previous video showed CNA A grab Resident #1 under her knees and pulled her legs off the edge of the bed. CNA A then put her left hand behind Resident #1's neck and pulled her up into a sitting position on the side of the bed as Resident #1 said Oh, Oh, quit and CNA A did not communicate with Resident #1 what she was doing nor stopped care. CNA A started to put her arms under Resident #1's arms and said Ms. (Resident's name) Ms. (Resident's name), give me a hug, give me a hug around my neck, come on, give me a big hug as Resident #1's arms laid across CNA A's back. CNA A then lifted Resident #1 from under her arms and by grabbing the back of Resident #1's pants and turned her toward the wheelchair. Resident #1 did not attempt to stand on her own or assist CNA A. Resident #1's RP #1 got up from his chair in the corner and said I'll hold the wheelchair and CNA A asked him to move it back some and as he was moving the wheelchair, CNA A slipped and Resident #1 sat back on bed and then CNA A appeared to struggle to stand her back up, still holding Resident #1 up (by lifting under her arms and holding the back of Resident #1's pants), and turned Resident #1 toward the wheelchair, as Resident #1 hollered Oh, Oh and allowed Resident #1 to sit hard into the wheelchair while RP #1 was holding the wheelchair. RP #1 said that hurt, rubbing the side of his face, and Resident #1 said you hit me. CNA A said, I hit you? and RP #1 said no, her head hit me it'll be alright and Resident #1 said no it won't, not right away.During an interview on 5/12/26 at 3:22 PM, CNA A stated she had worked at the facility since April 2026. CNA A stated she should have talked to the resident to let her know what care she was going to provide and she should have stopped care when Resident #1 stated quit. CNA A stated Resident #1 would sometimes tense up and lock up and that was what she felt when she lifted Resident #1. CNA A stated she should have used a gait belt and not the resident's pants to lift Resident #1 from the bed to the wheelchair. CNA A stated she was not familiar with a care plan and had not seen anything that would describe what care the resident needed.During an interview on 5/13/26 at 10:40 AM, LVN D stated Resident #1 would say no and quit for no reason during care. LVN D stated staff should talk to the resident and explain the care to be provided. LVN D stated it was all about the approach to make sure the resident felt comfortable and stop and acknowledged the resident's feelings. LVN D stated the purpose of the care plan was to make sure everyone was on the same page for the proper care of the resident. LVN D stated the care plan should include the resident's transfer status and devices needed. LVN D stated the care plan should be individualized to the resident because everyone was different. LVN D stated it was important to follow the care plan to provide safe care and minimize issues such as unsafe transfers and injuries. LVN D stated the risk to the resident for the care plan not being individualized or staff not following the care plan, could place the resident at risk for injury.During an interview on 5/13/26 at 12:05 PM, the DON stated the Kardex (resident care plan for the CNAs) should show what assistance the resident required for ADLs. The DON stated she did not see where the Kardex addressed what care or how much assistance was required for Resident #1's transfers. The DON stated Resident #1's care plan for pain had an intervention of RP #1 requesting a mechanical lift transfer but he changed his mind in January 2026 to not use the mechanical lift for transfers. The (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated the purpose of the care plan was so everyone taking care of the resident knew what care and how to care for the resident, it was a snapshot of the resident. The DON stated the care plan should include the assistance needed for transfers and what to do if the resident resisted or refused care, so everyone was aware of what the resident was capable of, and staff would know how to meet the resident's needs and what was required to take care of the resident. The DON stated the MDS Coordinator was ultimately responsible for the person-centered care plan. The DON stated the care plan should be individualized because every individual was different and required different care for all their ADLs. The DON stated if the care plan was not updated, the resident would not get the level of care that they needed, such as if they were a 2 person assist and it opened the resident up for injury. The DON stated she would expect the care plan to be individualized and followed by staff.During an interview on 5/13/26 at 12:38 PM, the MDS Coordinator stated the purpose of the care plan was, so everyone was on the same page on what care the resident required, was focused on the resident and was person-centered. The MDS Coordinator stated she put in the majority of the care plan, and she ultimately looked over everything. The MDS Coordinator stated the care plan should include the resident's transfer status and required assistance needed, such as if the resident needed 1 to 2-persons assistance or if they were a mechanical lift. The MDS Coordinator stated if she knew the resident was having behaviors during transfers, she would include it in the care plan. The MDS Coordinator stated she normally puts in 1 to 2-person assistance for transfers, so if there was an issue, then the staff could go get some help. The MDS Coordinator stated it was important for the care plan to be individualized so it focused on the resident and was person-centered. She stated the resident could be injured or dissatisfied, if care plan was not individualized or staff were not following the care plan. The MDS Coordinator stated she saw where the Resident #1's family member wanted a mechanical lift transfer, but she thought they stopped it, but that was all she saw for transfers in the care plan. The MDS Coordinator stated the care plan should have been updated to show Resident #1's current transfer status. The MDS Coordinator stated she was not sure why the care plan was not updated; she could have missed it. During an interview on 5/13/26 at 12:50 PM, the ADM stated the purpose of the care plan was individualized care to meet the resident's care needs to include emotional, physical, mental, and psychosocial needs. The ADM stated if a device was needed during transfers, then it should be listed in the resident's care plan. The ADM stated the care plan should be individualized for the overall well-being of the resident. The ADM stated if it was care planned, she would expect the care plan to be followed by staff and individualized. The ADM stated staff should tell the resident what care was being provided with anybody, not just residents with dementia. The ADM stated the resident probably would not want to participate in their care if staff did not explain or talk to them while performing care.Record review of the facility's policy dated revised April 2009 and titled Goals and Objectives, Care Plans, indicated . Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence . care plan goals and objectives were defined as the desired outcome for a specific resident problem . goals and objectives were entered on the resident's care plan so that all disciplines had access to such information and were able to report whether or not the desired outcomes were being achieved . goals and objectives were reviewed and/or revised . at least quarterly .Record review of the facility's policy titled Resident Transfers dated 2001, indicated . All resident transfers shall be performed using safe resident handling techniques appropriate to the resident's physical and cognitive condition. Staff should follow individualized care plans .

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 resident environment remained as free of accident hazards as was possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure CNA A performed a safe transfer from bed to wheelchair for Resident #1 on 5/2/26.This failure could place residents at risk of injury.Findings included:Record review of Resident #1's face sheet dated 5/12/26 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including Parkinsonism (disorder that causes movement problems), dementia (decline in cognitive abilities such as memory, reasoning, language, and behaviors that interfere with ADLs), hypertension (high blood pressure), and anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear or worry).Record review of Resident #1s quarterly MDS assessment dated [DATE] indicated she was usually understood and sometimes understood others. The MDS indicated she had a BIMS of 00, which indicated she had severe cognitive impairment. The MDS indicated Resident #1 had fluctuating inattention and disorganized thinking. The MDS did not indicate Resident #1 had behavioral symptoms. The MDS indicated Resident #1 used a wheelchair for mobility. The MDS indicated Resident #1 required substantial/maximal assistance dressing her lower body, going from lying to sitting on side of the bed, sit to stand, and chair/bed to chair transfers.Record review of Resident #1's undated care plan indicated she received restorative nursing care with interventions including perform safe bed, wheelchair and/or shower transfers. The care plan indicated Resident #1 had potential for pain related complaints of back, leg, and shoulder pain with interventions including per [relative] use mechanical lifts for transfers.Record review of video footage dated 5/02/26 beginning at 4:16 PM, started with Resident #1 lying in bed with her pants at approximately knee level. CNA A rolled resident from side to side to pull up her pants. CNA A then moved the wheelchair and positioned it at the end side of the bed. CNA A asked Resident #1's RP #1 if he wanted her to get Resident #1 into her chair and he said yes. CNA A then grabbed Resident #1 under her knees and pulled her legs off the edge of the bed and then put her left hand behind Resident #1's neck and pulled her up toward a sitting position. The video ended at 4:18 PM.Record review of video footage of a second video that was not dated but was a continuation of previous video showed CNA A grab Resident #1 under her knees and pulled her legs off the edge of the bed. CNA A then put her left hand behind Resident #1's neck and pulled her up into a sitting position on the side of the bed as Resident #1 said Oh, Oh, quit and CNA A did not communicate with Resident #1 what she was doing nor stop care. CNA A started to put her arms under Resident #1's arms and said Ms. (Resident #1's name) Ms. (Resident#1's name), give me a hug, give me a hug around my neck, come on, give me a big hug as Resident #1's arms laid across CNA A's back. CNA A then lifted Resident #1 from under her arms and by grabbing the back of Resident #1's pants and turned her toward the wheelchair. Resident #1 did not attempt to stand on her own or assist CNA A. Resident #1's RP #1 got up from his chair in the corner and said, I'll hold the wheelchair and CNA A asked him to move it back some and as he was moving the wheelchair, CNA A slipped and Resident #1 sat back on bed and then CNA A appeared to struggle to stand her back up, still holding Resident #1 up (by lifting under her arms and holding the back of Resident #1's pants), and turned Resident #1 toward the wheelchair, as Resident #1 hollered Oh, Oh and allowed Resident #1 to sit hard into the wheelchair while RP #1 was holding the wheelchair. RP #1 said that hurt, rubbing the side of his face, and Resident #1 said you hit me. CNA A said, I hit you? and the RP #1 said no, her head hit me it'll be alright and Resident #1 said no it won't, not right away.During an interview on 5/12/26 at 10:02 AM, Resident #1's RP #1 stated when CNA A picked Resident #1 up to put her in her wheelchair, CNA A slipped and almost dropped her. He stated CNA A was being rough (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with care. He stated he had not seen any staff use a gait belt during transfers and was even told using gait belts were against the rules.During an interview on 5/12/26 at 10:17 AM with Resident #1's RP #2, she stated she had gotten a call from RP #1 and he had told her to look at the video of the incident on 5/2/26. RP #2 stated when she saw CNA A was rough during Resident #1's care and CNA A did not transfer Resident #1 to her wheelchair safely and almost dropped her, she came to the facility and showed the nurses the videos.During an interview on 5/12/26 at 3:22 PM, CNA A stated she had worked at the facility since April 2026. CNA A stated she was in Resident #1's room and RP #1 had asked her to get Resident #1 up to earlier. CNA A stated she should not have pulled Resident #1 to a sitting position by putting her hand behind Resident #1's neck. CNA A stated she should have put her arm around Resident #1's shoulders and brought her to a sitting position. CNA A stated she knew she did an improper transfer. CNA A stated the bed level was to low and her hand positioning was wrong. CNA A stated sometimes Resident #1 would tense up and lock up and that was what she felt when she lifted Resident #1. CNA A stated she should have had a gait belt, but she did not. CNA A stated the gait belt would have given her more support instead of having a hold of Resident #1's pants. CNA A stated she almost lost her during the transfer and thought the wheelchair was too close. CNA A stated, to be honest, I should have gotten someone to come help me. CNA A stated she had not had any issues with Resident #1 prior to the incident. CNA A stated the nurses let them know if a resident required one-person or two-person assistance. CNA A stated she had not ever felt that she needed help with Resident #1 until that day (5/02/26). CNA A stated she did not know if she just was not doing things properly that day (5/02/26) but she had not even felt like she needed help before. CNA A stated she should have sat Resident #1 back down and readjusted, but she succeeded with the transfer, but barely. CNA A stated doing an improper transfer, placed the resident at risk of falling and getting hurt. CNA A stated she was not familiar with a care plan and had not seen anything that would describe what care the resident needed.During an interview on 5/12/26 at 3:35 PM, LVN C stated she had worked at the facility for a little over a year. LVN C stated RP #1 came up to her during dinner time on 5/02/26 and stated he did not want CNA A coming back into Resident #1's room. LVN C stated then she arranged it so CNA A would not go back into Resident #1's room. LVN C stated then about 45 minutes later RP #2 came up to the facility and showed her a video and she notified the ADM immediately. LVN C stated the video showed CNA A was rolling Resident #1 and Resident #1 was resistant to care and was hollering. LVN C stated when CNA A was transferring her Resident #1, she kind of locked up and CNA A slipped while trying to transfer but she never fell. LVN C stated Resident #1 did resist care at times. LVN C stated putting your hand behind the resident's neck to sit the resident up would not be proper. LVN C stated pulling the resident to the sitting position by the back of her neck could potentially cause the resident a neck injury and could be uncomfortable for the resident. LVN C stated she would have used a gait belt during the transfer and had Resident #1 put a foot between her legs and then used the gait belt to lift her and then pivot her to the wheelchair. LVN C stated when Resident #1 locked up and would not stand, she felt the aide should have stopped and came and got help. LVN C stated not doing a proper transfer could cause the resident to fall and skin injury. LVN C stated she did not feel CNA A performed a proper safe transfer.During an interview on 5/12/26 at 4:45 PM, the DOR stated when staff were bringing a resident from the lying position to sitting on the side of the bed, staff should log roll the resident onto their side and place a hand around the back top of shoulders and hand on legs and move to sitting position in one motion. The DOR stated staff should not place their hand behind the resident's neck and pull up from a lying position, because it could be brutal and the neck was easy to injure. The DOR stated staff should place a gait belt around the waist of the resident, make sure the wheelchair brakes were locked, and have the resident grab the back of the staff's arms and make sure the resident's feet were on the floor with non-skid socks or shoes before going from a sitting to standing position to transfer to a wheelchair. The DOR stated then grab the gait belt and let the resident know that they were going to stand on the count of three and then pivot to the chair and ease into chair. The DOR stated he did not suggest having the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident put their arms around the staff's neck, because it could injure the staff. The DOR stated staff should always use a gait belt to keep out of trouble and it gave a secure thing to hold. The DOR stated lifting under the resident's arms and grabbing the back of the resident's pants could injure the resident's shoulders and the pants could rip. The DOR stated the resident could be injured or fall if no gait was used and performing an improper transfer.During an interview on 5/13/26 at 10:40 AM, LVN D stated she reviewed the video when Resident #1's family came to the facility and showed them the video of care provided on 5/02/26. LVN D stated the aide was trying to lift Resident #1 from the bed to the wheelchair and she thought the bed being low made the transfer so difficult. LVN D stated staff should be using a gait belt for safety and not grabbing the resident under her arms and using the back of her pants to lift and transfer the resident. LVN D stated performing an unsafe transfer, could have resulted in a skin tear or injury to the resident. LVN D stated Resident #1 would sometimes help with standing during transfers, but it depended on what kind of mood she was in too. LVN D stated when Resident #1 did not help at all, the aide should have stopped and went and got help.During an interview on 5/13/26 at 12:05 PM, the DON stated she saw one video on the aide providing care mainly pulling Resident #1's pants up and turning her from side to side. The DON stated when Resident #1 stated no, the staff should have stopped and went to get help or reported it to the charge nurse. The DON stated she was not aware of the second video of the transfer. The DON stated CNA A stated the only thing she thought was an issue that when she stood Resident #1 up, Resident #1 stiffed and she had to sit her in the chair. The DON stated the staff should have not sat her up by the neck or head because it could cause injury to the resident. The DON watched the transfer video and stated with Resident #1 being kind of groggy and would not assist to sit up, the aide should have made her safe and used a gait belt. The DON stated she herself would have had two people. The DON stated the staff did not perform a safe transfer. The DON stated the body mechanics, the one person, under arms, the staff was already aware that RP #1 had told her about Resident #1 having shoulder pain. The DON stated the risk of major injury could have happened during the unsafe transfer. The DON stated when Resident #1 was alert, she would tell you not to grab her pants. The DON stated Resident #1 at times could be talked through the care, but she was not on the day of the incident (5/02/26). The DON stated Resident #1 when she wanted to, she could assist by grabbing the bars on the bed and would stand and shuffle her feet around and even put her feet up on the bed. The DON stated the staff should have given her time and came back and it would have probably made a world of difference in how Resident #1 responded.During an interview on 5/13/26 at 12:50 PM, the ADM stated she only knew about the one video and did not see what happened in the transfer. The ADM stated the nurse that reported the incident on 5/02/26 did not mention anything about a video with the transfer. The ADM reviewed video and stated CNA A should not have lifted Resident #1 under her arms and by the pants. The ADM stated Resident #1 looked like she was resistant and CNA A should have taken a break and got Resident #1 safe and then went and got the charge nurse or another aide or even given Resident #1 time and then came back. The ADM stated in watching the video of the transfer on 5/02/26, it did not appear to be a safe transfer. The ADM stated the staff could have dropped the resident or injured the resident in performing an unsafe transfer.Record review of the facility's CNA/Universal Worker Skills Competency Checklist, dated 4/05/26, indicated CNA A had successfully demonstrated transfer from bed to wheelchair, transferring techniques, and gait belt use and the form was signed by the DON.Record review of the facility's policy titled Resident Transfers dated 2001, indicated . All resident transfers shall be performed using safe resident handling techniques appropriate to the resident's physical and cognitive condition. Staff should follow individualized care plans, use proper assistive devices, and obtain assistance when necessary to prevent falls, skin injury, and other adverse events . staff shall follow the resident's individualized care plan and transfer status. Transfers shall only be completed by trained staff utilizing the appropriate equipment and level of assistance indicated in the care plan . Transfer procedures . b. ensure the environment is safe and free from obstacles . c. explain the procedure to the resident . e. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	avoid manually lifting a resident when mechanical assistance is indicated in the care plan . f. use gait belts when indicated . h. maintain proper body mechanics . i. request assistance when needed .

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents with dementia received appropriate treatment and services to maintain their highest practicable well-being for 1 of 8 residents reviewed for dementia care. (Resident #1)The facility failed to ensure CNA A provided appropriate dementia care and services while caring for Resident #1 on 5/02/26.This failure could place residents with dementia at risk for increased behaviors and decreased quality of life.Findings included:Record review of Resident #1's face sheet dated 5/12/26 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #1 had diagnoses including Parkinsonism (disorder that causes movement problems), dementia (decline in cognitive abilities such as memory, reasoning, language, and behaviors that interfere with ADLs), hypertension (high blood pressure), and anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear or worry).Record review of Resident #1s quarterly MDS assessment dated [DATE] indicated she was usually understood and sometimes understood others. The MDS indicated she had a BIMS of 00, which indicated she had severe cognitive impairment. The MDS indicated Resident #1 had fluctuating inattention and disorganized thinking. The MDS did not indicate Resident #1 had behavioral symptoms. The MDS indicated Resident #1 used a wheelchair for mobility. The MDS indicated Resident #1 required substantial/maximal assistance dressing her lower body, going from lying to sitting on side of the bed, sit to stand, and chair/bed to chair transfers. The MDS indicated Resident #1 required moderate assistance rolling side to side. The MDS indicated Resident #1 had non-Alzheimer's dementia.Record review of Resident #1's undated care plan indicated the following:*Resident #1 was dependent on staff for meeting emotional, intellectual, physical, and social needs with interventions including all staff to converse with Elder while performing care.* Resident #1 was at risk for physical aggressiveness when ADL care was provided without apparent cause with interventions to determine her mood prior to initiating verbal or physical contact and if resident was resistive, stop, make sure she was safe, allow her time to calm and try again later.* Resident #1 had impaired cognitive and communication function related to dementia with interventions including explaining care and procedures, do not rush, allow her time to ask questions. * Resident #1 had restorative nursing care with interventions including perform safe bed, wheelchair and/or shower transfers.Record review of video footage dated 5/02/26 beginning at 4:16 PM, started with Resident #1 lying in bed with her pants at approximately knee level. CNA A raised the bed up some and laid the resident flat in bed, there was no verbal communication from CNA A to let resident know what she was doing. CNA A started to pull Resident #1's pants up and grabbed under Resident #1's right hip and back of her right arm and pushed the resident onto her left side away from CNA A and Resident #1 said Oh and then continued talking (this surveyor was unable to understand what Resident #1 said). CNA A tried to pull up Resident #1's pants some more and allowed resident to come back onto her back. CNA A grabbed under Resident #1's left arm, then elbow and left hip and pulled resident toward her while trying to pull up resident's pants as Resident #1 said quit then resident yelled Quit louder and continued to talk (this surveyor was unable to understand what Resident #1 said) and CNA A continued to try to pull Resident #1's pants up and did not communicate with Resident #1 as she continued care. CNA A pushed Resident #1 back onto her left side with her left hand in the middle of Resident #1's back and finished pulling up her pants with her right hand. CNA A then moved the wheelchair and positioned it at the end side of bed. CNA A asked Resident #1's RP #1 if he wanted her to get Resident #1 into her chair and he said yes. CNA A then grabbed Resident #1 under her knees and pulled her legs off the edge of the bed and then put her left hand behind Resident #1's neck and pulled her up toward a sitting position. The video ended at 4:18 PM.Record review of video footage of a second video that was not dated but was a continuation of previous video showed CNA A grab Resident #1 under her (continued on next page)

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	676359	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone Retirement Community	4100 Moores LN Texarkana, TX 75503

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knees and pulled her legs off the edge of the bed. CNA A then put her left hand behind Resident #1's neck and pulled her up into a sitting position on the side of the bed as Resident #1 said Oh, Oh, quit and CNA A did not communicate with Resident #1 what she was doing nor stopped care. CNA A started to put her arms under Resident #1's arms and said Ms. (Resident's name) Ms. (Resident's name), give me a hug, give me a hug around my neck, come on, give me a big hug as Resident #1's arms laid across CNA A's back. CNA A then lifted Resident #1 from under her arms and by grabbing the back of Resident #1's pants and turned her toward the wheelchair. Resident #1 did not attempt to stand on her own or assist CNA A. Resident #1's RP #1 got up from his chair in the corner and said I'll hold the wheelchair and CNA A asked him to move it back some and as he was moving the wheelchair, CNA A slipped and Resident #1 sat back on bed and then CNA A appeared to struggle to stand her back up, still holding Resident #1 up (by lifting under her arms and holding the back of Resident #1's pants), and turned Resident #1 toward the wheelchair, as Resident #1 hollered Oh, Oh and allowed Resident #1 to sit hard into the wheelchair while RP #1 was holding the wheelchair.During an interview on 5/12/26 at 3:22 PM, CNA A stated she had worked at the facility since April 2026. CNA A stated she had received training on Caring for residents with Dementia upon hire. CNA A stated she should have talked to the resident during care to let her know what she was doing and stopped when Resident #1 stated quit and reported to her charge nurse. CNA A stated not explaining what care she was going to do for the resident or not stopping during care when a resident with dementia stated stop or quit, could cause the resident to shut down completely and not trust her caregivers.During an interview on 5/13/26 at 12:05 PM, the DON stated she saw one video on the aide providing care mainly pulling Resident #1's pants up and turning her from side to side. The DON stated they main thing she noticed was that CNA A did not talk to Resident #1 to explain what she was doing while providing care. The DON stated when Resident #1 stated no, the staff should have stopped and went to get help or reported it to the charge nurse. The DON stated Resident #1 at times could be talked through the care, but she was not on the day of the incident (5/02/26). The DON stated Resident #1 when she wanted to, she could assist by grabbing the bars on the bed and would stand and shuffle her feet around and even put her feet up on the bed. The DON stated the staff should have given her time and came back and it would have probably made a world of difference in how Resident #1 responded. The DON stated she would expect staff to stop, make the resident safe, and report to nurse if a resident was resistant to care or stated stop/quit. The DON stated staff should explain to the resident with dementia and all residents what they were doing, so the resident was aware of what was going on. The DON stated if a resident resisted care, staff should stop, make the resident safe and report to the charge nurse. The DON stated if staff did not explain what care they were going to provide or did not stop care when the resident stated quit/stop, the resident could become more agitated and could cause injury of any kind such as a fall.During an interview on 5/13/26 at 12:50 PM, the ADM stated she was notified by the DON that LVN C reported Resident #1's RP #2 had come to the facility and showed a video to them and claimed the aide was rough while providing care on 5/02/26. The ADM stated she showed CNA A the first video and asked her what she would have done differently and she stated when the resident resisted care, she should have stepped out and gotten the charge nurse. The ADM stated they provided education to CNA A. The ADM stated Resident #1 looked like she was resistant and CNA A should have taken a break and got Resident #1 safe and then went and got the charge nurse or another aide or even given Resident #1 time and then came back. The ADM stated if a resident with dementia, or any resident, hollered out quit, stop, she would expect staff to stop, make the resident safe, take a break, and/or tell the charge nurse. The ADM stated staff should tell the resident what care was being provided with anybody, not just residents with dementia. The ADM stated the resident probably would not want to participate in their care if staff did not explain or talk to them while providing care.Record review of the facility's CNA/Universal Worker Skills Competency Checklist, dated 4/05/26, indicated CNA A had successfully demonstrated dementia training, working with elders who have a diagnosis of dementia, redirecting, ADL (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	encouragement, managing refusal of ADLs, managing anger/aggression, and completed a 4-hour dementia training-Caring for Elders with Dementia and the form was signed by the DON.Record review of Education dated 5/03/26 for CNA A indicated . When providing care for Elders, talk through each step of care. This ensured the Elder understands exactly what was going on during the care . If the Elder was resistant to care, ensure the Elder was safe and notify the Charge Nurse . The form was signed by the DON, ADM and CNA A.Record review of the facility's policy titled Dementia Care and Behavioral Support dated February 2021, indicated . The facility shall provide individualized, person-centered dementia care that addresses each resident's physical, emotional, psychosocial, behavioral, and cognitive needs. Care shall be delivered in a safe, structured, and supportive environment using non-pharmacological interventions whenever possible and in accordance with federal and state regulations . nursing assistants and direct care staff will receive education on dementia care and management of dementia-related behaviors during orientation and through ongoing in-service education . communication approaches . a. approach residents calmly and respectfully, b. use simple, clear instructions, c. allow adequate time to respond, d. use reassurance and validation .