STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455278	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Healthcare and Rehab Center Inc	1208 N Llano Fredericksburg, TX 78624

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedure. In response to allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source for 1 of 2 residents (Resident #1) reviewed for reporting allegations of abuse and neglect. The facility DON failed to identify bruising to left eyebrow and right arm as an alleged violation of injury of unknown source for Resident #1 on 12/29/2025 resulting in the resident having a busted blood vessel to her left side of her head and bruising to her right shoulder in green stages of healing. The DON failed to report an alleged violation of injury of unknown source for Resident #1 on 12/29/2025 to the Administrator of the facility and the Administrator failed to report the violations of injury of unknown source not later than 24 hours to other officials (including to the State Survey Agency) in accordance with State law through established procedure.This deficient practice of not following ANE reporting protocol could place residents at risk of harm by not having their injuries investigated.The findings included:Review of Resident #1's admission record dated 1/07/2026 reflected that she was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior) with late onset, major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life, and type 2 diabetes mellitus without complications (condition where a person has elevated blood sugar levels but has not yet developed any secondary issues related to diabetes) and she was placed on hospice on 1/04/2026.Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 02, indicating severely impaired cognition. Resident #1's active diagnoses, included: non-traumatic brain dysfunction. Further review of Resident #1's quarterly MDS reflected that her functional abilities was Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity for toileting hygiene, shower/bathe self, and oral hygiene and functional abilities with mobility was Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity for sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer and she did not attempt sit to stand or toilet transfer due to medical condition or safety concerns.Review of Resident #1's care plan dated 10/08/2022 reflected the following: Resident #1 has a self-care performance deficit r/t Confusion, Dementia. The goals for Resident #1 were that she will maintain current level of function through next review period. Interventions, bathing/showering: Resident #1 is totally dependent on x1 staff to provide shower twice weekly and as necessary; bed mobility, Resident #1 is able to reposition herself in bed. Further review of #1's care plan reflected she required extensive assistance with x1 for incontinent care for toilet use and for transfers Resident #1 was totally dependent on x2 staff for transferring. Resident uses a Hoyer lift. Further review of Resident #1's care plan reflected that she had a terminal prognosis r/t Alzheimer's and Interventions included Consult with physician and Social Services to have Hospice care for resident in the facility. Review of Resident #1's EMR Nursing Visit Note dated 12/29/2025 at 8:45 AM revealed the following: Patient tolerated shower well.Multiple areas of bruising observed including right elbow, right distal/anterior shin, right lower extremity lateral aspect above the knee, left shoulder, left eyebrow, and right forearm.Patient remains total assist for all ADLs and is unable to verbalize needs; staff must anticipate all care needs.Review of an incident report titled #875 Injury dated 12/29/2025 at 12:36 PM reflected the following: Nursing Description: Resident has a blue/purple bruise with raised area to left eyebrow. Bruise to right arm had previously faded per wound healing, it is now dark purple in color. Resident Description: Resident Unable to give DescriptionWas the incident witnessed: NoImmediate Action Taken: Assessment complete, incident report made, notification made to DON, physician, hospice agency, and RP. DON to contact hospice company

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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, interviews and record review, the facility failed to have evidence all allegations of abuse, neglect, or mistreatment were thoroughly investigated and documented for 1 of 2 residents (Resident #1) reviewed for an injury of unknown origin.The facility failed to have evidence that a thorough investigation was conducted following the allegation Resident #1 had bruising to her left side of her face and right arm and origin was unknown on 12/29/2025.This deficient practice could place residents at risk for abuse and neglect by not investigating injuries of unknown origin.The findings included:Review of Resident #1's admission record dated 1/07/2026 reflected that she was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior) with late onset, major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life, and type 2 diabetes mellitus without complications (condition where a person has elevated blood sugar levels but has not yet developed any secondary issues related to diabetes) and she was placed on hospice on 1/04/2026.Review of Resident #1's quarterly MDS dated [DATE] reflected a BIMS score of 02, indicating severely impaired cognition. Resident #1's active diagnoses, included: non-traumatic brain dysfunction. Further review of Resident #1's quarterly MDS reflected that her functional abilities was Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity for toileting hygiene, shower/bathe self, and oral hygiene and functional abilities with mobility was Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity for sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer and she did not attempt sit to stand or toilet transfer due to medical condition or safety concerns.Review of Resident #1's care plan dated 10/08/2022 reflected the following: Resident #1 has a self-care performance deficit r/t Confusion, Dementia. 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Bruise was not present prior to resident shower with hospice.Resident Taken to Hospital? No Review of Resident #'s EMR New Skin & Wound - Total Body Skin assessment dated [DATE] at 1:57 PM revealed the following: skin assessment: bruise: location: right & left hand, left eyebrow, light purple and green bruiseReview of Resident #1's EMR Health Status Note dated 12/30/2025 at 12:34 AM reflected nursing staff documented Resident day 1 post incident report left eye bruise and right forearm bruise. Slight bruising noted to left eyeReview of Resident #1's EMR Health Status Note dated 12/30/2025 at 6:12 PM reflected nursing staff entered late entry on 12/29/2025 when nurse noted bluish/purplish raised area to left eyebrow. Resident's family member was present and was looking and asking resident if she knew what happened, resident did not answer. Notified doctor of area per hospice nurse. Did not observe distress or discomfort from resident.Review of Resident #1's EMR Health Status Note dated 12/31/2025 at 2:02 AM reflected

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	455278	A. Building B. Wing	01/09/2026

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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 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. (continued on next page)

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	455278	A. Building B. Wing	01/09/2026

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F 0644 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 interview and record review, the facility failed to ensure all individuals with mental health disorders were provided with accurate Preadmission Screening and Resident Review (PASRR) Screenings for 1 of 4 residents reviewed for PASRR. The facility failed to ensure that Resident #7 had an accurate PASRR Level 1 Screening which indicated a diagnosis of mental illness (Bipolar Disorder) and refer Resident #7 to the state designated authority. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs.The findings included: Record review of Resident #7 face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #7 had diagnosis which included Bipolar Disorder (serious mental illness causing extreme mood swings, from manic highs to depressive lows), Senile Degeneration of the Brain (age related cognitive decline), Seizures (temporary disruption of brain activity from uncontrolled electrical signals), Depression (serious mood disorder causing persistent sadness and loss of interest, affecting how you feel, think, and handle daily activities like sleeping, eating or working), Anxiety Disorder (mental health condition causing persistent excessive fear and worry that significantly interfere with daily life, going beyond normal occasional anxiety), and Cognitive Communication Deficit (difficulty with talking, listening, reading, or writing due to problems with thinking skills like memory, attention, problem-solving, and organization). Record review of Resident #7 quarterly MDS, dated [DATE], revealed diagnosis which included bipolar disorder and BIMS of 14. Record review of Resident #7 care plan revealed the resident suffered from depression related to the bipolar disorder, dated 12/10/2025. Care plan also stated that Resident #7 has little or no activity involvement related to anxiety, depression, disinterest, physical limitations, poor adjustment to facility/unit, resident wishes to not participate. Resident #7 care plan also states that resident has chronic pain related to depression. Record review of Resident #7 admission paperwork from referring facility, dated 04/23/2025, reflected a list of Resident #7 diagnosis which included bipolar disorder. Record review of Resident #7 Level 1 PASRR screening that was completed by the referring entity on 05/24/2025 indicated in section C0100 there was no evidence of this individual having mental illness. Record review of Resident #7 12/07/2025 indicated that there was not a THHS Form 1012 used for PASRR in resident paperwork. During an interview on 01/07/2026 at 12:05a.m. LPNM stated that she was responsible for entering the information from the PASRR into their system. She stated that she can only put what the screener marked and therefore could not make changes to PASRR. Surveyor asked how LPNM would she obtain a Level II screening for a resident with a newly diagnosed mental illness, and she stated that she would rescreen the resident since it was not accurate any longer. Surveyor then asked why LPNM could not do the same on admission when she noticed that the resident had a bipolar diagnosis. LPNM stated that the diagnosis of Senile Degeneration of the brain trumped the bipolar disorder diagnosis, which would in turn negate the need for a positive PASRR and a Level II PASRR screening. That would be why section C0100 of the PASRR was marked 'NO'. During an interview on 01/08/2026 at 10:33 DON stated that the facility does not have a policy for PASRR and that they just follow the guidelines. During a follow-up interview on 01/09/2026 at 1:35p.m. surveyor asked LPNM if they had completed a THHS Form 1012, the Mental Illness and Dementia Resident Review. LPNM was unsure what the form was. Surveyor explained that the form was completed only for nursing facility residents with a current Negative PASRR Level 1 (PL1) Screening for Mental Illness to determine whether to submit a new positive PL1 screening form on the Long-Term Care Portal because further evaluation was needed. LPNM claimed that they did not but that she would obtain it before the end of the day. LPNM was trained as a MDS Nurse per guidelines. LPNM will apply all guidelines moving forward. During a follow-up interview with LPNM on 01/09/2026 at 3:45p.m. LPNM presented surveyor with a Form 3071 that was filled out by hospice on 05/23/2025 that listed Senile degeneration of the brain as the primary diagnosis. PASRR guidelines for Health and Human Services dated June 2023 state that if a resident has a diagnosis for mental illness, a PASRR level II must be completed by appropriate entity. PASRR guidelines list bipolar disorder as a qualifying diagnosis to initiate this next step.

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	455278	A. Building B. Wing	01/09/2026

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	455278	A. Building B. Wing	01/09/2026

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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 0689 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 observations, interviews, and record reviews the facility failed to ensure the residents' environment remains was free from accidents and hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents, for 1 of 8 residents (Resident #48) and 1 facility reviewed for a wander guard system (a wander management system used in healthcare facilities to prevent residents at risk of wandering, such as those with dementia, from leaving safe areas, offering them freedom while ensuring safety through wearable devices and automated alerts. The system uses radio frequency identification technology with wristbands and door sensors that trigger alarms and notifications to staff when a resident approaches an exit, often locking doors automatically.) The wander guard system for the facility had an exit door without a functioning wander guard system. The facility failed on 01-06-206 when the door that gave access through wing-4 hallway. The door gave a person access to the facility exterior courtyard. The courtyard was not fenced and had a cement sidewalk which had access to state a state highway. The wing-4 hallway door was used by residents to get to the dining room and activities areas and the wander guard box had loose wires exposed, not connected and the wander guard system was disabled. This failure could place residents at risk of harm by elopement. The findings included: A record review of Resident #48's admission record dated 1/8/2025 revealed an admission date of 12/30/2024 with diagnoses which included dementia (a range of neurological conditions affecting the brain that worsens over time. It is the loss of the ability to think, remember, and reason to levels that affect daily life and activities), repeated falls, osteoporosis (a bone disease that develops when bone mineral density and bone mass decreases, or when the structure and strength of bone changes. This can lead to a decrease in bone strength that can increase the risk of fractures (broken bones). A record review of Resident #48's quarterly MDS assessment dated [DATE] revealed Resident #48 was an [AGE] year-old female admitted for long term care with safety and activities of daily life (ADLs). Resident #48 was assessed with adequate hearing and impaired vision. Resident #48 was assessed with a BIMS score of 7 out of 15 which indicated severe cognitive impairment. Resident #48 was assessed to use a walker to ambulate. Resident #48 was assessed with the ability to walk 150 feet independently. A review of Restraints and Alarms revealed Resident #48 was assessed with a need for a daily wander / elopement alarm. A record review of Resident #48's care plan dated 1/8/2025 revealed, Risk for Wandering / Elopement Identified, Date Initiated: 12/30/2024 . Goal: The Resident's safety will be maintained, Date Initiated: 01/29/2025, Target Date: 01/28/2026 . Risk for Falls, Date Initiated: 12/30/2024, Goal; Resident Will Be Free of Falls Date Initiated: 12/30/2024, Target Date: 01/28/2026. The resident is dependent on staff etc. for meeting emotional, intellectual, physical, and social needs r/t severe Cognitive deficits, Physical Limitations. Date Initiated: 01/08/2025 Revision on: 01/08/2025. Goal; . Resident will be participate in activities that are suitable for her, and not overly demanding due to sever cognitive impairment. Date Initiated: 01/08/2025, Target Date: 01/28/2026. Encourage out of room activities, and meals. Date Initiated: 01/08/2025. Redirect resident when resident is attempting to get out of her w/c, and wander. Date Initiated: 01/08/2025. A record review of Resident #48's physician's orders dated 1/8/2026 revealed on 12/30/2024 the physician prescribed a wander guard for Resident #48 and for it to be checked every shift. During an observation on 1/6/2025 at 5:10 PM, revealed an exit door which was accessed through wing-4 hallway. The door gave a person access to the facility exterior courtyard. The courtyard was not fenced and had a cement sidewalk which had access to state a state highway. wing-4 hallway was used by residents to get to the dining room and activities areas. Observation of the exit door revealed a wander guard system box affixed to the upper right door frame, however the wander guard box had loose wires exposed. During an observation and interview on 1/7/2025 at 8:35 AM revealed Resident #48 walked with her walker rollator (a four- or three-wheeled mobility aid designed for stability, featuring hand brakes, a seat, and a storage basket/pouch for increased independence) from the dining room, throughout the facility which included the wing-4 hallway, to her room, where CNA C assisted her to bed. CNA C stated Resident #48 was a wander risk and had a need for a wander guard bracelet and demonstrated the bracelet on Resident #48's right wrist. CNA C stated the doors were alarmed with the wander guard system. CNA C stated Resident #48 could walk through out the facility. During an observation and interview on 1/7/2026 at 10:29 AM revealed an exit door which was accessed through wing-4 hallway. The door gave a person access to the facility exterior courtyard. The courtyard was not fenced and had a cement sidewalk which had access to state a state

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 kitchen reviewed.The facility failed to employ a qualified dietician or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified nutrition professional last employed with the facility was in October 2025. The facility failed to employ a qualified dietician who designates a person to serve as a full-time director of food and nutrition services for the facility. The person designated to serve as a director of food and nutrition services was employed for less than 25 hours per week.These failures could place residents at risk of not having their nutritional needs met.Findings included:In an interview on 1/09/2026 at 12:58 PM, the Dietary Manager stated she has been employed with the facility for nearly 21 years. She stated there was no dietician employed with the facility. Dietary Manager stated the last dietician or other clinically qualified nutrition professional last employed with the facility was in October 2025. She stated the facility management has had challenges with finding a dietician on a consultant basis due to being in a rural area. She stated that currently she works 40 hours between two different facilities owned by the company. She stated she feels she possesses the competencies to carry out the food and nutrition services for the facility. She stated that she was tasked with completing resident assessments, collaborating with the physician, DON, speech therapist, resident and at times families to develop individual plans of care. She stated that currently all the tasks required of a dietician or other clinically qualified nutrition professional are being met by her. She stated there is no effect on residents' nutritional needs by not having a dietician on staff.In an interview on 1/09/2026 at 1:22 PM, the ADM stated at this time that the facility has been unable to employ a dietician or clinically qualified nutrition professional. She stated she could not recall the date the last dietician was employed, but less than six weeks. She stated there have been some challenges with finding a dietician to hire on a consultation basis as it is a small city with limited options. She stated yes, the Dietary Manager is not employed on a full-time basis, but she can be contacted by phone if the need arises. She stated residents do not complain about the food they receive and she does not believe there is an impact to patient care or nutrition as the Dietary Manager is constantly collaborating with the DON and physician for resident nutritional needs.Review of the dietary schedule for the kitchen, dated 1/6/2026, reflected no dietician on roster. Surveyor requested information for last dietician employed by the facility and information was not provided prior to exit of survey.Record review of document titled, POLICY AND PROCEDURAL GUIDE FOR THE FOOD SERVICES OF [NAME] NURSING AND REHAB CNTER FREDERICKSBURG, TEXAS undated reflected the following: ORGANIZATION OF THE DEPARTMENTA qualified Dietitian will serve as consultant to the Administrator and to the Food Service Supervisor.The Dietary Consultant works with the Administrator and Food Service Supervisor to:1. Evaluate procedures2. Identify problems3. Establish department goals4. Set up priorities5. Develop in-service training programs6. Assist with specific problems as requested by the Administrator, and Food Service Supervisor B. The consultant will make regular scheduled visits of (16) sixteen hours each month or (20) twenty hours depending on monthly census.C. Planning of general diets, preparation and serving of all diets. The consultant will plan only therapeutic dietsMENUB. the Consultant will review all menus for nutritional adequacy and will plan therapeutic menus.THERAPEUTIC DIETSTherapeutic diets shall be planned and based on current diet manual which has been approved by medical staff and dietary consultantEach patient, upon admission, will be visited by the Food Service SupervisorThe consultant, when requested by the charge nurse, will visit all patients on therapeutic dietsDietary data pertinent to a patient will be recorded on patients' diet card on file in kitchen or chart by charge nurse or consultantThe dietary consultant is on call to give assistance on diets at the discretion of the staff.Record review of document titled, Dietary Consultant dated March 1, 2012, reflected the following: Purpose: To maintain a dietary department in compliance with roles and regulations of Federal, State and local authorities. To provide therapeutic diets and meals, as prescribed by the physician, in a well-balanced, attractive and appetizing manner under safe, sanitary conditions for a reasonable cost.Qualifications: Must be a professional dietitian who is a member of the American Dietetic Association and meets the registration requirements, or is a graduate of a baccalaureate degree program with major studies in food service

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455278	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Knopp Healthcare and Rehab Center Inc	1208 N Llano Fredericksburg, TX 78624

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations, interviews and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 facility's reviewed for safe and functioning equipment in the laundry department. The facility had 3 commercial clothes washers with one of the three inoperable. The facility had 4 commercial clothes dryers with one of the four in-operable. This failure could place residents at risk for neglect by not having laundry services. The findings included: A record review of the facility's Resident census report dated 1/6/2026 revealed a census of 56 residents. A record review of the facility's Facility Assessment dated 8/12/2025 revealed, The purpose of this assessment is to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. Scope: this assessment addresses the following elements: the facility's Resident population, including but not limited to: the number of residents and the facility's Resident capacity. Licensed beds 119 . physical resources . laundry building . During an observation and interview on 1/7/2026 at 8:00 AM revealed the facility's laundry department had 3 commercial clothes washers and 4 commercial clothes dryers. One of the 3 commercial clothes washer was not in service and one of the four commercial clothes dryers was not in service. The Laundry Services Manager (LSM) stated she had been the LSM for the last year and during that time One of the 3 commercial clothes washer was not in service and one of the four commercial clothes dryers was not in service. The LSM stated laundry services were being provided for the 50-60 average census of residents, however the facility had a license for 119 and if the facility were to receive more residents the laundry services may not be accommodated without the in-operable equipment. A policy review was requested from the Administrator on 1/7/2026 at 9:51 AM and as of 1/15/2026 a policy was not provided prior to exit.