STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455069	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baylor Scott & White Continuing Care Hospital Skil	2401 South 31st St Temple, TX 76504

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which included measurable objectives and timeframes to meet resident's medical, nursing, and psychological needs for 3 of 6 residents (Resident #2, #7, and #32) reviewed care plans. The facility's failed to include that resident had a PEG tube in Resident #32's (08/21/2025) comprehensive care plan. The facility failed to include that resident had a foley catheter in Resident #2's (07/29/2025) and Resident #7's comprehensive care plan.This failure could place residents at risk for not receiving necessary care and services or having important care needs identified and met. Findings included: Record review of Resident #32's face sheet dated 08/21/25 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #32 had a diagnosis of aspiration pneumonia (a lung infection that develops from inhaling foreign substances like food, liquids, or stomach contents into the lungs.) Record review of Resident #32's admission MDS assessment dated [DATE], reflected that Resident #32 had a BIMS score of 09 which reflected the resident was moderately cognitively impaired. Resident #32's admission MDS assessment reflected that the resident had a feeding tube - nasogastric or abdominal (PEG) while a resident. Record review of Resident #32's Physician's Orders, dated 08/21/25, reflected the resident had an order initiated on 08/08/25 for: Feeding Tube Irrigation: 30 ml; per Feeding Tube Every 4 hours. Comments: Manually irrigate with additional 60 ml appropriate water type every 12 hours unless otherwise ordered by provider. Notify provider if tube gets occluded. For irrigation only. Record review of care plan dated 08/21/2025 reflected Resident #32 had not been care planned for having a PEG tube or enteral tube. In an observation and interview on 08/19/2025 at 10:43 AM Resident #32 was in bed and fall mats were placed on floor. Resident #32's call light was in reach. Resident # 32 awakened to name call but appeared very tired. Resident #32 answered that he was ok and that the staff all took good care of him. Resident #32 then went back to sleep. Resident #32 appeared clean and groomed and was in no sign of pain or distress. In an observation on 08/19/2025 at 10:57 AM, Resident #32's g-tube site was cleansed, and the dressing was changed by a staff member. No concerns were noted. Record review of Resident #2's face sheet, dated 08/21/25, reflected a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included physical debility, hypertension (high blood pressure), type 2 diabetes mellitus (a chronic condition characterized by high blood sugar levels), chronic kidney disease, intractable pain - chronic (constant pain). Record review of Resident #2's admission MDS assessment, dated 08/05/25, Section C reflected a BIMS score of 15 which indicated intact cognition. Section H reflected the resident had an indwelling catheter. Section V reflected Urinary Incontinence and Indwelling Catheter was triggered, and the decision to care plan was marked as yes. Record review of Resident #2's comprehensive care plan, initiated on 07/29/25, reflected the indwelling urinary catheter was not addressed. Record review of Resident #2's physician order, dated 07/29/25, reflected, Indwelling urinary catheter (Adult Insert and Maintain Indwelling Urinary Catheter Panel) Continuous Patient: Adult Indication (s): Acute urinary retention or bladder obstruction. Discontinue indwelling urinary catheter and order: Do not remove. Call provider when patient no longer meets criteria. An observation and interview on 08/19/25 at 11:56 AM, revealed Resident #2 sitting up in a chair, next to the bed, in her room. A catheter drainage bag hanging from the bed frame was observed. The urine in the bag was clear yellow. Resident #2 stated the staff provided catheter care regularly and she did not recall a recent urinary tract infection. Record review of Resident #7's face sheet dated 08/21/25 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #7 had diagnoses which included: acute hypoxic respiratory failure (a sudden and life-threatening condition where blood oxygen levels are dangerously low, often due to lung injury) and acute kidney injury (the sudden decrease in the kidneys' ability to filter waste and balance fluids, often due to infections, blood loss, dehydration, or certain medications). Record review of Resident #7's admission MDS assessment dated [DATE], reflected that Resident #7 had a BIMS score of 05 which reflected the resident was severely cognitively impaired. Resident #7's admission MDS assessment reflected that the resident had an indwelling catheter (including suprapubic catheter and nephrostomy tube). Record review of Resident #7's Physician's Orders, dated 08/21/25, reflected the resident had an order initiated on 08/07/25 for: Indwelling urinary catheter (Adult Insert & Maintain Indwelling Urinary Catheter Panel) Continuous. Record review of care plan dated 08/21/2025 reflected Resident #7 had not been care planned for having a foley catheter. In an observation