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	02/04/2026

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

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 in 1 of 1 kitchen reviewed for food service safety.1. The facility failed to ensure all food items were labeled in Freezer #1, Freezer #2, and in the pantry.2. The facility failed to ensure that all food items in Freezer #1 were properly stored.3. The facility failed to ensure that all lids to food bins in the pantry were closed properly.These failures could place residents at risk of foodborne illness and food contamination.Findings included:Record review of a Kitchen Cleaning List dated 02/02/26 - 02/08/26 indicated staff were to daily check labels in prep cooler, fry freezer, walk-in freezer, dry storage, walk-in cooler, cook's cooler and ensure all food was covered.During an observation on 02/02/26 at 8:10 a.m., in Freezer #1 there were 6 bags of beige food slices with no label, there were 3 bags of a light brown cylinder-shaped food item with no label, there were 8 bags of orange stick shaped food item with no label, there were 4 bags of light brown stick shaped food item with no label, and there were 6 bags of a round green breaded food item with no label. One of the 6 bags was open to air.During an observation on 02/02/26 at 8:15 a.m., in the pantry there was a storage bin labeled breadcrumbs with the lid open exposing the breadcrumbs to air. On a shelf in the pantry were 11 packages of a light beige colored, flat, round food item with no label.During an observation on 02/02/26 at 8:18 a.m., in freezer #2, inside the pantry, there were two packages of a large brown food items with no label, 3 packages of long brown food item that smelled like garlic with no label, and there was 1 package of a brown, round food items with no label.During an interview on 02/04/26 at 9:24 a.m., the Dietary Manager said normally they go by the labeling on the package the food items came in. He said he would expect all food items to be labeled. He said food bins should be closed as soon as staff were finished with them. He said that was standard practice. He said there was a cleaning list they use in the kitchen and part of that list included labeling of foods. He said foods not being labeled properly could cause the wrong food item to be served to a resident. Such as, if the resident was on a low sodium diet and they could be served something they could not have. He said bins being left open could cause cross contamination with foreign objects. He said foods being left open in the freezer could compromise the quality of the food and cause freezer burn.During an interview on 02/04/26 at 12:12 p.m., the Administrator said the person that unloaded the food and put it in the pantry or freezer was responsible for dating and labeling foods. She said she expected food items to be dated and labeled. She said whoever used food last should put the food item back to be stored appropriately. She said she expected food bins to be closed after use. She said food items not being labeled appropriately could cause an incorrect food item to be used. She said food items being left open in the freezer could cause freezer burn.Record review of an undated Food and Supply Storage Procedures, page 2 of 2, facility policy indicated, .Frozen Storage.Wrap food tightly to prevent cross contamination.Record review of a Food and Supply Storage policy last revised 01/2024 indicated, .All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption.Cover, label and date unused portions and open packages.Foods that must be opened must be stored in NSF (National Sanitation Foundation) approved containers that have tight-fitting lids.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #7) reviewed for infection control practices. The facility failed to ensure CNA C, CNA D, CNA G, and RN F utilized enhanced barrier precautions with Resident #7 while providing high-contact care activities on 02/03/2026. This failure could place residents and staff at risk for cross contamination and the spread of infection.The findings included: Record review of the face sheet, dated 02/04/2026, reflected Resident #7 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of acute on chronic diastolic (congestive) heart failure (the heart muscle doesn't pump blood as well as it should, which leads to fluid back up in the lungs that causes shortness of breath). Record review of the quarterly MDS assessment, dated 11/24/2025, reflected Resident #7 had clear speech, was understood by others, and was able to understand others. Resident #7 had a BIMS score of 15, which indicated no cognitive impairment. The MDS reflected Resident #7 usually required total staff assistance with toileting hygiene. Resident #7 had 1 stage 4 pressure ulcer that required pressure ulcer/injury care. Record review of the comprehensive care plan, dated 02/01/2025, reflected Resident #7 required assistance with ADLs or transfers and had a stage 4 pressure ulcer to her sacrum (triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis). The interventions reflected Enhanced barrier precautions in place. Record review of the order summary report, dated 02/04/2026, reflected Resident #7 had no orders for enhanced barrier precautions. Resident #7 had an order, which started on 11/29/2025, for wound care to the left gluteus (located on left buttock) that included: cleanse with saline, apply Venelex (topical ointment medication used to treat skin ulcers and wounds), and cover with foam dressing for wound healing. During an observation on 02/03/2026 beginning at 12:03 p.m., Resident #7 was lying in her bed. CNA C and CNA D performed incontinent care, which was a high-contact care activity, on Resident #7. Resident #7 had wound dressing on her sacrum, dated 02/03/2026. There was no signage on her door to indicate enhanced barrier precautions were required. There were no PPE supplies readily available inside her room. CNA C and CNA D did not wear an isolation gown while providing high-contact incontinent care. During an observation on 02/03/2026 beginning at 2:29 p.m., RN F performed wound care and CNA G assisted with turning and repositioning, which was a high-contact care activity, on Resident #7. Resident #7 smiled and talked with staff during the care activity. She had no signs of distress. Resident #7's wound was opened with depth unable to be measured related to tunneling. The skin around the wound was pale with no redness observed. The wound had no obvious signs of infection. RN F stated the wound was considered a stage 4 pressure ulcer but has continued to improve. There was no signage on her door to indicate enhanced barrier precautions were required. There were no PPE supplies readily available inside her room. RN F and CNA G did not wear an isolation gown while providing high-contact wound care. During an interview on 02/04/2026 beginning at 9:44 a.m., CNA C stated she was new to the facility and her first day was 02/02/2026. CNA C stated enhanced barrier precautions were required for residents with an indwelling catheter, any lines that connected to the body, and wounds or lesions. She stated enhanced barrier precautions included wearing a gown and gloves. She said enhanced barrier precautions should have been worn with any high-contact care activities, such as incontinent care. She said if a resident was on enhanced barrier precautions there would have been a sign on their door or inside their room with PPE supplies. CNA C stated Resident #7 was not on enhanced barrier precautions because she did not have the sign or PPE supplies in her room. CNA C stated she was unsure why Resident #7 was not on enhanced barrier precautions. She said it was important to ensure enhanced barrier precautions were used to protect the elder from bacteria or infection. During (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on 02/04/2026 beginning at 9:53 a.m., CNA E stated she was usually the staffing coordinator but was helping out on the floor. CNA E stated enhanced barrier precautions were required for residents with a feeding tube, wounds, and indwelling catheters. She stated enhanced barrier precautions were used to protect the elders from infections. CNA E stated elders who required enhanced barrier precautions had signage on their door and PPE supplies in their room. She stated an isolation gown, and gloves were required for high-contact care activities, such as incontinent care. CNA E stated Resident #7 was not on enhanced barrier precautions even though she had a wound. CNA E stated she had questioned the nurses and management staff about why Resident #7 was not on enhanced barrier precautions. She understood it was because of the current stage of Resident #7's wound. CNA E stated the staff were using enhanced barrier precautions for Resident #7 but stopped. She said it was important to ensure enhanced barrier precautions were used to protect the residents from the spread of infection. During an interview on 02/04/2026 beginning at 10:01 a.m., RN F stated enhanced barrier precautions were required for any residents with an indwelling device and some open wounds. RN F stated the wounds that required enhanced barrier precautions were the open ones that had significant drainage and were at risk for contamination. RN F stated Resident #7 did not require enhanced barrier precautions because she had no drainage on the dressing. She said the Infection Control Preventionist, and the Treatment Nurse decided Resident #7 did not require the use of enhanced barrier precautions. RN F said residents who required enhanced barrier precautions had signage in the room with PPE supplies readily available. She said there should have been an order for enhanced barrier precautions as well. RN F stated it was important to ensure enhanced barrier precautions were used for the safety of the resident in preventing infections. During an interview on 02/04/2026 beginning at 10:07 a.m., ADON stated she was also the infection control preventionist. ADON stated enhanced barrier precautions were used for residents with a feeding tube, indwelling catheter, suprapubic catheter, or large wounds. She stated large wounds were considered a stage 3 or stage 4 pressure ulcer. ADON stated wounds were a gray area and it was at the discretion of the facility whether or not to implement enhanced barrier precautions. ADON stated residents on enhanced barrier precautions had signs outside the door and isolation carts inside the room with PPE supplies. ADON stated Resident #7 required enhanced barrier precautions when she first developed the wound. ADON stated she discussed Resident #7's wound with NP H and she decided the wound was small enough that the wound no longer required enhanced barrier precautions. ADON stated the facility had training on enhanced barrier precautions that came from the corporate office. She stated she believed the training followed the CDC guidelines. ADON stated it was important to ensure enhanced barrier precautions were used to protect the residents from bacteria and germs the staff carried. During an interview on 02/04/2026 beginning at 10:27 a.m., DON stated she believed enhanced barrier precautions were required for all indwelling devices and any wounds that were infected or had excessive drainage and could not be covered. DON stated Resident #7 required enhanced barrier precautions when her wounds first started but was stopped because her wound significantly improved. DON stated the facility consulted with NP H and she was the one who made the decision that enhanced barrier precautions were not needed based on the facility policy. DON stated it was important to ensure enhanced barrier precautions were used to protect the elders from infections. During an interview on 02/04/2026 beginning at 10:37 a.m., NP H stated her understanding was wounds that had MDROs, or significant drainage required enhanced barrier precautions. NP H stated she was unaware enhanced barrier precautions were required for any open wounds. NP H stated she recently looked up the regulation, and it was more descriptive. NP H stated she was contracted by the facility but even her parent company had only used enhanced barrier precautions for wounds with MDROs or excessive draining. NP H stated the purpose of enhanced barrier precautions was to protect the residents from infections. During an interview on 02/04/2026 beginning at 12:53 p.m., Administrator stated she expected the facility staff to ensure CDC guidelines and facility policies were followed for enhanced barrier precautions. She said the infection control preventionist (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was responsible for monitoring to ensure enhanced barrier precautions were utilized. She said it was important to ensure enhanced barrier precautions were used to prevent the spread of infection and protect the elders. Record review of the Enhanced Barrier Precautions, dated December 2024, reflected Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. enhanced barrier precautions apply when: a resident is infected or colonized with a CDC-targeted MDRO, but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained; a resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained; and contact precautions do not otherwise apply.examples of secretions or excretions include wound drainage, fecal incontinence or diarrhea, or other discharges from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen.gloves and gown are applied prior to performing the high contact resident care activity.examples of high-contact care activities requiring the use of gown and gloves for EBPs include: .changing briefs or assisting with toileting.wound care. Record review of the CDC website, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) | LTCFs | CDC, accessed on 02/05/2026, reflected in the table labeled, ?Table: Summary of PPE Use and Room Restriction When Caring for Residents Colonized or Infected with MDROs in Nursing Homes', that Enhanced Barrier Precautions applied to all residents with wounds and/or indwelling medical devices regardless of MDRO colonization status.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the right to be free from abuse was provided for 1 of 14 residents reviewed for abuse. (Resident #35) The facility failed to ensure Resident #35 was free from verbal and physical abuse when CNA A shoved, called the resident mean, and used a harsh tone on the overnight shift of [DATE] -[DATE]. This failure could place residents at risk for abuse.Findings Included:Record review of a face sheet dated [DATE] revealed Resident #35 was [AGE] years old and was initially admitted on [DATE] with diagnoses including neurocognitive disorder with Lewy bodies (a progressive, incurable neurodegenerative disease caused by abnormal protein deposits (Lewy bodies) in the brain), diabetes, dementia, and anxiety disorder. The face sheet indicated the resident was discharged from the facility on [DATE].Record review of a quarterly MDS dated [DATE] revealed Resident #35 had unclear speech. The MDS indicated a BIMS interview was not conducted due to the resident being rarely to never understood. The MDS indicated Resident #35 was dependent on staff with most ADLs.Record review of a care plan last revised on [DATE] revealed Resident #35 was dependent on staff for meeting emotional, intellectual, physical, and social needs. There was an intervention for all staff to converse with Resident #35 while providing care. The care plan indicated that Resident #35 had an ADL self-care performance deficit. There were interventions to encourage the resident to participate to the fullest extent possible and praise all efforts of self-care. The care plan indicated Resident #35 required extensive assistance with one staff member.Record review of an undated video revealed Resident #35 was in the bed. Resident #35 had his left hand up. CNA A was providing care to Resident #35. Resident #35 was being combative with CNA A. After Resident #35 grabbed her wrist, CNA A then shoved Resident #35's legs over in an aggressive manner. CNA A then walks over to the closet and says, Why do you insist on fighting folks?. She then started roughly putting a shirt on Resident #35 and said, I know your sugar off and everything but you don't gotta be mean in a harsh tone. Throughout the video CNA A appeared frustrated. The CNA continued to roughly dress Resident #35.Record review of a text message sent from a family member of Resident #35 to the Social Worker indicated the Social Worker was sent the video. The Social Worker indicated that the Administrator and DON had been notified. The text message was sent to the Social Worker on [DATE] at 11:39 a.m.Record review of a progress note dated [DATE] at 11:55 a.m. indicated, Head to toe skin assessment completed. Noted coccyx (area located at the very bottom of the spine) red, blanchable (a red or discolored area that turns white (or pale) when pressed, indicating temporary capillary blood flow restriction rather than deep tissue damage) with documentation/preventive measures/moisture barrier in place. No other findings at this time. Full range of motion noted to all extremities. Elder voices no complaints, other than being hungry. Assisted to dining room for lunch. The note was created by the DON.Record review of an email from the Social Worker to the Administrator dated [DATE] at 4:35 p.m. concerning Resident #35 indicated, .SW (Social Worker) visit with Elder at [DATE] at 3:50pm. Elder in wheelchair in common space. SW approached Elder and touched Elders arm. Elder smiled with eyes closed. No flinching. Elder looked at SW at SW spoke but did not speak back. Elder appeared calm with no distress. SW assessed no difference in Elder's behavior from baseline.Record review of an undated Provider Investigation Report indicated a head-to-toe assessment was completed for Resident #35 by the DON with no findings. The report indicated a social work assessment was completed by the Social Worker with no findings. The report indicated CNA A was immediately suspended. The investigation summary indicated CNA A was terminated on [DATE] for misconduct. The report indicated the allegation of abuse was unconfirmed.Record review of an In-Service form dated [DATE] indicated 12 staff members were in-serviced concerning abuse by the Ombudsman. The twelve staff members did not include the Administrator. The in-service indicated, Ways Elders Are Abused.Using physical force to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause physical pain or injury.Causing emotion or psychological pain.Record review of an In-Service form dated [DATE] indicated 41 staff members were in-serviced concerning abuse by the Ombudsman. The in-service indicated, Ways Elders Are Abused.Using physical force to cause physical pain or injury.Causing emotion or psychological pain.Record review of a progress note dated [DATE] at 4:02 p.m. indicated, Resident #35 expired at 3:49 p.m. in the facility.Record review of a Personnel Action Form dated [DATE] at 11:35 a.m. inside the employee file of CNA A indicated CNA A was not eligible for rehire due to misconduct.During an interview on [DATE] at 10:53 a.m., a family member for Resident #35 said she was a nurse. The family member said on the night shift between [DATE] and [DATE] she saw a video of Resident #35. The family member said the video was of CNA A in his room. The family member said at first CNA A said something like, uggg I can't deal with this. The family member said CNA A then hit Resident #35 in the face. The family member said CNA A hit Resident #35 with an open hand and then she shoved him across the bed. The family member said Resident #35 had no injuries from the incident. The family member said Resident #35 would fall from time to time and that was why they had the camera in the room. The family member said Resident #35 was not able to tell her what happened due to his dementia. The family member said she had been told by staff that he would not cooperate, and he would resist care. The family member said you had to talk loudly and be patient. The family member said unfortunately it took time to provide his care. The family member said when they saw the video they were so upset. The family member said they were shaking. The family member said they went to the Administrator, but she was not in her office. The family member said they showed the video to the Social Worker. The family member said they sent the video to the Social Worker, and it was on her phone. The family member said what they saw in the video was clearly abuse. The family member said they were a long-term care nurse. The family member said they were very upset that CNA A was still able to work as a CNA.During an interview on [DATE] at 8:27 a.m., CNA A said the facility never told her what she did to be terminated. She said she asked to see the video, but they never showed it to her. She said when she was terminated, they told her she was not icares material. She said she did not hit or shove Resident #35. She said she did not remember calling him mean. She said, once he had wrapped her in a shirt being combative. She said calling a resident names, hitting a resident, or shoving a resident was not appropriate behavior. She said she did not remember doing any of the things in the video.During an interview on [DATE] at 8:48 a.m., LVN B said she was the nurse on the night of shift of [DATE] - [DATE]. She said at one point CNA A called her into the room to assist her in changing Resident #35. She said Resident #35 was impulsive and aggressive. She said he would grab the staff. She said while the resident was being changed, she did not see any injuries and his behavior was normal. She said CNA A did not seem frustrated. She said after the incident the resident's behavior remained normal. She said calling a resident mean, hitting them, or shoving them was abuse.During an interview on [DATE] at 9:36 a.m., the Social Worker said they were alerted by Resident #35's family member towards the end of February 2025 that the family member saw something concerning on the resident's camera. The Social Worker said the family member then sent her the video. She said she watched it and then the Administrator watched the video. She said an investigation was started. She said she completed safe surveys per protocol. She said there were no concerns. She said what happened in the video was not right. She said it was not the facility's protocol to be disrespectful to the elderly. She said abuse was causing physical, mental, or emotional harm. She said she did feel like the actions in the video were abusive. She said when she did her assessment, she did not see any physical injuries, and Resident #35 was his normal self. She said he did not show any signs of withdrawing. She said he was not able to verbalize what happened. She said his personality did not change. She said the police were not called and the CNA's license was not referred to her knowledge.During an interview [DATE] at 9:43 a.m., the DON said Resident #35's family member said they were watching the camera in Resident #35's room and said they were not exactly sure, but the CNA was rough with Resident #35. She said the family member sent them the video. She said in the video CNA A was rough with turning Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#35. She said it appeared that CNA A hit him in the video. She said, when interviewed, CNA A just tried to justify what she did by saying he grabbed her, and she was stressed. She said CNA A admitted to maybe being a little rough. The DON said she did feel like what CNA A did was abuse. She said Resident #35 could not tell her what happened. The DON said she did a head-to-toe skin assessment. She said there were no injuries. She said she went back several times to check for a delayed injury. She said there were never any injuries. She said his demeanor never changed and he stayed the same. She said being treating this way could cause physical and emotional trauma. She said she did not know why the police were not notified. She said if they had learned about it at the time it happened, they may have been. She said CNA A was suspended immediately and never returned to the facility. She said she did not know why CNA A's certification was not referred to the nurse aide registry. She said the Administrator did all of the leg work. She said icares means Integrity, Compassion, Accountability, Respect and Excellence. She said this was part of the facility's mission statement. She said they expected staff to display the icares values at all times.During an interview on [DATE] at 12:12 p.m., the Administrator said they became aware of the video of Resident #35 from the family member through the Social Worker. She said she reviewed the video and had two hours to report to the state because of the suspected abuse. She said when she watched the video, she felt CNA A was overly disrespectful to Resident #35. She said they immediately called CNA A to interview and suspend her. She said CNA A told her that she could not recall anything that had happened during her shift. She said she then interviewed LVN B, and she did not recall anything out of the normal other than Resident #35's blood sugar being high. She said LVN B did not notice anything different about CNA A. She said the Social Worker did an assessment and did not find anything abnormal. She said the DON did a head-to-toe assessment and there were no abnormal findings. She said it was reported to the Ombudsman and an Inservice was scheduled. She said safe surveys were conducted with no findings. She said she did staff surveys with no findings there. She said she reviewed a provider letter concerning abuse. She said in this letter abuse was defined as physical or emotional harm. She said after reviewing the letter the team did not feel he had any physical or emotional harm. She said that was why the allegation was unconfirmed because there was no harm. She said after reading the definition of abuse she did not feel it was abuse. She said CNA A was disrespectful and did not show compassion. She said CNA A was terminated for those reasons. She said the police were not called because it was not required for suspected abuse and they did not feel like it was substantiated for abuse.Record review of an Abuse Prevention Program facility policy revised in [DATE] indicated, .Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse.As part of the resident abuse prevention, the administration will.Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff.

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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 observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 1 of 14 residents reviewed for comprehensive care plans. (Resident #2) The facility failed to ensure Resident #2's fall interventions, identified on the comprehensive care plan, were implemented on 02/02/2026, 02/03/2026, and 02/04/2026. This failure could place residents at risk of not having individual needs met and a decreased quality of life. The findings included: Record review of the face sheet, dated 02/04/2026, reflected Resident #2 was a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of hemiplegia (paralysis) and hemiparesis (weakness) following a stroke that affected the right dominant side. Record review of the quarterly MDS assessment, dated 12/18/2025, reflected Resident #2 had unclear speech, was sometimes understood by others, and was usually able to understand others. Resident #2's BIMS score was not assessed, and the staff assessment of mental status reflected the following: short-term and long-term memory was okay; she was able to recall current season, location of own room, staff name and faces, and that they were in a nursing home; and a modified independence decision making ability. The MDS reflected Resident #2 had an upper and lower functional limitation in range of motion that interfered with daily functions and placed resident at risk of injury. Resident #2 had no recent falls. Record review of the comprehensive care plan, dated 09/18/2025, reflected Resident #2 was at risk for falls related to gait and balance problems. The interventions reflected .right fall mat at bedside when in bed. Record review of the order summary report, dated 02/04/2026, reflected Resident #2 had an order, which started on 11/12/2025, for fall mat on right side of bed due to high risk for falls. Record review of Resident #2's MAR, dated February 2026, reflected the fall mat on right side of bed was signed off every twelve hour shift. During an observation on 02/02/2026 at 9:53 a.m., Resident #2 was lying in bed with the head of her bed elevated to approximately 80 degrees. She had a pillow under her head and was sleeping. No distress was observed. Her grey fall mat was folded up and leaning against the wardrobe. During an observation on 02/03/2026 at 9:00 a.m., Resident #2 was lying in bed with the head of her bed elevated slightly. No distress was observed. Her grey fall mat was folded up and leaning against the wardrobe. During an observation on 02/04/2026 at 8:55 a.m., Resident #2 was lying in bed. No distress was observed. Her grey fall mat was folded up and leaning against the wardrobe. During an interview on 02/04/2026 beginning at 9:44 a.m., CNA C stated she was new to the facility and her first day was 02/02/2026. CNA C stated residents at risk for falls were identified by a fall risk sign on the door and some residents had fall mats in their room. CNA C stated Resident #2 had a fall mat in her room. CNA C stated Resident #2's fall mat should have been down if she was lying in the bed. CNA C stated sometimes the fall mats were moved when meal trays came so the bedside tables could have fit under the bed. CNA C stated fall mats should have been replaced once the meal tray was picked up. CNA C stated it was important to ensure fall interventions were in place to prevent injuries related to falls. During an interview on 02/04/2026 beginning at 9:53 a.m., CNA E stated residents at risk for falls were identified by knowing the elders or observing a fall mat in the room. CNA E stated fall mats should have been used when a resident was lying in the bed. CNA E stated during breakfast time the fall mats were folded up and moved out of the way so the bedside tables could fit close to the bed. CNA E stated Resident #2's fall mat was folded up during breakfast time and was not laid back down. CNA E stated fall interventions were listed in the charting system but was unsure if it pulled from the care plan or if the CNAs had access to the care plan. CNA E stated it was important to ensure fall interventions were implemented to secure the safety of the elders. During an interview on 02/04/2026 beginning at 10:01 a.m., RN F stated fall interventions such as a low bed or fall mat were (continued on next page)

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	02/04/2026

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	included in the resident's orders. She stated the nurses had to sign off every shift to ensure the fall mat was in place. RN F stated the nursing staff had to constantly monitor to ensure the fall mat remained in place because they were moved frequently. She stated the fall mats were moved during mealtimes, or when hospice companies came in to provide care. RN F stated Resident #2 should have had her fall mat beside her bed when she was lying down. RN F stated it was important to ensure fall interventions were in place to prevent injuries from falls. During an interview on 02/04/2026 beginning at 10:07 a.m., ADON stated fall interventions were listed in the Kardex (electronic system that CNAs are able to access that pulls information from the care plan) and the plan of care, which pulls from the care plan. She said the nurses also verbally tell the CNAs if new fall interventions were implemented. ADON stated the CNAs and nurses were responsible for monitoring to ensure fall interventions were in place. She stated the nursing management made rounds and performed spot checks. ADON stated it was important to ensure fall interventions were implemented to prevent major injuries from falls. During an interview on 02/04/2026 beginning at 10:27 a.m., DON stated she expected the staff to ensure fall interventions were implemented. DON stated she expected Resident #2's fall mat to be in place when she was lying in her bed. DON stated sometimes the staff would have removed the fall mat during mealtimes, but it should have been replaced when the tray was removed. DON stated the charge nurse was responsible for monitoring to ensure the fall mat was in place. DON stated nursing management was responsible for monitoring the nurses. DON stated it was important to ensure fall interventions were implemented to prevent injuries from falls. During an interview on 02/04/2026 beginning at 12:53 p.m., the Administrator stated she expected the nursing staff to follow the care plan when implementing fall interventions. Administrator stated she expected staff to replace Resident #2's fall mat after care was performed. Administrator stated the person that provided care was responsible for making sure the fall interventions were in place. Administrator stated it was important to ensure fall interventions were implemented for resident safety. Record review of the Fall and Fall Risk, Managing policy, dated March 2018, reflected Resident-Centered Approaches to Managing Falls and Fall Risk.the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.the staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.