STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676469	A. Building B. Wing	11/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Premier Snf of Alice	800-A Coyote Trail Alice, TX 78332

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff demonstrated appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, for one (Resident #1) of four residents reviewed for skin integrity.The facility failed to ensure on 11/27/2025, NA A failed to follow the facility's procedure when she observed Resident #1's left forearm with 3 brown and yellow skin irregularities. This failure could potentially negatively compromise a resident's well-being by prolonging warranted skin assessments and monitoring. The findings included: Record review of Resident #1's admission's record dated 11/28/2025 revealed Resident #1 was an [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE]. Resident #1 was admitted with multiple diagnoses including severe protein calorie malnutrition, dementia (cognitive impairment), and surgical aftercare following surgery on the digestive system. Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1's BIMS score of 99- indicated Resident #1 was unable to complete the interview and needed substantial/maximal assistance with ADLs. Resident #1 was not coded for any skin impairment conditions. Record review of Resident #1's care plan revision date on 07/18/2025 revealed The resident has the potential for pressure ulcer development. The resident will have intact skin, free of redness, blisters or discoloration through review date. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Incontinent care after each episode and apply moisture barrier. Inform the resident/family/caregivers of any new area of skin breakdown. Notify nurse immediately of any new areas of skin breakdown: Open area, Redness, Blisters, Bruises, discoloration noted during bath or daily care. Record review of Resident #1's weekly Skin Assessments dated 11/10/2025, 11/18/2025 and 11/25/2025 there were no skin irregularities noted. Record reviewed Resident #1's progress notes date ranges from 10/29/2025-11/29/2025 revealed no documentation of NA A's 11/27/2025 observation. During an interview and observation on 11/28/2025 at 1:47 p.m., observed Resident #1's left forearm and found 5 skin irregularities on Resident #1 left forearm. The first 4 skin irregularities were clustered together on the top part of Resident #1's left forearm, and each contained red discoloration and were roughly less than a penny in size. The 5th skin irregularity appeared to be a discoloration which was also located on top of Resident #1's left forearm but closer to Resident #1's wrist. The 5th discoloration appeared circular with dark purple discoloration and appeared to be somewhat fresh looking. Resident #1 stated she did not know where the bruises came from, but that no person had ever hit/hurt or scared her. Resident #1 stated the skin irregularities did not hurt. Resident #1 did not appear to be in any distress nor was any indication of malicious intent. During an interview on 11/28/2025 at 1:54 p.m., NA A stated she had observed roughly 3 skin irregularities on Resident #1's left forearm on 11/27/2025 prior to lunch, while she was assisting Resident #1 to dress. NA A stated while she inspected the skin she inquired if Resident #1 knew the origin of the discoloration of skin irregularities, to which Resident #1 could not recall. NA A stated the 3 discolorations were brown and yellow but could not determine circumference nor diameter of the irregularities, however stated they did not look suspicious. NA A stated she did not notify the charge nurse, treatment nurse, ADONs, nor DON as the skin irregularities were not suspicious and did not think it was that serious. NA A stated Resident #1 never presented fearfull of staff nor residents. When NA A was asked if she should have notified the charge nurse when she saw the skin irregularities, NA A reiterated the skin irregularities did not look suspicious and therefore did not think it was serious and did not warrant any notification to the charge nurse. NA A did not verbalize how her inaction to notify her chain of command could have affected Resident #1's well-being. NA A stated she had attended the facility's change in condition in-service as part of her orientation and recalled being educated that she is expected to notify her chain of command when she observes anything abnormal, however NA A reiterated the skin irregularities were not suspicious, Resident #1 never presented fearfully or scared of any person. During an interview on 11/29/2025 at 3:06 p.m., the DON stated she was notified of Resident #1's skin irregularities on 11/28/2025 and immediately directed the treatment nurse to perform a thorough head to toe assessment on Resident #1 and concluded the left arm skin irregularities stemmed from Resident #1's wheelchair arm placement when Resident #1 was attempting to pass through a doorway. The DON stated once NA A observed Resident #1's skin irregularities, she should have immediately notified her charge nurse so that the charge nurse could accurately assess

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain clinical records in accordance with accepted professional standards of practice, that were complete and accurately documented, for one resident (Resident #1) of three residents reviewed for skin assessments. The facility failed to ensure on 11/17/2025 around 9:00 p.m., LVN A failed to accurately document the description of three discolored dots on Resident #1's left forearm as well as light brown/purple bruise on the top of Resident #1's right forearm. This failure could place residents at risk of having incomplete and accurate records and not receiving appropriate treatment and services. The findings included: Record review of Resident #1's admission's record dated 11/28/2025 revealed Resident #1 was an [AGE] year-old female who was initially admitted on [DATE] and readmitted on [DATE]. Resident #1 was admitted with multiple diagnoses including severe protein calorie malnutrition, dementia (cognitive impairment), and surgical aftercare following surgery on the digestive system. Record review of Resident #1's Quarterly MDS dated [DATE] revealed Resident #1's BIMS score of 99- indicating Resident #1 was unable to complete the interview and needed substantial/maximal assistance with ADLs. Resident #1 was not coded for any skin impairment conditions. Record review of Resident #1's care plan revision date on 07/18/2025 revealed The resident has the potential for pressure ulcer development. The resident will have intact skin, free of redness, blisters or discoloration through review date. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Incontinent care after each episode and apply moisture barrier. Inform the resident/family/caregivers of any new area of skin breakdown. Notify nurse immediately of any new areas of skin breakdown: Open area, Redness, Blisters, Bruises, discoloration noted during bath or daily care. Record reviewed of Resident #1's weekly Skin Assessments dated 11/10/2025, 11/18/2025 and 11/25/2025 revealed, there was no skin irregularities noted. Record reviewed Resident #1's progress notes date ranges from 10/29/2025-11/29/2025 revealed no documentation of LVN A's 11/17/2025 observation. During an interview on 11/28/2025 at 2:44 p.m., CNA A stated while she was working on 11/17/2025 she entered Resident #1's room with LVN A and assisted LVN A with redirecting Resident #1 as LVN A was attempting to provide enteral nutrition. CNA A stated while she was redirecting Resident #1, she noticed Resident #1's right forearm had a yellowish-brown bruise-like discoloration roughly 3inches in length and roughly 1inch in width. CNA A stated simultaneously LVN A saw the discoloration as well and commenced an assessment on Resident #1's skin irregularity. CNA A stated she did not notify any other nurse as LVN A was the charge nurse on 11/17/2025 and had fulfilled her scope of practice. During an interview on 11/28/2025 at 3:22 p.m., LVN A stated while she was working on 11/17/2025 she entered Resident #1's room with CNA A to perform enteral nutrition. LVN A stated while she was with Resident #1, she noticed Resident #1 had light brownish/light purple bruise-like discoloration on Resident #1's right forearm that was no more than the size of a quarter. LVN A stated she additionally observed two unmeasurable little dots on Resident #1 left forearm. LVN A stated she followed the facility's protocol and notified the DON of the skin irregularities but missed the documentation aspect of the protocol. LVN A stated she should have documented her observable findings to ensure accurate monitoring of the observed skin irregularities. LVN A stated she should have documented the findings to monitor if the skin irregularities progressed to ensure the well-being was not compromised, but reiterated the skin irregularities had resolved, but going forward she will be more intentional and document accurately and in a timely manner. During an interview on 11/29/2025 at 3:06 p.m., the DON stated once LVN A recognized the skin irregularities on Resident #1 on 11/17/2025 she should have documented the observed findings as part of the facility's protocol. The DON stated the reason she should have documented the skin assessment on 11/17/2025 was to ensure accurate monitoring of the skin irregularities to prevent any further progression of any compromising skin integrity issue. The DON stated Resident #1's well-being was not compromised as the skin irregularities had resolved with no evidence of any malice intent. The DON stated the discoloration could have stemmed from when Resident #1 attempts to pass through doorways with her wheelchair. The DON stated going forward, the facility has planned to conduct an as needed in-service regarding documenting skin assessment. Record review of the facility's Skin Assessment undated revealed 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission.The assessment may also be performed after a change in condition or after any newly identified pressure injury. b. Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and