STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews and record reviews, the facility failed to ensure that the resident environment remains as free of accident hazards as possible for 6 of 6 residents (Resident's #30, # 70, #81, #40, #58, and #6) reviewed for accidents.1.The facility failed to ensure CNA E and CNA B locked the mechanical lift during a transfer for Resident #30 on 05/19/26.2. The facility failed to ensure the mechanical lift was locked when transferring Resident #70.3.The facility failed to ensure Resident #81 had bilateral landing mats when in bed. 4.The facility did not ensure Alcohol Wipes was not stored in Residents #40 and #58's bathroom.5.The facility failed to ensure Resident #6 did not have bath wash left out in the bathroom sitting on the toilet. These failures could place residents at risk of injury or harm. Findings included: 1. Record review of Resident #30's face sheet, dated 05/21/26, indicated an [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia (loss of memory), muscle weakness, depression (sadness), and bipolar disorder (mental health condition characterized by extreme, alternating shifts in mood, energy, and activity levels). Record review of Resident #30's quarterly MDS dated [DATE] indicated she usually understood and was usually understood by others. The MDS indicated she had a BIMS score of 00 which meant she was severely cognitively impaired. The MDS indicated Resident #30 required total assistance with her ADLs including transfer. Record review of Resident #30's comprehensive care plan revised date of 05/05/26, indicated Resident #30 was at risk for falls due to unsteady gait, decreased balance, medications, and poor safety awareness. Resident #30 used a wheelchair for mobility and required 2-person mechanical lift for all transfers. The interventions were to anticipate and meet the resident's needs. Record review of Resident #30's physician order dated 04/10/26 indicated: Resident #30 was at risk for falls, ensure all her needs were met every shift. Record review of Resident #30's physician order dated 05/19/26 did not reveal an order for a mechanical lift. During an observation on 05/19/26 at 9:31 a.m., Resident #30 was in her wheelchair. CNA E and CNA B explained to Resident #30 that they were going to assist her to bed using the mechanical lift. Resident #30 agreed. CNA E and CNA B started connecting the mechanical lift to the sling without (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
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	locking the wheels of the mechanical lift. CNA E and CNA B then transported Resident #30 to her bed and started disconnecting the sling from the mechanical lift without locking the wheels. During an interview on 05/19/26 at 9:50 a.m., CNA E said she realized after the transfer that they did not lock the wheels of the mechanical lift when they connected and disconnected the mechanical lift sling. She said they should have locked the wheels on the mechanical lift for the safety of Resident #30. During an interview on 05/19/26 at 9:51 a.m., CNA B said they did not lock the wheels of the mechanical lift when they connected and disconnected the mechanical lift sling for Resident #30. She said they should have locked the wheels on the mechanical lift when connecting and disconnecting for the safety of Resident #30. During an interview on 05/21/26 at 10:55 p.m., RN A said he was Resident #30's day shift nurse and was responsible for random checks of the CNAs to ensure they were locking the mechanical lift during the transfer process. He said it was important to lock the wheels of the mechanical lift because the resident's weight could shift and cause the resident to fall out of the slings or the mechanical lift slings could move and the resident could get hit in the head. During an interview on 05/21/26 at 3:25 p.m., the DON said she expected the staff to lock the mechanical lift during the transfer process. She said they trained on how to use the mechanical lift on hire, annually and as needed. She said she was the overseer of nursing. She said it was important to lock the mechanical lift wheels during the connection and disconnection of the sling to prevent it from moving. She said if the sling moved it could cause the resident to get hurt by falling out, hitting a resident in the head, or pinching the staff hands. During an interview on 05/21/26 at 4:21 p.m., the Administrator said she expected the staff to use the mechanical lift as they had been trained. She said she was not completely sure but believed staff were trained on hire, annually and as needed. She said the DON was the overseer of the mechanical lift program. She said she knew if they did not lock the wheels during the mechanical 2.Record review of face sheet dated 05/20/2026 revealed Resident #70 was a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of muscle wasting and atrophy (causes loss of muscular use). Record review of quarterly MDS dated [DATE] revealed Resident #70 was able to make self-understood and able to understand others. MDS assessment indicated Resident #70 had a BIMS score of 15 indicating no cognitive impairment. MDS assessment indicated Resident #70 used a wheelchair for mobility devices. MDS assessment indicated Resident #70 was a max assist for transfers. Record review of order summary report dated 05/20/2026 revealed Resident #70 was ordered for activity as tolerated started on 12/02/2025. Record review of care plan dated 05/20/2026 revealed Resident #70 had special instructions for mechanical lift for transfers. Resident #70 was care planned for ADL self-care performance deficit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with an intervention of assistance x2 with transfer using mechanical lift. During an observation on 05/19/2026 at 9:54 a.m., CNA H and CNA K performed a transfer without locking the wheels of the mechanical lift before lifting Resident #70. During an interview on 05/19/2026 at 10:00 a.m., CNA K stated that she did not know to lock the wheels before lifting Resident #70. CNA K stated that Resident #70 was at risk of falling and injury. During an interview on 05/19/2026 at 10:03 a.m., CNA H stated that she did not remember to lock the wheels, but she stated that she checked the sling to make sure it was in place. During an interview on 05/20/2026 at 9:30 a.m., RN A stated that the wheels on the mechanical lift should be locked before raising Resident #70 into the air. 3.Record review of face sheet dated 05/19/2026 revealed Resident #81 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of epilepsy (condition that causes seizures) and traumatic subdural hemorrhage (brain bleed). Record review of comprehensive MDS assessment dated [DATE] revealed Resident #81 had the ability to understand others and made himself understood. MDS assessment revealed that Resident #81 had a BIMS score of 13 indicating only minimal cognitive impairment. MDS assessment indicated he had a fall since he was admitted to the facility and there was no injury. Record review of order summary report dated 05/19/2026 revealed Resident #81 had an order for bilateral landing mats in place while in bed started 02/25/2026. Record review of care plan dated 05/19/2026 revealed Resident #81 was care planned for falls indicated on 09/04/2025 with the intervention of fall mat while in bed. Record review of administration record dated 05/19/2026 revealed bilateral landing mats in place while in bed was documented for the day shift and night shift for the entire month of May 2026. During an observation on 05/18/2026 at 11:29 a.m., revealed Resident #81 had a black fall mat folded up against his bedside dresser while Resident #81 was asleep in bed. During an observation on 05/18/2026 at 1:04 p.m., revealed Resident #81 had a black fall mat folded up against his nightstand while Resident #81 was asleep in bed. During an interview on 05/19/2026 at 11:30 a.m., Resident #81 stated he was supposed to use the fall (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mat when in bed. During an interview on 05/19/2026 at 1:30 p.m., CNA H stated that Resident #81 has a black fall mat in his room to be put down when in bed. CNA H stated that nursing staff were responsible for putting the fall mat down. CNA H stated that the resident was a fall risk for injury. During an interview on 05/20/2026 at 9:30 a.m., RN A stated that the fall mats were optional to her knowledge. RN A stated that Resident #81 had one black mat in his room. RN A stated that he was a high fall risk resident according to his fall risk assessment. RN A stated that it was all nursing staff responsibility to put the mat down. During an interview on 05/20/2026 2:52 p.m., the DON stated that she expected nursing staff to lock the mechanical lift when raising Resident #70 up for the transfer. The DON stated that she expected the bilateral fall mats to be in place when Resident #81 was in bed at all times. The DON stated both residents were at risk of falling and injury. The DON stated that she was unsure when the last in-service on mechanical lifts and fall mats was. The DON stated that all nursing was responsible to prevent falls and incidents. During an interview on 05/20/2026 at 3:48 p.m., the Administrator stated that she expected staff to properly use all fall prevention equipment and lifts. The Administrator stated that both Resident #70 and Resident #81 were at risk of accidents due to improper use the mechanical lift and fall mat. The Administrator stated that all staff were responsible for preventing accidents. The Administrator stated that she expected the CNAs to know how to use the mechanical lift the correct way and the DON was responsible for competency. The Administrator stated that she expected nursing staff to check for fall mats to be beside the bed when Resident #81 was in bed. 4. Resident #40 Record review of Resident #40's face sheet, dated 05/21/26, reflected Resident #40 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included Angelman syndrome (neuro-genetic disorder that impairs nervous system development). Record review of Resident #40's quarterly MDS assessment, dated 04/09/26, reflected Resident #40 rarely/never made himself understood, and rarely/never understood others. The assessment did not address Resident #40's BIMS score but reflected he had long-term and short-term memory problems. Resident #40 cognitive skills were severely impaired for daily decision making. Record review of Resident #40's undated comprehensive care plan reflected Resident #40 had a cognitive loss related to Angelman syndrome. Resident #40 required total/maximum assistance with decision making. The care plan interventions included: use simple direct communication with resident, offer simple 1-2 items choices and provide redirection, verbal cues and repeat as needed. Resident #58 Record review of Resident #58's face sheet, dated 05/21/26, reflected Resident #58 was a [AGE] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old male, admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (irregular, often rapid heart rate). Record review of Resident #58's quarterly MDS assessment, dated 03/31/26, reflected Resident #58 sometimes made himself understood, and sometimes understood others. Resident #58 had a BIMS score of 4, which reflected his cognition was severely impaired. The assessment did not address Resident #58's cognitive skills related to daily decision making. Record review of Resident #58's undated comprehensive care plan reflected Resident #58 had long term and short-term memory problems, needs verbal cues, redirection and needs supervision and extensive assistance for decisions. The care plan interventions included: allow resident extra time to communicate needs, provide verbal cues as needed to assist with communication. During an observation and interview on 05/18/26 at 11:40 a.m., there was a plastic container labeled Micro-Kill One Germicida Alcohol Wipes on their bathroom countertop. An attempted interview with Resident #40, reflected he was non-interview able due to cognitive loss. Resident #58 was not in the room at the time of the observation. During an interview on 05/20/26 at 9:00 a.m., RN A stated all staff were responsible for ensuring items were stored properly and securely. RN A stated she did not go into the residents' bathroom on 05/18/26. RN A stated wipes should be stored on the medication cart or in the storage room. RN A stated it was important to ensure items were not left in the residents' bathroom for residents' safety. During an interview on 05/20/26 at 3:05 p.m., CNA B stated all staff were responsible for ensuring items were stored properly and securely. CNA B stated she did not see the alcohol wipes on 05/18/26 when she went into Residents #40 and #58's bathroom. CNA B stated wipes should be stored in the supply closet. CNA B stated it was important to ensure items were not left in the residents' bathroom for residents' safety. During an interview on 05/21/26 at 1:57 p.m., the DON stated she expected wipes to be stored out of reach of the resident in a locked area or supply room. The DON stated all staff were responsible for ensuring items were stored properly and securely. The DON stated she monitored compliance by daily rounds. The DON stated she made rounds on 05/18/26 but did not see any wipes in the bathroom. The DON stated it was important to ensure items were not left at the bedside for residents' safety. During an interview on 05/21/26 at 2:45 p.m., the Administrator stated all staff were responsible for ensuring items were stored properly and securely. The Administrator stated wipes should be stored on the cart or supply room. The Administrator stated she made rounds all day while in the building. The Administrator stated, Honestly I don't know if I went into the room or not. The Administrator stated it was important to ensure items were not left in the residents' bathroom for residents' safety. 5. Record review of Resident #6's face sheet dated 05/21/2026 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included chronic heart failure (a long-term condition in which the heart muscle is weakened or stiffened), major depressive disorder (a serious mood disorder characterized by persistent feeling of sadness, emptiness, and a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	severe loss of interest in activities), cognitive communication deficit (difficulty with communication arising from underlying impairments in thinking processes rather than physical speech or primary language skills), and delirium due to known physiological condition (acute, fluctuating state of confusion caused directly by an underlying medical issue). Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated she made herself understood and she understood others. The MDS also indicated she had a BIMS score of 9 which indicated she had moderate cognitive impairment. The MDS also indicated she had hallucinations and required maximal assistance from staff for toileting and showering, set up assistance from staff for eating and dressing, and independent for bed mobility and eating. Record review of Resident #6's comprehensive care plan revised 11/08/24 indicated she had impaired visual function related to aging and ADL self-care deficit with interventions to provide assistance with bathing and personal hygiene. During an observation on 05/18/2026 at 11:22 AM Resident #6 was lying in bed in her room and had bath wash on the toilet in her bathroom. During an observation on 05/19/2026 at 9:51 AM Resident #6 continued to have bath wash on the toilet in her bathroom. During an observation and interview on 05/20/2026 at 8:21 AM Resident #6 said she was going home today when surveyor walked in and continued to have bath wash in her bathroom. During an interview on 05/20/2026 at 8:37 AM LVN F said the bath wash should not have been left in the room because that placed a risk for other residents that wander to go in and drink it or misuse it. She said all staff were responsible for making sure hazardous items were put up. During an interview on 05/21/2026 at 2:07 PM the DON said the bath wash should not have been left out in any resident bathrooms. The DON said the facility had specific storage containers for each resident to store personal items. The DON said the failure placed a risk for a resident's consumption. During an interview on 05/21/2026 at 2:29 PM the Administrator said her expectation was for the staff to ensure the suave bath wash was not be kept in the rooms of the residents. The Administrator said the residents have specific storage areas that are locked in the bathroom. The Administrator said the suave bath wash should have been kept on the treatment cart or the nurse cart. The Administrator said the failure placed a risk for residents getting it and ingesting. Record review of Lifting Machine, using a mechanical policy dated 03/2025 revealed steps in the procedure which included make sure the lift is stable and locked. Record review of Falls and Fall risk, Managing policy dated 11/14/2024 revealed based on previous evaluations and current data, the staff will identify interventions related to the resident specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Record review of the Safety Data Sheet .revised on 10/23/23 reflected. Hazards Identification.Classification: acute toxicity, serious eye damage/eye irritation and specific target organ toxicity.Storage: store locked up. General Information: keep out of reach of children.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs were stored in a locked compartment, only accessible by authorized personnel, and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable for 4 of 22 residents (Resident #6, Resident #38, Resident #8, and Resident #90) and 2 of 10 medication carts (Hall 500 hall nurse's medication cart and the hall 400 nurse medication cart) observed for medication storage.1. The facility failed to ensure Resident #6 did not have zinc oxide wound care cream in her bathroom left in the caddy by the sink.2. The facility failed to ensure Resident #38's Novolog (fast-acting insulin to control high blood sugar) insulin was dated when opened on Hall 400's nurse's medication cart.3. The facility failed to ensure Resident #8's Lantus (Long-acting insulin that regulates blood sugar levels at a stable rate throughout the day) was dated when opened on Hall 400's nurse's medication cart. 4. The facility failed to ensure the hall 400 nurse's medication cart did not have 2 bottles of nystop (wound care powder) powder with no resident's name on it. 5. The facility failed to ensure RN D locked the hall 500 nurse's medication cart prior to entering a room to administer medications. 6. The facility failed to ensure Resident #90's room was free of medications.These failures could place residents at risk for not receiving drugs and biologicals as needed and injury. Findings included: 1. Record review of Resident #6's face sheet dated 05/21/2026 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included chronic heart failure (a long-term condition in which the heart muscle is weakened or stiffened), major depressive disorder (a serious mood disorder characterized by persistent feeling of sadness, emptiness, and a severe loss of interest in activities), cognitive communication deficit (difficulty with communication arising from underlying impairments in thinking processes rather than physical speech or primary language skills), and delirium due to known physiological condition (acute, fluctuating state of confusion caused directly by an underlying medical issue). Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated she made herself understood and she understood others. The MDS also indicated she had a BIMS score of 9 which indicated she had moderate cognitive impairment. The MDS also indicated she had hallucinations and required maximal assistance from staff for toileting and showering, set up assistance from staff for eating and dressing, and independent in bed mobility and eating. Record review of Resident #6's comprehensive care plan revised 11/08/24 indicated she had impaired visual function related to aging and ADL self-care deficit with interventions to provide assistance with bathing and personal hygiene. During an observation on 05/18/2026 at 11:22 AM Resident #6 was lying in bed in her room and had zinc oxide 4-ounce tube in the caddy by her sink in her bathroom. During an observation on 05/19/2026 at 9:51 AM Resident #6 continued to have zinc oxide 4-ounce tube in the caddy by her sink in her bathroom. During an observation on 05/20/2026 at 8:21 AM Resident #6 said she was going home today when surveyor walked in and continued to have zinc (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxide 4-ounce tube in the caddy by her sink in her bathroom. Resident #6 said she did not know what the medication was. During an interview on 05/20/2026 at 8:37 AM LVN F said the zinc oxide should not be left in the room. LVN F said the failure placed a risk for residents that wander to go in and drink it or misuse it. During an interview on 05/21/2026 at 2:07 PM the DON said the zinc oxide should not have been left in any resident's room. The DON said the zinc oxide should have been stored in the treatment or medication carts. The DON said the failure placed a risk for resident consumption. During an interview on 05/21/2026 at 2:29 PM The Administrator said her expectation was for the staff to ensure the medications were not kept in the rooms of the residents. The Administrator said the residents have specific storage carts that are locked. The Administrator said the zinc oxide should be kept on the treatment cart or the nurse cart. The Administrator said the failure placed a risk for residents getting the zinc oxide and ingesting it. 2. During an observation on 05/20/2026 at 10:01 AM the hall 400's nurse's medication cart revealed Resident #38's Novolog insulin flex pen was opened and undated, Resident #8's Lantus insulin was open and undated, and 2 bottles of Nystop prescription wound care powder with no resident name label. During an interview on 05/20/2026 at 10:20 AM LVN F said she normally checked the nurse's cart to ensure insulins were labeled but she failed to check the insulins on 05/20/2026 when she began her shift. LVN F said all the insulins should have dates when they were opened and all nurses who open the insulin were responsible for ensuring the insulins were dated. LVN F said the failure placed a risk of the insulin not being effective when used. LVN F said the Nystop powders were just extras she believed but was unsure why the pharmacy would send the medication to the facility with no resident name on them. During an interview on 05/21/2026 at 2:09 PM the DON said all insulins should be labeled and dated as they were opened as well as the Nystop wound care powder should have had a label from the pharmacy, which should be specific to the residents. The DON said the failure of undated insulin placed a risk for the insulin being used while expired. The DON said risk of using expired medications for a resident could be the medication given and not being effective. The DON said the unlabeled Nystop placed a risk for cross contamination or expired medications. During an interview on 05/21/2026 at 2:33 PM The Administrator said her expectation was for all meds to be labeled correctly and not be expired. The Administrator said all nurses were responsible and the failure of having the nystop opened and unlabeled placed a risk for a resident getting the medication who did not have it ordered or a resident getting the wrong dosage. The Administrator said the failure of expired insulin was the resident getting the wrong dosage of insulin or it not being effective . 3. During an observation and interview on 05/20/2026 at 8:45 AM RN D entered a resident's room to provide medications and left the 500-hall nurse's medication cart open and unattended. RN D said he was responsible for ensuring the hall 500 nurse's medication cart was locked while unattended and the failure placed a risk for any staff or resident getting into the cart and possible overdose of medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/21/2026 at 2:14 PM The DON said her expectation was for the medication carts to always be locked if not in use and the charge nurses were responsible for ensuring they are locked. The DON said the failure placed a risk for being open for other residents or staff to access medications. During an interview on 05/21/2026 at 2:37 PM the Administrator said her expectation was for the medication carts to always be locked if unattended. The Administrator said the failure placed a risk for residents or staff to get medication out of the cart and misuse it. 4. Record review of face sheet dated 05/20/2026 revealed Resident #90 was a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of fracture of the right femur (broke the right leg) unilateral osteoarthritis of the right hip (inflammation that causes pain) and primary hypertension (elevated blood pressure). Record review revealed no MDS available for Resident #90. Record review of Resident #90's care plan dated 05/20/2026 revealed no care plan or interventions for pain control and use of topical medications. Record review of Resident #90's order summary dated 05/20/2026 revealed no order for any topical ointment. An order dated 05/14/2026 started to assess nonverbal and verbal pain every shift. During an observation and interview on 05/18/2026 at 11:47 a.m., Resident #90 stated a medication cup of 30mL full of white cream was sitting on Resident #90's nightstand. During an interview on 05/18/2026 at 11:50 a.m., Resident #90 stated that the medication cup on his bedside nightstand was a cream given to him by the nightshift nurse for pain of the back and an extra cup for throughout the day. Resident #90 stated that he gets back pain from sitting in bed too long. During an interview on 05/20/2026 at 8:30 a.m., the CNA H stated that residents are now allowed to have medication at bedside. The CNA H stated that they are responsible on every 2-hour rounds for monitoring safety for all residents. During an interview on 05/20/2026 at 9:20 a.m., the RN A stated that Resident #90 does not have an order for any topical medications. The RN A stated that Resident #90 is not allowed to have medications at the bedside and that it was all nursing staff responsibility to ensure that the resident does not have them in his room. The RN A stated that Resident #90 was at risk of using nonordered medication and improper consumption. During an interview on 05/20/2026 at 3:07 p.m., the DON stated that she expected nursing staff to monitor for safety, the MA to not give the resident any cream, the CNA to check on their rounds for safety hazards, and the RN to assess the safety on their assessment. The DON stated that Resident #90 did not have an order for topical medication. The DON stated that Resident #90 is not supposed to have any medications on his nightstand. The DON stated that Resident #90 was at risk of improper use of medication and harm. During an interview on 05/20/2026 at 3:57 p.m., the Administrator stated that all staff are responsible for ensuring safety and free from medications at bedside. The Administrator stated that staff do daily angel rounds to check resident rooms for inappropriate things and make sure all needs are met. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration stated that Resident #90 is not allowed to have medication on his nightstand. The Administrator stated that Resident #90 and other residents were at risk of harm from consumption or improper treatment. Record review of Storage of Medications policy dated 04/2019 revealed the facility stores all drugs and biologicals in a safe, secure and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 3 of 4 residents (Resident #44,Resident #75 and Resident #87) reviewed for hospice services.1.The facility failed to maintain Resident #44's hospice binder containing information related to hospice services provided for the resident such as the Physician certification of the terminal illness, the last two IDG also known as Interdisciplinary Group meetings (a regular, collaborative team review of a patient's care meetings),or updated recertification form.2.The facility failed to obtain Resident #75's most current Interdisciplinary Group Meeting. 3.The facility failed to ensure Resident #87's hospice binder included the updated hospice election form, the certification of illness, IDG meetings, most recent medication profile, and the most recent plan of care.These deficient practices could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings included: 1. Record review of Resident #44's face sheet, dated 05/21/26, reflected Resident #44 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental ability that interferes with daily life), muscle weakness, anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life). Record review of Resident #44's significant change MDS assessment, dated 03/04/26, reflected Resident #44 rarely made herself understood, and was sometimes understood by others. Resident #44 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident #44 was on hospice services. Record review of Resident #44's comprehensive care plan revised 03/04/26 indicated Resident #44 had a terminal prognosis and was on hospice services. The intervention was to work cooperatively with the hospice team to ensure the residents' spiritual, emotional, intellectual, physical, and social needs were met, and for the nursing staff to provide maximum comfort for the resident. Record review of Resident #44's physician orders dated 02/25/26 indicated an order for {name} hospice. Record review of Resident #44's hospice binder on 05/20/26 at 11:09 a.m., revealed it did not have the Physician certification of the terminal illness, the last two IDG (Interdisciplinary Group) meetings or updated recertification form. The last recertification was dated 02/19/26-05/19/26. During a phone interview on 05/20/26 at 11:27 a.m., the hospice RN K said the binders at the facility should contain any supporting notes or documentation needed for Resident #44. She said the binder should at least have the face sheet, election form, code status, certification of terminal illness, plan of care, and medications. She said they meet every two weeks on Thursday for the IDG meetings and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the documentation should be updated at least the following week after the IDG meetings. She looked at the office's records and said Resident #44's last IDG meeting was 04/29/26 and 05/14/26 and had not been delivered to the facility. She said she did not see the certification of death in the office. She said she would get someone from the office to bring over the last two meetings, the recertification and certification of terminal illness. She said the recertification should also be in the facility's chart the week of the termination of the recertification period. She said they had someone at the office who brought over the information to the facility and placed it in the resident's binder. She said it was important to have the binders at the facility to help the facility know the care and services they were providing. During an interview on 05/20/26 at 10:39 a.m., RN G said he was not sure of all the information that needed to be included in the hospice binder. He said he thought the hospice binder should include the name of the hospice, diagnosis, face sheet, and code status. He said management was responsible for ensuring the hospice binders were updated. He said any information the hospice company had for Resident #44 should be at the facility for effective communication because their care was combined. During an interview on 05/21/26 at 2:22 p.m., the DON said she expected the hospice binders to be updated on all material required in the book. She said she thought the SW was over the hospice binder but learnt she was not. She said they did not have an effective system in place. She said the risk of the binders not being updated was not knowing all of Resident #44's plan of care. During an interview on 05/21/26 at 3:04 p.m., the Administrator said the DON was responsible for ensuring all hospice documents were up to date. She said the books should be updated for effective communication between hospice and the facility for the care of the residents. 2.Record review of a sheet dated 05/20/2026 indicated Resident #75 was a [AGE] year old female admitted to the facility on [DATE] with a primary diagnosis of senile degeneration of brain and a secondary diagnosis of major depressive disorder. Record review of quarterly MDS dated [DATE] indicated Resident #75 usually makes self-understood and only sometimes understands others. The MDS assessment indicated Resident #75 had a BIMS score of 02, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #75 received hospice services while a resident at the facility. Record review of order summary dated 05/19/2026 reflected Resident #75 had an order to admit to Hospice services with the primary diagnosis of senile degeneration of the brain on 11/28/2025. Record review of care plan report undated indicated Resident #75 was care planned for terminal prognosis related to senile degeneration of the brain; admit to Hospice with a intervention of work cooperatively with Hospice team to ensure resident's spiritual, emotional, intellectual, physical, and social needs are met. Record review of Resident #75's hospice binder indicated: Interdisciplinary Group Meeting 04/23/2026 for the certification period of 02/26/2026-04/26/2026. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no current hospice Interdisciplinary Group Meeting. During an interview on 05/20/2026 at 9:04 a.m., the RN A stated that she coordinates care with the hospice RN. RN A stated she was unsure who updated the binders. RN A stated that the binders are used for coordinating care. During an interview on 05/20/2026 at 11:11 a.m., Hospice RN stated that the Marketing Coordinator was responsible for the binder being up to date with all paperwork. The Hospice RN stated that there was an interdisciplinary group meeting for Resident #75 Hospice Care on 05/07/2026. The Hospice RN stated that it was important for the binder to be up to date for coordination of care with the facility and the Hospice doctor. During an interview on 05/20/2026 at 11:51 a.m., the Hospice Regional Marketing Coordinator stated that she was responsible for printing and delivering all paperwork for the hospice binder. The Hospice Regional Marketing Coordinator stated that every 2 weeks an Interdisciplinary group meeting was conducted to coordinate care. The Hospice Regional Marketing Coordinator stated that the week following the meeting she was responsible for printing and bringing in the updated paperwork. The Hospice Regional Marketing Coordinator stated that she should have brought the updated paperwork and the 05/07/2026 meeting was missing from the binder at the time. The Hospice Regional Marketing Coordinator stated that it was important that the binder is updated for coordination of care. During an interview on 05/20/2026 at 3:15 p.m., the DON stated that she expects the hospice binders to be updated and the nursing staff to call the hospice RN for immediate care. The DON stated that she does not have a system in place who was responsible for the binders were current. DON stated that the binders are used to ensure coordination of quality care with hospice. DON stated that Resident #75 was at risk of not receiving the plan of care. During an interview on 05/20/2026 at 4:02 p.m., the Administrator stated that she expected the hospice binder to be updated according to the interdisciplinary group meetings. The Administrator stated that she does not know who was responsible for the binders and who was responsible for the paperwork in the binder. The Administrator stated that the binders were used for coordination of care. The Administrator stated they did not have a system in place and Resident #75 was at risk of not receiving the intended care. 3.Record review of Resident #87's face sheet dated 05/21/2026 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses which included high blood pressure, other symptoms involving cognitive functions following cerebrovascular disease (diagnosis that includes memory loss, difficulty paying attention, slowed thinking, and executive dysfunction), and gastroesophageal reflux (acute pain related to irritated area between a person's throat and stomach, from acid). Record review of Resident #87's admission MDS assessment dated [DATE] indicated she understood others and was understood by others. Resident #87's BIMS score was 1, which indicated her cognition was severely impaired. Resident required setup with eating, dependent on staff for toileting, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing, hygiene, and independent with bed mobility. Record review of Resident #87's care plan dated 05/15/2026 indicated she had a terminal prognosis related to cerebrovascular disease and was on hospice services with interventions to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. Record review of Resident #87's hospice binder on 05/20/2026 indicated it was missing the updated hospice election form, the certification of illness, IDG meetings, most recent medication profile, and the most recent plan of care. During an interview on 05/20/2026 at 12:40 PM the Hospice BOM said the nurse was responsible for bringing the paperwork to the facility. The Hospice BOM said Resident #87's paperwork should have been provided to the facility binder on 05/08/2026 when she admitted to the facility. The Hospice BOM said she was unsure of the importance of having the information in the chart. During an interview on 05/20/2026 at 1:13 PM the Hospice RN said Resident #87's paperwork should have been in the facility on admission. The Hospice RN said she was responsible and thought she provided everything in Resident #87's binder but she had not checked it. The Hospice RN said the failure placed a risk of staff in the facility needing the information and not having it and cordination with the facility was not being completed. During an interview on 05/21/2026 at 2:19 PM The DON said her expectation was for the hospice company to keep the charts updated and to ensure the paperwork is available to staff in the facility if needed. The DON said the failure placed a risk of not having updated plan of care for Resident #87. During an interview on 05/21/2026 at 2:38 PM The Administrator said her expectation was for all the hospice paperwork to be updated in the binders and the risk was interference with the continuity of care. Record review of the facility policy, revised July 2017, Hospice Program indicated: Policy Statement: Hospice services are available to residents at the end of life.d.Policy Interpretation and implementation: 1. Our facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so. Obtaining the following information from the hospice:(1)The most recent hospice plan of care specific to each resident;(2)Hospice election form;(3)Physician certification and recertification of the terminal illness specific to each resident;(4)Names and contact information for hospice personnel involved in hospice care of each resident;(5)Instructions on how to access the hospice's 24-hour on-call system;(6)Hospice medication information specific to each resident; and(7)Hospice physician and attending physician (if any) orders specific to each resident.e.Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 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 observations, interviews, and record reviews, the facility failed to 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 7 of 22 residents (Resident #52, Resident #4, Resident #87, Resident #91, Resident #12, Resident #82, and Resident #44) rooms reviewed for infection control practices and enhanced barrier precautions.1. The facility failed to ensure LVN F used the proper PPE while administering gastrostomy tube medications and feeding for Resident #52 on 05/20/2026. 2. The facility failed to ensure Resident #4, Resident #87, Resident #91, and Resident #12 had their toothbrushes stored and labeled in the bathrooms to distinguish from one another. 3. The facility failed to ensure CNA E wiped correctly and performed hand hygiene while providing incontinent care for Resident #82 on 05/18/26.4. The facility did not ensure CNA E performed hand hygiene before leaving Resident #82's room and before entering Resident #44's room on 05/19/26. These failures could place any resident at the facility at risk for cross-contamination and the spread of infection. Finding included: 1. Record review of Resident #52's face sheet dated 05/21/2026 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included altered mental status (broad non-specific term describing a change in a person's baseline cognition, or consciousness), gastrostomy status (presence of an artificial opening , stoma, in the stomach used for nutrition and medication administration), unspecified intellectual disabilities (condition beginning in childhood that limits intelligence and disrupts abilities necessary for independent living), and high blood pressure. Record review of Resident #52's quarterly MDS dated [DATE] indicated she usually understood others and usually made herself understood. The MDS also indicated she had a BIMS score of 8 which indicated she had moderate cognitive impairment. The MDS also indicated she required moderate assistance for bathing, bed mobility, and transfers, maximal assistance for toileting, and total assistance for eating. Record review of Resident #52's comprehensive care plan revised 04/28/2026 indicated she required EBP related to having increased risk of MDRO acquisition due to resident having an indwelling medical device with interventions for gowns and gloves to be worn during dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or use, and wound care. Record review of Resident #52's order summary report dated as of 05/21/2026 indicated nursing intervention: implement and maintain enhanced barrier precautions when performing high contact care activities every shift for indwelling medical device with a start date of 04/14/2026 and no end date. During an observation on 05/20/2026 at 8:44 AM Resident #52 had the EBP signage on the door and observed LVN F giving Resident #52 gastrostomy tube medications and tube feeding without having on any PPE. During an interview on 05/20/2026 at 9:07 AM LVN F said Resident #52 did have a gastrostomy tube and she was providing her medications as well as a bolus feeding(a liquid feeding given by gastrostomy tube administered at gravity). LVN F said she did not need to wear a gown while providing Resident #52's medication or feeding. LVN F said she only needed to wear gloves (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when she gave her medications or bolus feeding via the gastrostomy tube. LVN F said the only time she wore a gown and gloves, was if the resident had a respiratory infection. LVN F said she had an in-service on when to wear PPE but could not remember the date. LVN F said not wearing PPE if needed placed a risk of contamination and infection. During an interview on 05/21/2026 at 2:12 PM The DON said her expectation was for the charge nurse to wear the proper PPE for EBP, which included a gown and gloves, when providing direct care. The DON said the signage was on the door and the charge nurse was responsible. The DON said the failure placed a risk of exposure to infection. During an interview on 05/21/2026 at 2:34 PM the Administrator said her expectation was for the nurse to use the proper PPE, which included a gown and gloves, to keep herself and the resident healthy. The Administrator said the failure placed a risk for infection. 2. Record review of Resident #4's face sheet dated 05/21/2026 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), psychosis (a loss of contact with reality that affects the mind and causes delusions, hallucinations, inappropriate behaviors), depression (mood disorder characterized by persistent sadness and loss of interest, significantly impacting daily functioning and requiring professional diagnosis and treatment), and anxiety disorder (mental illness defined by feelings of uneasiness, worry and fear). Record review of Resident #4's Quarterly MDS assessment dated [DATE] indicated she usually understood others and was understood by others. Resident #4's BIMS score was 3, which indicated her cognition was severely impaired. Resident #4 was dependent on staff for all ADLs. Record review of Resident #4's care plan dated 03/06/2026 indicated she required placement on the secure unit due to history of elopement and wandering behaviors. Resident #4 had an ADL self-care performance deficit related to anxiety, dementia, weakness, and safety awareness deficit with interventions to assist her with her personal hygiene, bathing, dressing, eating, and toilet use. 3. Record review of Resident #87's face sheet dated 05/21/2026 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses which included high blood pressure, other symptoms involving cognitive functions following cerebrovascular disease (diagnosis that includes memory loss, difficulty paying attention, slowed thinking, and executive dysfunction), and gastroesophageal reflux (acute pain related to irritated area between a persons throat and stomach, from acid). Record review of Resident #87's admission MDS assessment dated [DATE] indicated she understood others and was understood by others. Resident #87's BIMS score was 1, which indicated her cognition was severely impaired. Resident required setup with eating, dependent on staff for toileting, dressing, hygiene, and independent with bed mobility. Record review of Resident #87's care plan dated 05/15/2026 indicated she required the secured unit due to dementia, wandering behaviors, and elopement risk and ADL self-care performance deficit with interventions to assist her with her personal hygiene, bathing, dressing, and toilet use. During an observation on 05/18/2026 at 11:46 AM Resident #87 and Resident #4 had 2 toothbrushes in the two resident's personal bathrooms lying together with no container and unlabeled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/19/2026 at 10:07 AM Resident #87 and Resident #4 had 2 toothbrushes in the two resident's personal bathroom lying together with no container and unlabeled. During an observation on 05/20/2026 at 8:29 AM Resident #87 and Resident #4 continued to have 2 toothbrushes in the two resident's personal bathroom lying together with no container and unlabeled. 4. Record review of Resident #91's face sheet dated 05/21/2026 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and diabetes mellitus (a disease in which the body cannot regulate blood sugars). Record review of Resident #91's admission MDS assessment dated [DATE] indicated he rarely understood others and he rarely made himself understood. The MDS also indicated he had short-term and long-term memory problems and could not complete the BIMS assessment. The MDS also indicated he was dependent on staff for bed mobility, toileting, bathing, and transfers, and he required setup for eating. Record review of Resident #91's care plan dated 05/11/2026 indicated he Requires secure unit related to Alzheimer's disease, wandering behaviors, and elopement risk and he had an ADL self-care performance deficit with interventions for staff to assist with all ADLs. 5. Record review of Resident #12's face sheet dated 05/21/2026 indicated he was an [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), depression (mood disorder characterized by persistent sadness and loss of interest, significantly impacting daily functioning and requiring professional diagnosis and treatment), and paranoid schizophrenia (a complex brain disorder causing severe psychosis). Record review of Resident #12's quarterly MDS assessment dated [DATE] indicated he usually understood others and he usually made himself understood. The MDS also indicated he had a BIMS score of 07 which indicated he had severely impaired cognition. Resident #12 required maximal assistance from staff for eating, moderate assistance from staff for bed mobility and transfers, and total assistance from staff for toileting, and bathing. Record review of Resident #12's comprehensive care plan revised 02/17/2026 indicated he had ADL self-care performance deficit related to Alzheimer's and bilateral knee contractures with interventions for staff to assist with all ADLS. During an observation on 05/18/2026 at 11:29 AM in Resident #12's and Resident #91's bathroom there were 2 toothbrushes lying in a caddy beside the sink without a container and unlabeled. During an observation on 05/20/2026 at 8:26 AM in Resident #12's and Resident #91's bathroom there was 1 toothbrush on the sink behind the handles and one toothbrush in a caddy lying without a container and unlabeled. During an interview on 05/20/2026 at 8:37 AM LVN F said all resident toothbrushes should be stored in separate containers and labeled. LVN F said the CNAs and nurses on the hall were responsible. LVN F said the failure placed a risk for contamination and infection for other residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/20/2026 at 10:24 AM CNA G said she and the charge nurses were responsible for ensuring the toothbrushes were in a container and labeled. CNA G said the failure placed a risk for resident placing other toothbrushes in their mouth and causing infection. During an interview on 05/21/2026 at 2:07 PM the DON said the nurses and CNAs were responsible and neither of the toothbrushes should have been left out in resident bathrooms. The DON said the facility had specific storage containers for each resident to store personal items. The DON said the risk associated with the failure involved infection control and risk for cross contamination. During an interview on 05/21/2026 at 2:36 PM the Administrator said her expectation was for the toothbrushes to be stored in a container with the resident's names on them and the failure placed a risk for contamination for using dirty items or other resident personal items. 6. Record review of Resident #82's face sheet, dated 05/21/26, revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses to include dementia (a decline in mental ability that interferes with daily life), depression (sadness), and muscle weakness. Record review of Resident #82's quarterly MDS assessment, dated 05/13/26, indicated Resident #82 usually understood and was understood at times by others. Resident #82's BIMS score was 09, which indicated her cognition was moderately impaired. The MDS indicated Resident #82 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS indicated she was always incontinent of bladder. Record review of Resident #82's comprehensive care plan, revised on 01/30/26, indicated that Resident #82 had an ADL Self Care Performance Deficit and totally incontinent of bladder related to dementia. The care plan interventions were for staff to provide toileting. Check as required for incontinence: wash, rinse, and dry perineum. 7. Record review of Resident #44's face sheet, dated 05/21/26, reflected Resident #44 was an [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included dementia (forgetfulness) and muscle weakness. Record review of Resident #44's significant change MDS assessment, dated 03/04/26, reflected Resident #44 rarely made herself understood, and she sometimes understood others. Resident #44 had severely impaired cognitive skills for daily decision making. Record review of Resident #44's comprehensive care plan dated 03/19/26 reflected Resident #44 had impaired cognitive function/dementia or impaired thought processes related to dementia. The intervention was for staff to totally assist with ADLs. During an observation on 05/18/26 at 12:22 p.m., CNA E provided incontinent care of bladder for Resident #82. She wiped her front area and then her backside using front to back and back to front motion. CNA E did not change her gloves or perform hand hygiene when wiping from front to her backside. She then grabbed a clean brief, applied it, and pulled up her linen, while using the same dirty gloves. CNA E then removed her gloves, gathered her equipment, left the room, and then went into Residents #44's room without washing her hands and handed Resident #44 her cup of water and straightened up her covers. Shen then left Resident #44's room and washed her hands. During an interview on 05/18/26 at 12:41 p.m., CNA E said she did not realize she did not perform hand hygiene or change her gloves after wiping Resident #82 then touching the clean brief, linen, and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her gown with dirty gloves. She said she realized after cleaning Resident #82that she wiped front to back and back to front. She said the proper way to wipe was from front to back to prevent urinary tract infections. She said she was supposed to wash her hands after completing care with Resident #82 and before going into Resident #44's room. She said she knew that without hand hygiene or removing dirty gloves, she could cause cross-contamination and infection. During an interview on 05/20/26 at 11:44 a.m., RN A said he was Resident #82's and Resident #44's nurse. He said he expected the CNAs to perform incontinent care the correct way. He said he expected them to wipe front to back and change their gloves between clean and dirty to prevent cross-contamination. During an interview on 05/21/26 at 2:22 p.m., the DON said she expected the CNAs to perform incontinent care correctly. She said she expected staff to wipe front to back and not back to front. She said she expected staff to change their gloves between dirty to clean and use hand hygiene between glove changes and before leaving one room and entering another. The DON said they went over incontinence care and hand washing on hire, annually, and as needed. She said she was the overseer of infection control. She said staff should wipe front to back, change gloves and practice hand hygiene to prevent Urinary Tract Infection also known as UTI (an infection anywhere in your urinary system (kidneys, bladder, or urethra) caused by bacteria), infection, and cross-contamination. During an interview on 05/21/26 at 3:04 p.m., the Administrator said she expected all staff to use proper hand hygiene techniques between dirty and clean areas with all care. The Administrator said the DON was responsible for ensuring staff were trained on incontinent care and infection control. She said improper wiping and hand hygiene could place residents at risk for cross-contamination. Record review of the facility's policy titled Incontinent Care, revised 06/10, indicated, Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. Steps in the procedure: 9. For a female resident: A. Wet washcloth and apply soap or skin cleansing agent. B. Wash perineal area, wiping from front to back. D Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Record review of the facility's policy titled Hand Hygiene, revised 12/22/23, indicated, Policy: This facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation: 1. All personnel shall be trained and regularly in service on the importance of hand hygiene in preventing the transmission of healthcare associated infection. #2. All personnel shall follow hand washing/ hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and family. #6. Wash hands with soap and water for the following: A when hands are visibly sold #7Use an alcohol-based hand rub containing at least 60 - 90% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents;c. Before preparing or handling medications; Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, N access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc. H. Before moving from a contaminated body site to a clean body site during resident care; 1. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; I. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; and q. After personal (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use of the toilet or conducting your personal hygiene. Record review of the facility's policy titled Implementation of Standard and Transmission-Based Precautions, dated 03/24, indicated, Infection control measures are implemented in attempts to prevent the spread of communicable diseases. Each facility's goal is to practice infection control and strategies for surveillance, prevention, and control of healthcare-associated infections, antimicrobial resistance, and related events. Multidrug-resistance organism (MDRO) transmission has become even more prevalent lending the necessity for further review to prevent potential for adverse psychological impact on the infected or colonized resident. Policy Implementation: The facility will incorporate Transmission-Based Precautions as a second tier of basic infection control and used in addition to Standard Precautions for residents who are or may be infected or colonized with certain infectious agents for which additional precautions are necessary to prevent infection transmission. #3. Enhanced Barrier Precautions (EBP) - Expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. I. Examples of Enhanced-Based Precaution residents: ˆWounds - Includes chronic wounds, but are not limited to pressure ulcers, diabetic ulcers, unhealed surgical wounds and venous stasis ulcers; ˆIndwelling medical devices - Include central lines, urinary catheters, feeding tubes, and tracheostomies/vents. NOTE: a peripheral intravenous line is not considered an indwelling medical device for the purpose of EBP. ˆInfection or colonization with a CDC targeted MDRO when Contact Precautions do not otherwise apply. II. Enhanced-Based Precautions are indicated during: ˆ Dressing, ˆ Bathing/showering in a shared/common shower room, ˆTransferring, ˆ Providing hygiene, ˆ Changing linens, ˆ Changing briefs or assisting with toileting, ˆDevice care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, ˆWound care; any skin opening requiring dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 22 residents (Resident #75) for resident rights. The facility failed to ensure MA L did not call Resident #75 a feeder while assisting her to eat on 05/18/2026. This failure could place residents at risk of decreased self-worth, loss of dignity, and a diminished quality of life.Findings included: Record review of a face sheet dated 05/20/2026 indicated Resident #75 was a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of senile degeneration of brain (condition that causes decrease function of the brain) and a secondary diagnosis of major depressive disorder (extreme sadness). Record review of quarterly MDS dated [DATE] indicated Resident #75 usually makes self-understood and only sometimes understood others. The MDS assessment indicated Resident #75 had a BIMS score of 02, which indicated her cognition was severely impaired. MDS assessment indicated Resident #75 had the eating ability to use suitable utensils to bring food or liquids to the mouth and swallow food once the meal was placed before the resident. The MDS assessment was coded Helper sets up or cleans up; resident completes activity.Helper assists only prior to or following the activity. Record review of order summary dated 05/19/2026 revealed Resident #75 had an order to offer and encourage fluids with a start date of 10/30/2024 and offer bedside snack with a start date of 10/30/2024. Record review of Resident #75's care plan report indicated Resident #75 was care planned for ADL self-care performance deficit related to muscle weakness with an intervention of resident requires supervision/set up assistance with eating. Record review of meal ticket dated 05/18/2026 indicated Resident #75 had adaptive equipment of 2 handed cup. During an interview on 05/18/2026 at 11:20 a.m., MA L stated in the hall while CNA H was passing trays that Resident #75 was a feeder indicating that Resident #75 required assistance with meals from CNA H. During an attempted interview on 05/19/2026 at 12:00 p.m., Resident #75 would not respond when spoken to. During an interview on 05/19/2026 at 12:05 p.m., CNA H stated that Resident #75 required assistance with meals. CNA H stated it was important to assist Resident #75 with meals to prevent weight loss. During an interview on 05/19/2026 at 12:15 p.m., MA L stated that she accidentally called Resident #75 a feeder. The MA L stated that calling Resident #75 a feeder was undignifying. During an interview on 05/20/2026 at 9:26 a.m., RN A stated that she expected the nursing staff to address all residents with dignity and respect. RN A stated that staff should call Resident #75 by her name and state that (Resident #75) is an assisted diner. During an interview on 05/20/2026 at 2:48 p.m., the DON stated that she expected all staff to treat all residents with dignity and respect. The DON stated that she had held an in-service on 4/16/2026 regarding assistance with feedings. The DON stated that Resident #75 was at risk of loss of dignity. During an interview on 05/20/2026 at 3:44 p.m., the Administrator stated that all staff are responsible for treating Resident #75 with dignity and respect. The Administrator stated that she expected staff to address the needs of Resident #75 in a manner that is dignified. The Administrator stated that it was inappropriate to call Resident #75 a feeder at all times. Record review of Assistance with Meals policy dated 02/09/2024 revealed Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 5 residents (Residents #61) reviewed for reasonable accommodation.The facility failed to ensure Resident #61's call button was within reach while Resident #61 was in his bed on 05/18/26 and 05/19/26.This failure could place residents at risk of a delay in assistance and dignity.Findings included:Record review of Resident #61's face sheet, dated 05/21/26, indicated an [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), type 2 diabetes (uncontrolled blood sugar), depression (low mood), and high blood pressure.Record review of Resident #61's admission MDS assessment, dated 03/20/26, indicated Resident #61 understood and was understood by others. Resident #61's BIMS score was 11, which meant he was moderately cognitively impaired. The MDS indicated Resident #61 required supervision with toileting, bed mobility, dressing, transfers, personal hygiene, and set up with eating. The MDS indicated he was occasionally incontinent of his bladder.Record review of Resident #61's care plan with a revised date of 04/28/26 indicated he was at risk for falls related to gait/balance problems and unaware of safety needs. The interventions were for staff to be sure the call light was within reach and encourage the resident to use it for assistance as needed. The resident needed prompt response to all requests for assistance.During an observation on 05/18/26 at 11:57 a.m., Resident #61 was lying in his bed, and his call light was noted on the other side of his roommate's bed.During an observation and interview on 05/19/26 at 9:38 a.m., Resident #61 was lying in his bed, and his call light was noted on the other side of his roommate's bed. Resident #61 looked for his call light when the surveyor asked him what he would do if he needed help. Resident #61 said he did not see his call light, he said at times they hooked it to his recliner or the curtain, but he looked and could not find it. He said he guessed he would have to yell for help if needed. During an observation and interview on 05/19/26 at 9:39 a.m., CNA B said Resident #61 could move around the room, with his walker. She verified the call light was on the other side of his roommate's bed. She said all residents' call lights should always be in reach. She said call lights should be in reach to prevent falls and for staff to be able to help the residents in a timely manner. She said she arrived at work at 6am but had not checked Resident #61's call light. She said it was the CNAs responsibility to ensure the call light was in reach. She placed Resident #61's call light on his bed within reach.During an interview on 05/21/26 at 4:51 p.m., RN A said he expected all residents to have their call light. He said even if they could do for themselves or have a cognitive deficit, they should have their call light because sometimes their cognition changes throughout the day. He said the call light was a means of communication to let staff know if they needed something.During an interview on 05/21/26 at 2:22 p.m., the DON said all staff should check on the residents and ensure they have a call light within reach. She said call lights should be within reach of residents so they could use them when they needed assistance. She said she and the charge nurses should make random rounds to ensure call lights were within reach. The DON said failure to have or keep call lights within reach could cause a resident to fall, receive a bump, or bruise.During an interview on 05/21/26 at 3:04 p.m., the Administrator said all staff were responsible for ensuring call lights were within reach. She said the failure of not having the call light accessible could lead to several things such as a resident falling or not getting the help they needed timely.Record review of the facility's policy titled, Resident Call Light System, revised 06/23, indicated, Purpose: The purpose of this procedure: #1 to respond to the resident's requests and needs. Policy implementation: A call light system (audible and visual) is in place and operative in the facility. This system allows individual residents to access a system that notifies nursing that the resident has a need. Residents can communicate with the Nurse's Station (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from their room and/or bathing and toileting facilities. General Guidelines: #4 Ensure that the call light is easily reachable by the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' right to formulate an advanced directive was provided for 2 of 22 residents (Residents #40 and #64) reviewed for advanced directives. 1. The facility did not ensure Resident #40's OOH-DNR included the legal guardian's signature, printed name, and date the document was signed. The facility did not ensure Resident #40's OOH-DNR included the date the document was signed by the two witnesses. 2. The facility did not ensure Resident #64s OOH-DNR included the physician's signature. These failures could place residents at risk of not having their end-of-life wishes honored. Findings included: 1. Record review of Resident #40's face sheet, dated [DATE], reflected Resident #40 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included Angelman syndrome (neuro-genetic disorder that impairs nervous system development). Record review of Resident #40's quarterly MDS assessment, dated [DATE], reflected Resident #40 rarely/never made himself understood, and rarely/never understood others. The assessment did not address Resident #40's BIMS score but reflected he had long-term and short-term memory problems. Record review of Resident #40's undated comprehensive care plan, reflected resident/family had chosen DO NOT RESUSCITATE. The care plan interventions included: complete out of hospital DNR form with resident/family, send to MD for signature, and place completed form in chart. Record review of Resident #40's order summary dated [DATE] reflected an active DNR order effective [DATE]. Record review of Resident #40's OOH-DNR form dated [DATE] reflected a missing legal guardian's signature, printed name, and date the document was signed by the legal guardian and the two witnesses. 2. Record review of Resident #64's face sheet, dated [DATE], reflected Resident #64 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included spondylosis (age related degeneration of the spine). Record review of Resident #64's quarterly MDS assessment, dated [DATE], reflected Resident #64 usually made herself understood and usually understood others. Resident #64's BIMS score was 10, which reflected her cognition was moderately impaired.Record review of Resident #64's undated comprehensive care plan, reflected resident/family had elected a DNR status. The care plan interventions included: ensure appropriate paperwork is in the chart.Record review of Resident #64's order summary dated [DATE] reflected an active DNR order effective [DATE]. Record review of Resident #64's OOH-DNR form dated [DATE] reflected a missing physician's signature. During an interview on [DATE] at 11:00 a.m., the Social Worker stated she was responsible for completing DNRs. After reviewing Resident #40's electronic medical record, the Social Worker stated Resident #40 OOH-DNR was missing the legal guardian's signature, printed name, and date the document was signed. After reviewing Resident #64's electronic medical record, the Social Worker stated Resident #64 OOH-DNR was missing the physician's signature. The Social Worker stated, it was a human error. The Social Worker stated for a DNR to be accurate all required information must be filled out completely to ensure the resident/family's wishes were carried out. During an interview on [DATE] at 1:57 p.m., the DON stated she expected DNRs to be filled out completely. The DON stated the Social Worker was responsible for completing the DNRs accurately. The DON stated the Administrator was responsible for monitoring and overseeing DNRs. The DON stated it was important to ensure the DNRs were completed to be able to honor their wishes at end of life or perform CPR per their request. During an interview on [DATE] at 2:45 p.m., the Administrator stated she expected DNRs to be filled out correctly. The Administrator stated the Social Worker was responsible for completing the DNRs correctly. The Administrator stated she was responsible for monitoring and overseeing but the system the facility had in place monitored if someone had a DNR, uploaded, right order, and care planned but it had not been specified to inspect the actual document. The Administrator stated it was important to ensure the DNRs were completed to ensure the resident/family's wishes were respected. Record (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's policy titled Advanced Directive revised [DATE] reflected. Advance directives will be respected in accordance with state law and facility policy. 10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, 2 of 7 (Residents #56 and #49) reviewed for abuse.The facility did not ensure the Abuse Coordinator implemented their policy on reporting abuse to state agency for a resident-to-resident altercation that occurred on 12/05/25 between Resident #56 and Resident #49. This deficient practice could place residents at risk of abuse, neglect, and a decreased quality of life. Findings includedRecord review of the facility policy for Abuse Prohibition Policy, revised 10/15/22 reflected, Policy Statement All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation :4. The Administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented. In the case of resident-to-resident suspected of abuse, the parties will remain separated from one another until investigation has been completed. Reporting: 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: A. Two (2) hours if the alleged violation involves abuse.1.Record review of Resident #56's face sheet, dated 05/21/26, reflected Resident #56 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnoses which included dementia (forgetfulness), anxiety, (a group of mental health conditions that cause fear, dread and other symptoms), depression (sadness), and high blood sugars.Record review of Resident #56's quarterly MDS assessment, dated 04/20/26, reflected Resident #56 made herself understood and was sometimes understood by others. Resident #56's BIMS score was 03, which reflected her cognition was severely impaired. Resident #56 had no behaviors or refusal of care during the look-back period.Record review of Resident #56's comprehensive care plan revised on 12/05/25 reflected Resident #56 had a potential to be verbally aggressive related to dementia, ineffective coping skills, and poor impulse control. The care plan interventions included when the resident becomes agitated to intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; If response was aggressive, staff should walk calmly away, and approach later.Record review of the verbal aggression incident report dated 12/05/25 at 12:54 p.m. charted by RN D reflected RN D was at the nurses' station when he heard commotion in the dining room. It indicated when he arrived in the dining room Resident #56 and Resident #49 were arguing with each other and holding each other's arms. It indicated RN D separated the residents and assessed Resident #56 with no injuries and no emotional or mental turmoil noted. Resident #56 said, She stole my sweater from the laundry and would not give it back. I should have hit her.During an interview on 05/21/26 at 2:04 p.m., Resident #56 said she could not recall an altercation with Resident #49 that occurred on 12/05/25.2.Record review of Resident #49's face sheet, dated 05/21/26, reflected Resident #49 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included dementia(loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), high blood sugars, and depression (sadness).Record review of Resident #49's admission MDS assessment, dated 03/31/26, reflected Resident #49 usually made herself understood and sometimes understood others. Resident #49's BIMS score was 03, which reflected her cognition was severely impaired. Resident #49 had no behaviors or refusal of care during the look-back period.Record review of Resident #49's comprehensive care plan, revised on 12/05/25 reflected Resident #49 had a potential to be verbally aggressive related to dementia, ineffective coping skills, and poor impulse control. The care plan interventions included when the resident becomes agitated to intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; If response was aggressive, staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should walk calmly away, and approach later.Record review of the verbal aggression incident report dated 12/05/25 at 12:54 p.m., charted by LVN A reflected LVN A was at the nurses' station charting when she heard commotion in the dining room. It indicated when he arrived in the dining room Resident #56 and Resident #49 were yelling with each other, holding each other's hands, and becoming aggressive. It indicated LVN A separated the residents and assessed Resident #49 with no injuries and no emotional or mental turmoil noted. It indicated Resident #49 said, She did not hit me, but I should have hit her.Record review of the verbal aggression incident report dated 12/05/25 at 12:54 p.m., charted by the DON revealed, Resident #56 propelled close to Resident #49's wheelchair, Resident #56 tapped her right hand against her own wheelchair. Resident #56 then took her left hand and slapped at Resident #49's right upper arm. Resident #49 responded with a closed fist waving it at Resident #56. Staff quickly intervened. Both residents were verbally aggressive, verbally threatened each other and were grabbing at each other's hands. Residents were easily redirected and separated. Resident #49 removed the grey sweater aggressively and gave it to staff and said, She can have the D-m sweater, she gave it to me.During an interview on 05/20/26 at 5:24 p.m., the Treatment Nurse said she was on hall 200 and heard yelling. She said she saw the occupational therapist N running towards the dining room. She said by the time she got into the dining room the residents were separated. She said Resident #56 was standing up and Resident #49 was sitting in her wheelchair. She said they removed one of the residents from the dining room, but she could not recall which one. She said she did not see what happened but could tell it was commotion because she heard yelling all the way on the 200 hall. She said she could hear yelling but could not recall what was said. She said the DON was notified at the time of the altercation but said she was not sure if the Administrator was aware. She looked in the computer system and saw that the Administrator had signed the incident report and said if she was not notified at the time of the incident, she was aware when she signed the incident report. During an interview on 05/20/26 at 5:46 p.m., Occupational therapist N said she was walking on the 200 hall and heard yelling in the dining room. She said she could not make out what was being said but said it was very loud. She said by the time she got into the dining room the residents were separated. She said Resident #56 was holding onto Resident #49's sweater. She said she did not see any hitting but again said they were very loud. During an interview on 05/21/26 at 9:31 a.m., CNA K said she was in the dining room when she heard Resident #56 having words with Resident #49. She said Resident #56 and Resident #49 were sitting at the dining room table next to the wall and she was over by the drink area setting up drinks for the lunch meal. She said she had her back turned away from the residents. She said when she looked Resident #56 was standing up over Resident #49 and that was when she knew Resident #56 was upset. She said Resident #56 was prone to stand up when she was upset. She said both residents were cursing and Resident #49 said if she could get up out of her chair, she would kick Resident #56's A--. She said she could not recall what other curse words were used or who said what, but curse words were used. She said both residents were swinging at each other but to her knowledge neither resident made contact. She said she moved Resident #56 to another table and 2 other residents who were sitting at the table with both residents moved themselves. She said both residents were verbally aggressive and believed it would have gotten worse if she had not intervened. She said both residents had been aggressive at times but never to this extent. She said she was not aware if the DON or Administrator were aware at the time of the altercation but they both usually helped at meal service. She said staff were good at reporting things to the Administrator and the DON. During an interview on 05/21/26 at 2:04 p.m., Resident #49 said she could not recall an altercation with Resident #56.During an interview on 05/21/26 at 2:09 p.m., the SW said she came up after the altercation between Resident #56 and Resident #49 occurred. She said Resident #56 told her she did not like Resident #49 and did not want to sit by her. The SW explained that she did not have to sit by Resident #49 and she then assisted Resident #56 to her room. The SW said Resident #56 was upset when she first started talking to her but after a while, she calmed down and seemed to be okay.During an interview on 05/21/26 at 2:22 p.m., the DON said she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not present but was aware of the altercation between Resident #56 and Resident #49. She said she talked with Resident #56 after the altercation and Resident #56 seemed very heated but calmed down very quickly and had no recall of the incident after it happened. She said she spoke to Resident #49 after the altercation, and she was worked up but was not mad. She said she felt like Resident #49 did not know how to process what had just happened. She said she talked with staff who were aware or present during the altercation and they said both residents were verbally aggressive. She said the staff said Resident #56 seemed upset and was speaking to Resident #49 when staff intervened and separated them. She said she did watch a video of the altercation. She said it had no sound but utilized what staff told her and compared it to the video footage. She said she talked with the other residents present in the dining room during the altercation and could not conclude if any ill effects occurred to them. She said the altercation was over a sweater. The DON said both residents had cognitive issues and just because 2 residents spoke ugly to one another was not enough to report to HHSC. She said if it were physical abuse she could possibly see reporting to HHSC, but it was only verbal. She said she read the abuse policy and from what she read she did not feel the altercation needed to be reported. She said she did tell the Administrator, and the Administrator determined it did not need to be reported. During an interview on 05/21/26 at 3:04 p.m., the Administrator said she did not recall the altercation between Resident #56 and Resident #49. She said she knew that Resident #56 yelled and could get worked up at times. She said she could recall that both residents had dementia, and she knew they were arguing about something and later that day they did not recall the altercation. She said she did not believe the altercation was willful. She said if she were to report, she would report according to her flow chart. She said she could not recall when she was required to report, it was either within 2 hours or 24 hours because she did not have the chart in front of her. This surveyor asked if she wanted to refer to her flow chart and the incident report and she declined. She said she does not have to report a lot but does refer to her policy and flow chart when she does. She said she did not feel this altercation should have been reported to HHSC. She said she was the Abuse Coordinator, and she was to protect each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 2 of 7 (Residents #56 and #49) residents reviewed for reporting abuse.The facility did not report the resident-to-resident altercation between Resident #56 and Resident #49 to the State Survey Agency within 2 hours of being notified on 12/05/25. This failure to report could place the residents at risk for abuse. Findings include:1.Record review of Resident #56's face sheet, dated 05/21/26, reflected Resident #56 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included dementia (forgetfulness) , anxiety, (a group of mental health conditions that cause fear, dread and other symptoms), depression (sadness), and high blood sugars.Record review of Resident #56's quarterly MDS assessment, dated 04/20/26, reflected Resident #56 made herself understood and was sometimes understood by others. Resident #56's BIMS score was 03, which reflected her cognition was severely impaired. Resident #56 had no behaviors or refusal of care during the look-back period.Record review of Resident #56's comprehensive care plan revised on 12/05/25 reflected Resident #56 had a potential to be verbally aggressive related to dementia, ineffective coping skills, and poor impulse control. The care plan interventions included when the resident becomes agitated to intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; If response was aggressive, staff should walk calmly away, and approach later.Record review of the verbal aggression incident report dated 12/05/25 at 12:54 p.m. charted by RN D reflected RN D was at the nurses' station when he heard commotion in the dining room. It indicated when he arrived in the dining room Resident #56 and Resident #49 were arguing with each other and holding each other's arms. It indicated RN D separated the residents and assessed Resident #56 with no injuries and no emotional or mental turmoil noted. Resident #56 said, She stole my sweater from the laundry and would not give it back. I should have hit her.During an interview on 05/21/26 at 2:04 p.m., Resident #56 said she could not recall an altercation with Resident #49 that occurred on 12/05/25.2.Record review of Resident #49's face sheet, dated 05/21/26, reflected Resident #49 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included dementia(loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), high blood sugars, and depression (sadness).Record review of Resident #49's admission MDS assessment, dated 03/31/26, reflected Resident #49 usually made herself understood and sometimes understood others. Resident #49's BIMS score was 03, which reflected her cognition was severely impaired. Resident #49 had no behaviors or refusal of care during the look-back period.Record review of Resident #49's comprehensive care plan, revised on 12/05/25 reflected Resident #49 had a potential to be verbally aggressive related to dementia, ineffective coping skills, and poor impulse control. The care plan interventions included when the resident becomes agitated to intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; If response was aggressive, staff should walk calmly away, and approach later.Record review of the verbal aggression incident report dated 12/05/25 at 12:54 p.m., charted by LVN A reflected LVN A was at the nurses' station charting when she heard commotion in the dining room. It indicated when he arrived in the dining room Resident #56 and Resident #49 were yelling with each other, holding each other's hands, and becoming aggressive. It indicated LVN A separated the residents and assessed Resident #49 with no injuries and no emotional or mental turmoil noted. It indicated Resident #49 said, She did not hit me, but I should have hit her.Record review of the verbal aggression incident report dated 12/05/25 at 12:54 p.m., charted by the DON revealed, Resident #56 propelled close to Resident #49's wheelchair, Resident #56 tapped her right hand against her own (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair. Resident #56 then took her left hand and slapped at Resident #49's right upper arm. Resident #49 responded with a closed fist waving it at Resident #56. Staff quickly intervened. Both residents were verbally aggressive, verbally threatened each other and were grabbing at each other's hands. Residents were easily redirected and separated. Resident #49 removed the grey sweater aggressively and gave it to staff and said, She can have the D-m sweater, she gave it to me.During an interview on 05/20/26 at 5:24 p.m., the Treatment Nurse said she was on hall 200 and heard yelling. She said she saw the Occupational Therapist N running towards the dining room. She said by the time she got into the dining room the residents were separated. She said Resident #56 was standing up and Resident #49 was sitting in her wheelchair. She said they removed one of the residents from the dining room, but she could not recall which one. She said she did not see what happened but could tell it was commotion because she heard yelling all the way on the 200 hall. She said she could hear yelling but could not recall what was said. She said the DON was notified at the time of the altercation but said she was not sure if the Administrator was aware. She looked in the computer system and saw that the Administrator had signed the incident report and said if she was not notified at the time of the incident, she was aware when she signed the incident report. During an interview on 05/20/26 at 5:46 p.m., Occupational Therapist N said she was walking on the 200 hall and heard yelling in the dining room. She said she could not make out what was being said but said it was very loud. She said by the time she got into the dining room the residents were separated. She said Resident #56 was holding onto Resident #49's sweater. She said she did not see any hitting but again said they were very loud. During an interview on 05/21/26 at 9:31 a.m., CNA K said she was in the dining room when she heard Resident #56 having words with Resident #49. She said Resident #56 and Resident #49 were sitting at the dining room table next to the wall and she was over by the drink area setting up drinks for the lunch meal. She said she had her back turned away from the residents. She said when she looked Resident #56 was standing up over Resident #49 and that was when she knew Resident #56 was upset. She said Resident #56 was prone to stand up when she was upset. She said both residents were cursing and Resident #49 said if she could get up out of her chair, she would kick Resident #56's A--. She said she could not recall what other curse words were used or who said what, but curse words were used. She said both residents were swinging at each other but to her knowledge neither resident made contact. She said she moved Resident # 56 to another table and 2 other residents who were sitting at the table with both residents moved themselves. She said both residents were verbally aggressive and believed it would have gotten worse if she had not intervened. She said both residents had been aggressive at times but never to this extent. She said she was not aware if the DON or Administrator were aware at the time of the altercation but they both usually helped at meal service. She said staff were good at reporting things to the Administrator and the DON. During an interview on 05/21/26 at 2:04 p.m., Resident #49 said she could not recall an altercation with Resident #56.During an interview on 05/21/26 at 2:09 p.m., the SW said she came up after the altercation between Resident #56 and Resident #49 occurred. She said Resident #56 told her she did not like Resident #49 and did not want to sit by her. The SW explained that she did not have to sit by Resident #49 and she then assisted Resident #56 to her room. The SW said Resident #56 was upset when she first started talking to her but after a while, she calmed down and seemed to be okay.During an interview on 05/21/26 at 2:22 p.m., the DON said she was not present but was aware of the altercation between Resident #56 and Resident #49. She said she talked with Resident #56 after the altercation and Resident #56 seemed very heated but calmed down very quickly and had no recall of the incident after it happened. She said she spoke to Resident #49 after the altercation, and she was worked up but was not mad. She said she felt like Resident #49 did not know how to process what had just happened. She said she talked with staff who were aware or present during the altercation and they said both residents were verbally aggressive. She said the staff said Resident #56 seemed upset and was speaking to Resident #49 when staff intervened and separated them. She said she did watch a video of the altercation. She said it had no sound but utilized what staff told her and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	compared it to the video footage. She said she talked with the other residents present in the dining room during the altercation and could not conclude if any ill effects occurred to them. She said the altercation was over a sweater. The DON said both residents had cognitive issues and just because 2 residents spoke ugly to one another was not enough to report to HHSC. She said if it were physical abuse she could possibly see reporting to HHSC, but it was only verbal. She said she read the abuse policy and from what she read she did not feel the altercation needed to be reported. She said she did tell the Administrator, and the Administrator determined it did not need to be reported. During an interview on 05/21/26 at 3:04 p.m., the Administrator said she did not recall the altercation between Resident #56 and Resident #49. She said she knew that Resident #56 yelled and could get worked up at times. She said she could recall that both residents had dementia, and she knew they were arguing about something and later that day they did not recall the altercation. She said she did not believe the altercation was willful. She said if she were to report, she would report according to her flow chart. She said she could not recall when she was required to report, it was either within 2 hours or 24 hours because she did not have the chart in front of her. This surveyor asked if she wanted to refer to her flow chart and the incident report and she declined. She said she does not have to report a lot but does refer to her policy and flow chart when she does. She said she did not feel this altercation should have been reported to HHSC. She said she was the abuse coordinator, and she was to protect each resident. Record review of the facility policy for Abuse Prohibition Policy, revised 10/15/22 reflected, Policy Statement All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation :4. The Administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented. In the case of resident-to-resident suspected of abuse, the parties will remain separated from one another until investigation has been completed. Reporting: 2. An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: A. Two (2) hours if the alleged violation involves abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure assessments were coordinated with Preadmission Screening and Resident Review (PASRR) program under Medicated in subpart C to the maximum extent practicable to avoid duplicative testing and effort and coordination included incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care for 1 of 8 residents (Resident #5) reviewed for PASRR.The facility did not ensure the correct PASRR (a preliminary assessment completed for all individuals before admission to a Medicaid-certified nursing facility to determine whether they might have a mental illness or intellectual disability) Level 1 Screening was submitted to the local authority for Resident #5 who had a diagnosis of mental illness upon admission. This failure could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Findings include: Record review of Resident #5's face sheet, dated 05/21/26, reflected Resident #5 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included major depressive disorder (chronic sadness that interferes with daily life), bipolar (a disorder associated with episodes of mood swings ranging from depression lows to manic highs) and anxiety (excessive worry). Record review of Resident #5's annual MDS assessment, dated 08/18/25, reflected Section A1500 asked Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? This section was marked 0 which meant No. Section A.1510 Level II Preadmission Screening and Resident Review (PASRR) Conditions did not have A. Serious mental illness, B. Intellectual Disability, or C. Other related conditions checked. Resident #5 usually understood others and usually made herself understood. Resident #5 had a BIMS score of 15, which indicated her cognition was intact. Record review of Resident #5's undated comprehensive care plan, reflected Resident #5 used antidepressant medication related to depression, and antianxiety medication related to anxiety disorder. The care plan interventions included: give medications as ordered by physician, monitor/document side effects and effectiveness. Record review of Resident #5's PASRR Level 1 Screening form, dated 06/01/22, reflected Resident #5 had no evidence or indicator of dementia or a mental illness. Record review of Resident #5's PASRR Level 1 Screening form, dated 05/19/26, reflected Resident #5 had no evidence or indicator of dementia or a mental illness. Record review of Mental Illness/Dementia Resident Review Form 1012 reflected the form was submitted on 05/19/26.During an interview on 05/18/26 at 11:59 a.m., Resident #5 sated she always had a history of mental illness. During an interview on 05/20/26 at 11:20 a.m., the MDS Coordinator stated the previous MDS Coordinator was responsible for ensuring Resident #5 PASRR Level 1 was completed accurately. The MDS Coordinator stated a Form 1012 should have been completed to correct the inaccurate PASRR Level 1, which would determine whether to submit a new PASRR Level 1 screening form for a possible PASRR positive diagnosis. The MDS Coordinator stated it was important for Resident #5 to be screened for PASRR to ensure she got the services she was eligible for. During a telephone interview on 05/21/26 at 10:12 a.m., the Clinical Reimbursement Specialist stated if a Level 1 was incorrect he expected a Form 1012 to be completed so the resident could be reevaluated for services. The Clinical Reimbursement Specialist stated the MDS Coordinator was responsible for ensuring a Form 1012 was completed for Resident #5 when the first PASARR Level 1 was completed inaccurately. The Clinical Reimbursement Specialist stated he started focus audits to ensure compliance with PASRR a few weeks ago (unable to give exact date). The Clinical Reimbursement Specialist stated it was important for residents to be screened for PASRR to ensure residents were evaluated for eligibility and services. During an interview on 05/21/26 at 1:57 p.m., the DON stated she expected the appropriate paperwork to be filled out (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	correctly. The state surveyor asked what paperwork, the DON stated, the paperwork that goes along with PASARR. The DON stated the MDS Coordinator was responsible for ensuring Resident #5 PASRR Level 1 was completed accurately. The DON stated she was responsible for monitoring and overseeing PASARR by attending the meetings and reviewing the paperwork to ensure the paperwork get submitted into SIMPLE (software to manage PASRR compliance) and rehabilitation appropriately. The DON stated she did not know how this was missed. The DON stated it was important for Resident #5 to be screened for PASRR to ensure she received all the services she was entitled to. During an interview on 05/21/26 at 2:45 p.m., the Administrator stated she expected Form 1012 to be completed and an updated PASARR Level 1 submitted. The Administrator stated the MDS Coordinator was responsible for ensuring a Form 1012 was completed for Resident #5 when the first PASARR Level 1 was completed inaccurately. The Administrator stated the DON was responsible for monitoring and overseeing the MDS Coordinator. The Administrator stated it was important for Resident #5 to be screened for PASRR to ensure she received the services she wanted or needed. Record review of the facility policy for Preadmission and Screening Resident Review Rules and Guidelines, revised 01/09/26 reflected. It is the intent of Priority Management Group to meet and abide by all State and Federal regulations that pertain to Preadmission and Screening Resident Review (PASRR) Rules.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 2 residents (Resident #10) reviewed for respiratory care. 1. The facility failed to ensure Resident #10's oxygen tube was changed weekly as ordered. 2. The facility failed to ensure Resident #10's water container was replaced when empty. These failures could place residents requiring respiratory care at risk for shortness of breath, respiratory distress, or complications.Findings included: Record review of face sheet dated 05/19/2026 revealed Resident #10 was a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of diffuse traumatic brain injury loss of consciousness (injury to the brain due to impact). Record review of MDS dated [DATE] revealed Resident #10 was rarely understood by others and was rarely able to understand others. The MDS assessment indicated Resident #10 had a BIMS score of 00, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #10 received oxygen while a resident in the facility. Record review of order summary dated 05/19/2026 revealed Resident #10 had an order for oxygen nasal cannula 2-3L started on 03/11/2025 and orders to change nasal cannula, oxygen tubing, water bottle and clean concentrator filter every night shift every Wednesday for oxygen dependence. Record review of care plan dated 05/19/2026 revealed Resident #10 had a care plan for altered respiratory status with an intervention of oxygen setting of 2-3L/min for hypoxemia (low oxygen level in the blood) indicated on 04/17/2024. During an observation on 05/18/2026 at 11:32 a.m., Resident #10's nasal cannula tubing and water container was dated 05/07/2026 and the water container was empty. Oxygen was in use of 3L with nasal cannula. During attempted interview on 05/18/2026 at 11:35 a.m., Resident #10 did not respond to when aroused. During an interview on 05/19/2026 at 1:45 p.m., the CNA H stated that it was the charge nurse's responsibility to change the oxygen supplies, but all nursing staff are responsible for checking to make sure the tubing and water container was in date. The CNA H stated she was unsure when Resident #10's oxygen tubing was to be changed and was unaware of the oxygen water canister being empty. During an interview on 05/20/2026 at 11:20 a.m., the RN A stated that she changed the oxygen tubing on, Monday afternoon, 05/18/2026, when she noticed it needed to be changed. The RN A stated that she was unsure when the oxygen supplies were scheduled to be changed but saw it was out of date. The RN A stated that the nursing staff are responsible for oxygen supplies to be changed per order for infection control. During an interview on 05/20/2026 at 3:03 p.m., the DON stated it was all nursing responsibility for ensuring oxygen supplies are stored and changed properly to ensure infection control. The DON stated that Resident #10 had an order to change his oxygen tubing and water canister every week on Wednesday. The DON stated she expected the oxygen tubing and water canister to be changed per orders and policy. During an interview on 05/20/2026 at 3:54 p.m., the Administrator stated that nursing was responsible for oxygen supplies. The Administrator stated that she was unaware of the order or policy but she expected it to be followed accordingly. The administrator stated she was unsure what the use of the water canister was for, but she expected all oxygen supplies to be changed when ordered to prevent bacteria growth. Record review of oxygen administration policy dated 02/2025 revealed oxygen cannula and tubing will be changed every 7-10 days or if visibly soiled and change the prefilled humidifier when the water level becomes low.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure that residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 2 of 3 residents (Resident # 87 and Resident #46) reviewed for trauma-informed care.1.The facility did not ensure Resident #87's experienced trauma was identified in her trauma assessment, social history, and her baseline care plan. 2. The facility did not ensure Resident #46's trauma screening was completed upon admission to the facility. These failures could put residents at an increased risk for severe psychological distress due to re-traumatization. Findings included:1. Record review of Resident #87's face sheet dated 05/21/2026 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses which included high blood pressure, other symptoms involving cognitive functions following cerebrovascular disease (diagnosis that includes memory loss, difficulty paying attention, slowed thinking, and executive dysfunction), and gastroesophageal reflux (acute pain related to irritated from the throat to the stomach from acid). Record review of Resident #87's admission MDS assessment dated [DATE] indicated she understood others and was understood by others. Resident #87's BIMS score was 1, which indicated her cognition was severely impaired. Resident required setup with eating, dependent on staff for toileting, dressing, hygiene, and independent with bed mobility. Record review of Resident #87's baseline care plan dated 05/08/2026 did not indicate any past trauma nor triggers. Record review of Resident # 87's trauma informed care assessment dated [DATE] indicated the social worker was unable to determine if Resident #87 had experienced any traumatic event. Record review of Resident #87's social history dated 05/11/2026 indicated Resident #87 was understood by others and sometimes understood and the assessment was completed by Resident #87 and a family member. The social history assessment did not indicate any past trauma or triggers. During an interview on 05/20/2026 at 4:26 PM LVN F said she was aware that Resident #87 had previous trauma related to a group of men breaking in her house. LVN F said being confined and men triggered her and set her off (caused her to have behaviors). LVN F said her trauma and triggers should have been in her trauma assessment and social history as well as her baseline care plan. LVN F said the failure placed a risk for unwanted behaviors related to triggers. During an interview on 05/20/2026 at 4:03 PM the Hospice RN said she remembered when Resident #87 admitted on [DATE] the floor staff were notified that she had trauma related to being attacked in her home by a group of men and that men triggered her. During an interview on 05/20/2026 at 4:57 PM the Social Worker said Resident #87 was not an accurate historian, but she had spoken with a family member about 2 days after Resident #87 was admitted on [DATE]. The Social Worker said the family member notified her of childhood trauma to where Resident #87 had been teased by kids for being cross-eyed and that she had a prior attack at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her home by a group of men. The Social Worker said she should have included the information in her assessment record, but initially she did not have the information. The social worker said the trauma and triggers of men should have been included in her care plan as well. The Social Worker said she thought she added the information to Resident #87's care plan but failed to provide it. The Social Worker said the failure created a risk of staff being unaware and care being missed. During an interview on 05/21/2026 at 2:16 PM the DON said her expectation was for the social history and trauma assessments to be completed by the Social Worker and the appropriate family should have been contacted to get information on any trauma or triggers and ensure the trauma and triggers were included in care planning. The DON said the Social Worker was responsible for getting the information. The DON said the failure placed a risk for decreased quality of life for Resident #87 and the risk of staff not knowing what triggered her or startled her to prevent behaviors. During an interview on 05/21/2026 at 2:39 PM the Administrator said the expectation was for the Social Worker to obtain information and to document trauma and triggers and ensure the trauma and triggers were included in the baseline care plan. The Administrator said the failure placed a risk for Resident #87 being triggered and having behaviors. 2.Record review of Resident #46's face sheet, dated 05/10/25, indicated Resident #46 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses which included Post-traumatic stress disorder also known as PTSD (a mental health condition that can develop after a person has experienced or witnessed a traumatic event), anxiety(a feeling of fear, dread, and uneasiness), and Chronic Obstructive Pulmonary Disease also known as COPD (a progressive, incurable lung disease that blocks airflow and makes breathing difficult). Record review of Resident #46's quarterly MDS, dated [DATE], indicated Resident #46 understood others and usually made himself understood. Resident #46 had a BIMS score of 13, which indicated his cognition was intact. The MDS assessment indicated Resident #46 had a diagnosis of post-traumatic stress disorder. Record review of Resident #46's medical records did not reveal a trauma assessment or trauma screen. Record review of Resident #46's comprehensive care plan, revised 05/17/22, indicated Resident #46 had behavior problems related to his diagnosis of mental illness (a wide range of health conditions that affect a person's thinking, emotions, and behaviors) and PTSD. The intervention was for staff to administer medications as ordered. Monitor/document for side effects and effectiveness, anticipate and meet the resident's needs daily. Assist the residents to develop more appropriate methods of coping and interacting during behavioral episodes. Encourage the residents to express feelings appropriately. Explain all procedures to the residents before starting and allow the resident time needed to adjust to changes. If reasonable, discuss the resident's behavior with the resident. Explain/reinforce why behavior was inappropriate and/or unacceptable to the resident. During an interview on 05/21/26 at 9:45 a.m., the DON said she could not find Resident #46's trauma assessment and had asked the SW and she could not find it either. She said she guessed the trauma assessment had not been done. During an attempted phone interview on 05/21/26 at 9:50 a.m., with Resident #46's family member, who was unable to be reached, a message was left. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 05/21/26 at 9:54 a.m., the family member's attorney said she was told by the family member that Resident #46's neighbors (prior to admit) convinced him he could not leave his apartment and they also felt like there was some sexual abuse by the way the resident was acting. She said she did not have all the details but to reach out to his family. During an interview on 05/21/26 at 10:11 a.m., the Social Worker said she was responsible for the trauma assessments. She said Resident #46 was at the facility prior to her being hired but she was aware his family member reported sexual trauma prior to him been admitted . She said the family member did not have proof of any sexual trauma but said Resident #46's mood changed. She said Resident #46 does not talk about the trauma so therefore she does not know his triggers. She said she does not believe they were doing trauma assessments when she was first hired. She said when they initiated the trauma assessments (unknown date), she was told (unknown person) to start trauma assessments from that day going forward. She said she did not do any trauma assessments on residents who had PTSD prior to them initiating trauma assessments. She said it was their process to do trauma assessments on new admits and recently they added if a resident goes to the hospital for more than 72 hours to redo the trauma assessment. She said trauma assessments were done to see if the residents had any trauma in their past. She said based on the resident's trauma experienced they would develop a plan of care to alleviate or minimize the trauma from recurrence. The Social Worker said it was important to assess trauma and the triggers to understand the residents' behaviors. During an interview on 05/21/26 at 10:18 a.m., RN D said he was Resident #46's charge nurse. He said he believed he had some sexual abuse from his past. He said he could tell when Resident #46 was about to have his a mood or behavior issue because he would act invisible and he would look through you. Sometimes he would refuse care and make statements such as: that was not right or what you do that for. RN D said he knew Resident #46 was about to have a behavior issue when he made those statements or acted invisible. He said he had instructed the aides to walk away when he started making those statements. He said Resident #46 could walk and go to the bathroom but was incontinent at times. RN D said they would document on the MAR if he had any issues. During an attempted interview on 05/21/26 at 12:26 p.m., Resident #46 was lying in his bed. He did not respond when asked about his history of trauma. During an interview on 05/21/26 at 2:22 p.m., the DON said the SW completed the trauma assessments. She said she did not know Resident #46 did not have his trauma assessment done until questioned by the surveyor. She said trauma assessments were done on admission, re-admission (after being discharged 72-hours) and any change in condition. She said it was important for trauma assessments to be completed so that staff would be aware of past trauma and to prevent any further trauma if possible, for a better quality of life. During an interview on 05/21/26 at 3:04 p.m., the Administrator said the charge nurse, or the SW, were responsible for completing the trauma assessments. The Administrator said it was important for trauma assessments to be completed to see if the resident had any past trauma and what staff needed to do to prevent the resident from reliving the trauma as much as possible. Record review of the facility policy titled, Trauma Informed Care, dated 10/24/22, indicated, Policy Statement Providing behavioral health care is an integral part of the person-centered environment. Person-centered behavioral health care requires an interdisciplinary approach to care, and staff demonstrate the competencies and skills necessary to provide appropriate services to the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy implementation and interpretation: Intent - to ensure upon admission if assessed or diagnosed with a mental or psychosocial adjustment difficulty or documented history of trauma and/or post-traumatic stress disorder (PTSD), does not develop patterns of decreased social interaction and/or withdrawn, angry, or depressive behaviors while residing in the facility. Traditional types of trauma would be: Natural Disasters, Mass interpersonal Violence, Domestic Fires, Motor Vehicle Accidents, Rape and Sexual Assaults, physical Assaults, Partner/Family Battery, Torture, War, Child Abuse, or Emergency Worker Exposure. During the admission process, with quarterly, significant change and as needed, residents will be screened by Social Services and/or designee using the initial social history or the social progress review to assess for areas or patterns of decreased social interaction and/or withdrawn, angry or depressive behaviors while residing in the facility. Each employee will be educated on signs and symptoms and report as necessary to the Charge Nurse to assess. The Care Plan will be person-centered and include interventions that are individualized and have worked in the past, simple and include triggers that the resident may have. Examples of non-pharmacological interventions to be placed on the electronic record as necessary. Building confidence among staff and education is key in having the ability to prevent potential re-traumatization of our resident's and recognize trauma-related symptoms and behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676458	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabank Nursing Center	18957 US Hwy 175 W. Mabank, TX 75147

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record review the facility failed to provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service for 1 out of 7 dietary staff. (Dietary Aide C).The facility failed to ensure that dietary staff (Dietary Aide C) serving in the kitchen maintained a current Food Handler Certificate. This failure could place residents who consumed food prepared from the kitchen at-risk of foodborne illness. Findings included:Record review of Dietary Aide C's employee file indicated her date of hire was 10/01/23, and her Texas Food Handler Certificate was issued 02/14/24 and expired 02/13/26. During an interview on 05/21/26 at 2:19 p.m., the Dietary Manager said the food handler certificate should be obtained every 2 years. The Dietary Manager said she did not pay attention to when Dietary Aide C's food handler certificate would expire. The Dietary Manager said she and the Business Office Manager were responsible for ensuring the dietary staff had their food handler certificates. The Dietary Manager said it was important for the kitchen staff to have food handler certificates, so they knew the importance of food temperatures, cleaning, and safety of the food. During an interview on 05/21/26 at 2:29 p.m., Dietary Aide C said she did not realize her food handler certificate had expired. She said the DM told her yesterday (5/20/26) that it had expired. Dietary Aide C said she realized it was a requirement to have her food handlers certificate but did not see the risk if it was not updated because she knew what to do. Dietary Aide C said it was important to have a food handler certificate to know how to handle food and prevent cross contamination or infection. During an interview on 05/21/26 at 2:22 p.m., the DON said the DM was responsible to ensure staff have their food handler certificate. The Administrator was the overseer. She said it was important that no bacteria got into the food and staff handled food safely. During an interview on 5/21/26 at 3:04 p.m., the Administrator said she was not aware Dietary Aide C's food handler certificate had expired. The Administrator said the Dietary Manager was responsible for ensuring the food handler certificates were maintained up to date. The Administrator said Dietary Aide C did not serve on the line, so she did not know the risks associated with dietary staff having an expired food handler certificate. She said it was important for staff to know how to handle food properly for all who ate the food.Record review of the policy titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated 10/2008, indicated, Policy Statement: Food Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Policy Interpretation and Implementation:1. All employees who handle, prepare, or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. The policy did not address the certification requirements.