STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455549	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jourdanton Nursing and Rehabilitation	1504 Highway 97e Jourdanton, TX 78026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated and report the results of all investigations to the state survey agency within five working days of the incident for 5 (Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6) of 8 residents reviewed for abuse and neglect. The facility failed to thoroughly investigate 4 separate facility reported incidents involving Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 within five (5) days regarding allegations of abuse or neglect and submit a 3613-A of the findings. This deficient practice could place residents at risk of harm from neglect due to not having a thorough investigation done for facility reported incidents. The findings included. 1. Record review of Resident #2’s face sheet dated 7/10/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included severe protein-calorie malnutrition, lack of coordination, contracture to right and left knee, pain, muscle wasting, muscle weakness, unsteadiness of feet, fracture of the right foot, and need for assistance with personal care. Record review of Resident #2’s most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, required substantial/maximal assistance with transfers and was always incontinent of bowel and bladder. Record review of Resident #2’s comprehensive care plan with revision date 8/13/24 revealed the resident was impaired with physical functioning related to muscle weakness with interventions that included substantial/maximal assistance with transfers, and partial/moderate assistance with rolling left to right. During an observation and interview on 7/8/25 at 11:01 a.m., Resident #2 stated she reported to a family member about CNA C being rough with her when the CNA tried to reposition her while in bed. Resident #2 stated her family member reported the complaint to the former SW (Social Worker). Resident #2 stated, CNA C “would turn me over, and I would hit the wall.” Resident #2’s bed was placed up against the wall on the right side of the bed and a large piece of padded foam was observed covering the right side of the wall. Resident #2 stated the padded foam was placed on the right of the bed against the wall because CNA C would turn her and her legs, which were contracted and bent at the knee, “would bang her against the wall.” Resident #2 stated the former Administrator had informed her that he had talked to CNA C about the incident, had moved her to another hall, but then CNA C stopped working a short time later. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/9/25 at 1:18 p.m., CNA C stated she had provided care to Resident #2 on several occasions and recalled being suspended because Resident #2 had accused her of hitting the resident’s legs against the wall when repositioning. CNA C stated, Resident #2 never complained to her about it and denied the allegation. During an interview on 7/9/25 at 1:27 p.m., the former SW stated she interviewed Resident #2 regarding the allegation that CNA C had hit her knees against the wall and the former SW then reported the incident to the former Administrator. The former SW stated she recalled doing interviews with other residents regarding abuse/neglect as part of the investigation but then the former Administrator and the former DON took over after that. During an interview on 7/10/25 at 3:47 p.m., the ADON stated the former Administrator at the time made himself in charge of doing the investigation portion that would have been submitted to the State Survey Agency. The ADON stated there was no documentation showing an investigation had been done for the incident involving Resident #2 and CNA C, reported on 1/26/25. 2. Record review of Resident #3’s face sheet, dated 7/9/25, revealed a [AGE] year-old male resident admitted on [DATE] and discharged on 2/17/25 with diagnoses of encounter for surgical aftercare following surgery on the nervous system (his back), partial traumatic amputation of two or more right lesser toes (two toes were surgically removed), type 2 diabetes mellitus with unspecified complications (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. Insulin is a hormone that regulates blood glucose.), intraspinal abscess (collection of pus and infectious material in the spine, often resulting from a bacterial infection) and granuloma (localized area of inflammation that forms around an infection often as a response to the immune system’s attempt to clear the infection), depression, osteomyelitis of vertebra- thoracolumbar region (an infection of the vertebrae in the spine), discitis (inflammation or infection that develops between the intervertebral discs of your spine), spondylosis without myelopathy or radiculopathy (degeneration of the vertebral column), schizophrenia (a chronic mental health condition characterized by symptoms of hallucinations (seeing or hearing things that are not there), delusions (false beliefs), disorganized thinking, and difficulty distinguishing reality from imagination.), and methicillin susceptible staphylococcus aureus infection (a type of bacterial infection caused by staphylococcus aureus). Record review of Resident #3’d discharge MDS assessment, dated 2/17/25, revealed the resident memory was severely impaired for daily decision making. Record review of Resident #3’s admission and baseline care plan/summary, dated 2/13/25, revealed the Resident had an IV PICC to the left arm and had staples on his back from prior surgery. Record review of Resident #3’s comprehensive care plan, dated 7/9/25, revealed he had impaired cognitive function process related to disease process with interventions to monitor/document/report physician changes in cognitive function, specifically changes in: a) decision making ability b) memory, recall and general awareness c) difficulty expressing self d) difficulty understanding others e) level of consciousness f) mental status, and notify the physician with an initiated date of 2/20/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3’s physician orders, dated 7/9/25, revealed an order for Cefazolin sodium injection solution reconstituted 2 grams, use 2 grams intravenously three times a day related to methicillin susceptible staphylococcus aureus infection until 5/2/25 to be given three times a day for 11 weeks. The order had a started date of 2/14/25 and an end date of 5/2/25. Record review of Resident #3’s February MAR, dated 7/9/25, revealed an order for Cefazolin three times a day. The MAR reflected the following administration records: -2/13/25 the 6 p.m.-10 p.m. dose was missed (order not entered until 2/14/25 at 3:15 p.m.) -2/14/25 the 6 a.m.- 10 a.m. dose was missed (order not entered until 2/14/25 at 3:15 p.m.) -2/14/25 the 2 p.m.- 6 p.m. dose was administered (not documented on the MAR but in a late entry nursing note on 2/17/25) -2/14/25 the 6 p.m.-10 p.m. dose was missed (pulled PICC line) -2/15/25 the 6 a.m.- 10 a.m. dose was missed -2/15/25 the 2 p.m.- 6 p.m. dose was administered -2/15/25 the 6 p.m.- 10 p.m. dose was administered -2/16/25 the 6 a.m.- 10 a.m. dose was administered -2/16/25 the 2 p.m.- 6 p.m. dose was administered -2/16/25 the 6 p.m.-10 p.m. dose was missed (pulled PICC line) Record review of nursing progress notes, dated 7/9/25 revealed the following notes: -2/14/25 at 5:30 p.m., written by LVN D, stated “resident is not cooperating staying in his chair or bed. he keeps trying to get up from chair and is rolling around everywhere. CNA tried to adjust him for him to feel comfortable but still is not cooperative” -2/14/25 at 10:38 p.m., written by LVN E, stated “resident pulled his PICC line out earlier, pending new insertion, no IV access at this time”. -2/15/25 at 1:19 p.m., written by LVN B, stated “Picc line placed to Left Upper Arm resident tolerated procedure well no complications or complaints. Pending x-ray results to verify placement to start IV medication.” -2/16/25 at 12:14 p.m., written by RN F, stated “… [Resident #3] continues to be confused and forgetful. Has attempted x1 to remove PICC, was stopped prior to removing bandage, PICC in place, bandage reinforced. He is able to feed himself but continues to try and transfer himself but is unable to (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stand well even with x2 staff full assist. He removes his clothing, brief and bed sheets/linen repeatedly. No s/s of pain or distress. States . who put me here. Call light within reach, however [Resident #3] does not appear to be able to use it appropriately as indicated by unclipping it and throwing on floor along with everything else. Staff continues to monitor.” -2/16/25 at 7:08 p.m., written by LVN B, stated “Resident continuously found hanging head off the side off the bed and legs/feet bed in lowest position against wall with fall mat in place. Resident pulled blinds completely off window and was trying to eat the pieces he pulled off. Resident cannot use call light or bed remote properly cords found wrapped around his arms.” -2/16/25 at 9:16 p.m., written by LVN B, stated “Notified by cna resident was in bed blood noted on sheets upon assessment midline had been pulled out and resident covered in fresh feces resident noted to be eating feces. ADON notified via text PCP paged. Midline found behind the bed line intact resident arm clean dry no bleeding noted.” -2/16/25 at 9:59 p.m., written by LVN B, stated “resident pulled midline out”. -2/17/25 at 12:58 p.m., written by LVN D, stated “resident threw sweet tea at the window and started to lick it off from it. reoriented resident and offer him a new drink” -2/17/25 at 1:23 p.m., written by LVN D, stated “called hosipital [sic] Atascosa to give report but no answer from the hospital x3” During an interview on 7/10/25 at 1:30 p.m. LVN B stated the couple of times she had worked with Resident #3 he had behaviors of trying to get out of bed, playing with his feces, trying to eat the blinds, and pulling his PICC line. LVN B stated she made the ADON and provider aware of the resident’s status. LVN B stated she was not the nurse who did the admission assessment for Resident #3 and was not aware of what his admission orders were. LVN B stated since then they used an admission check list form to track and communicate new admission orders. During an interview on 7/9/25 at 3:33 p.m. the ADON stated the previous Administrator had reported on 2/14/25 facility failed to notify MD that resident pulled out midline resulting in non-administration of meds. No hold order was obtained; no documentation obtained for monitoring the midline. Resident sent to hospital for assessment to the state. The ADON stated they did not have any investigation reports for this self-report. The ADON stated they had done several in-services over the incident because LVN D never in put the order for the antibiotic on admission. The ADON stated she entered the order herself the on 2/14/25. The ADON stated they also implemented the use of a new check list form since the incident. The ADON stated LVN D no longer worked for the facility and was terminated due to another med error. 3. Record review of Resident #4’s face sheet, dated 7/10/25, revealed a [AGE] year-old male resident admitted on [DATE] and readmitted on [DATE]. with diagnoses of hypo-osmolality and hyponatremia (lower than normal concentrations of solutes leading to low sodium levels in the blood), polydipsia (excessive thirst), and vascular dementia (cognitive impairment resulting from conditions that affect blood flow to the brain) with other behavioral disturbance. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of review of Resident #4’s quarterly MDS assessment, dated 6/18/25, revealed he had moderately impaired cognition for daily decision making. Record review of Resident #4’s care plan, revised 4/8/25, stated “I have angry outbursts at times when I don't get the response that I am seeking. I rummage through belongings that are not mine. I layer my clothing and take things that do not belong to me. At times I am observed having auditory and visual hallucinations. Resident to Resident: I pushed another resident and caused skin tears to arm.” Interventions included document behaviors, psych eval and medication review, refer to behavior health as needed, staff to explain care prior to and during process of care, staff to involve family as necessary to assist with behavioral management, and staff to redirect resident to other activities. Record review of Resident #5’s face sheet, dated 7/10/25, revealed an [AGE] year-old made resident admitted on [DATE], readmitted on [DATE], and discharged on 6/5/25 with diagnoses of chronic obstructive pulmonary disease (damage to the lungs leading to swelling and irritation in the airways that restrict airflow), type 2 diabetes (when the body cannot use insulin correctly and sugar builds up in the blood), and vascular dementia with other behavioral disturbances (cognitive impairment resulting from conditions that affect blood flow to the brain). Record review of Resident #5’s significant change MDS assessment, dated 5/6/25, revealed the resident cognition was severely impaired for daily decision making. Record review of Resident #5’s care plan, last revised 6/9/25, revealed the resident had potential for skin related issues related to poor hygiene, decreased mobility, squamous cell carcinoma of skin of scalp and neck (skin cancer), and bullous pemphigoid (rare skin condition that causes large fluid filled blisters), with intervention to provide wound care/ preventative skin care per order, skin checks weekly per facility protocol, document findings, treatment as ordered an x-ray to arm, and wound care consultation to evaluate and treat. Record review on 7/9/25 at 1:55 p.m. revealed an intake was submitted to the state agency reporting Resident #4 shoved Resident #5 on 2/13/25. No provider investigation report was available. During an interview on 7/9/25 at 3:14 p.m. the ADON stated the only documents they had related to this investigation was an in service. The ADON stated the previous Administrator was handling the self-reports. The ADON stated during the altercation Resident #4 pushed Resident #5 with his hands. Resident #5 already had skin tears on his arms that had scabbed over but reopened when he was pushed. The ADON stated the Residents were separated and monitored after. The ADON stated Resident #4 had more health-related issues recently and mostly used a wheelchair to ambulate and was no longer aggressive towards other residents. At the time of the interview Resident #4 was in the hospital for an unrelated health issue. 4. Record review of Resident #6’s face sheet, dated 7/10/25, revealed an [AGE] year-old made resident admitted on [DATE], readmitted on [DATE], with diagnoses of major depressive disorder single episode, legal blindness, anxiety disorder, post-traumatic stress disorder, attention and concentration deficit, and unspecified mood [affective] disorder. Record review of Resident #6’s Annual MDS assessment, dated 6/15/25, revealed the resident cognition was severely impaired for daily decision making. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6’s care plan, last revised 4/8/25, revealed the “I get nervous and anxious at times. I repeatedly state help me even after staff have attempted to reassure me that I am okay. When asked what is wrong, I typically respond I don't know. I report symptoms of depression (feeling down, little pleasure in doing things, poor concentration, poor appetite, difficulty sleeping, feeling bad about myself) and sometimes relate them to experiences from my past.” Interventions included call resident by name, if upset redirect the conversation or task, offer things that are soothing, and avoid things that make the resident more anxious. Record review on 7/9/25 at 1:55 p.m. revealed an intake was submitted to the state agency reporting Resident #6 reported a staff member struck him in the face with an open hand on 1/31/25. Resident refused to provide a name of the staff member. No provider investigation report was available. During an interview on 7/10/25 at 7:21 p.m. Resident #6 stated something happened about 6 months ago but he did not want to talk about it. Resident #6 stated he felt safe at the facility. Resident #6 then stopped answering question and pursed his lips. During an interview on 7/9/25 at 3:12 p.m. the ADON stated they did not have any investigation reports related to the incident with Resident #6. The ADON stated she did recall they had done resident safe interviews but could not locate them. The ADON stated the resident reported this incident to his behavior health therapist. The ADON stated the resident is blind and provided a physical description of the alleged perpetrator but there was not staff that fit the description. The ADON stated they had the resident listen to staff who worked the day voices, and he denied it was any of those staff members. The ADON stated a full body assessment was done, and the resident had no marks. During a follow up interview on 7/10/25 at 6:09 p.m., the ADON stated she had contacted the former Administrator and was told he left all the facility investigation reports in the current Administrator’s office. The ADON stated the current Administrator was looking for the reports in the office but could not find them and were not made available to the survey team at the time of exit. The ADON was unfamiliar with official reporting requirements to the state. Record review of the facility document titled, Abuse Prevention Program, dated 2022 revealed in part, “…Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to…verbal, mental, sexual or physical abuse…As part of the resident abuse prevention, the administration will…Protect our residents from abuse by anyone including…staff, other residents, or any other individual…Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents…Implement measures to address factors that may lead to abusive situations…Identify and asses all possible incidents of abuse…Investigate and report any allegations of abuse within timeframes as required by federal requirements…”

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 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 interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #3) of 3 residents reviewed for pharmacy services. The facility failed to ensure staff timely acquired and administered Resident #3's cefazolin (antibiotic used to treat and prevent bacterial infections. It is administered intravenously) per physician orders on 2/13/25 and 2/14/25. The failure could place residents at risk for exacerbation of health conditions, worsening of conditions, and physical/emotional discomfort. Findings included:Record review of Resident #3's face sheet, dated 7/9/25, revealed a [AGE] year-old male resident admitted on [DATE] and discharged on 2/17/25 with diagnoses of encounter for surgical aftercare following surgery on the nervous system (his back), partial traumatic amputation of two or more right lesser toes (two toes were surgically removed), type 2 diabetes mellitus with unspecified complications (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. Insulin is a hormone that regulates blood glucose.), intraspinal abscess (collection of pus and infectious material in the spine, often resulting from a bacterial infection) and granuloma (localized area of inflammation that forms around an infection often as a response to the immune system's attempt to clear the infection), depression, osteomyelitis of vertebra-thoracolumbar region (an infection of the vertebrae in the spine), discitis (inflammation or infection that develops between the intervertebral discs of your spine), spondylosis without myelopathy or radiculopathy (degeneration of the vertebral column), schizophrenia (a chronic mental health condition characterized by symptoms of hallucinations (seeing or hearing things that are not there), delusions (false beliefs), disorganized thinking, and difficulty distinguishing reality from imagination.), and methicillin susceptible staphylococcus aureus infection (a type of bacterial infection caused by staphylococcus aureus). Record review of Resident #3'd discharge MDS assessment, dated 2/17/25, revealed the resident memory was severely impaired for daily decision making. Record review of Resident #3's admission and baseline care plan/summary, dated 2/13/25, revealed the Resident had an IV PICC to the left arm and had staples on his back from prior surgery. Record review of Resident #3's comprehensive care plan, dated 7/9/25, revealed he had impaired cognitive function process related to disease process with interventions to monitor/document/report physician changes in cognitive function, specifically changes in: a) decision making ability b) memory, recall and general awareness c) difficulty expressing self d) difficulty understanding others e) level of consciousness f) mental status, and notify the physician with an initiated date of 2/20/25. Record review of Resident #3's physician orders, dated 7/9/25, revealed an order for Cefazolin sodium injection solution reconstituted 2 grams, use 2 grams intravenously three times a day related to methicillin susceptible staphylococcus aureus infection until 5/2/25 to be given three times a day for 11 weeks. The order had a started date of 2/14/25 and an end date of 5/2/25. Record review of Resident #3's February MAR, dated 7/9/25, revealed an order for Cefazolin three times a day between 6 a.m.-10 a.m., 2 p.m.-6p.m., and 6p.m. -10 p.m. The MAR reflected the following administration records: -2/13/25 the 6 p.m.-10 p.m. dose was missed (order not entered until 2/14/25 at 3:15 p.m.)-2/14/25 the 6 a.m.- 10 a.m. dose was missed (order not entered until 2/14/25 at 3:15 p.m.) Record review of Resident #3's hospital #1's discharge paperwork, dated 2/12/25, reveled he needs to be on IV antibiotics 12 weeks followed by long-term oral antibiotics . Record review of Resident #3's hospital #2 admission record, dated 2/17/25, did not reveal much information and only stated AMS altered mental status under the stated complaint. Record review of Resident #3' hospital #3 admission record, dated 2/17/25, stated [Resident #3] . a significant past medical history of: Diabetes mellitus type 2, hypertension, hyperlipidemia, iron deficiency anemia, schizophrenia, infectious disease with osteomyelitis on the right foot toes. Patient who presents as a transferred from the outlying [Hospital 1] for higher level of care due to complaints of altered mental status and worsening of back pain, no history on note and patient is encephalopathy (broad term for any disease or disorder that affects the brain's function or structure. It can result from various causes including infections, toxins, metabolic issues, or lack f oxygen) unable to provide any history.At the initial evaluation the patient appears: confused, hypoxic (inadequate levels of oxygen in the tissues and cells of the body), somnolent (sleepy or drowsy). recommendation will be observation admission for medical management and evaluation.Hx Obtained From Prior medical records. During an interview on 7/10/25 at 1:30 p.m. LVN B stated the couple of times she had worked with Resident

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 2 of 6 residents (Residents #1 and Resident #3) reviewed for medical records. 1. The facility failed to ensure Resident 1's use of a wander guard (electronic monitoring device) was accurately documented on the TAR (Treatment Administration Record). 2. The facility failed to ensure the ADON documented the administration of Resident #3's cefazolin (antibiotic used to treat and prevent bacterial infections. It is administered intravenously.) at the time of administration on the MAR. This deficient practice could place residents at risk of delayed or improper care due to inaccurate medical records.The findings included: 1.Record review of Resident #1’s face sheet dated 7/8/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included senile degeneration of brain (age-related deterioration of brain tissue and function), schizoaffective disorder (chronic mental health condition characterized by a combination of hallucinations or delusions and mood), need for assistance with personal care and Alzheimer’s disease (a progressive brain disorder that gradually destroys memory, thinking skills, and the ability to carry out simple tasks). Record review of Resident #1’s most recent comprehensive MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills, required substantial/maximal assistance with transfers, utilized a wheelchair and utilized a wander/elopement alarm. Record review of Resident #1’s comprehensive care plan with revision date 7/8/25 revealed the resident had wandering behaviors and had been seen near exit doors but had a wander guard in place. Review of Resident #1’s comprehensive care plan revealed the resident was at risk for injury related to wandering behavior with interventions that included the use of the wander guard, and when the resident was observed wandering to re-direct to another activity. Record review of Resident #1’s Order Summary Report dated 7/9/25 revealed the following: - Signaling Device: Change electronic monitoring device according to manufacturer's recommendations and as needed if noted non-functional, every shift with order date 6/24/25 and no end date. - Signaling Device: Check electronic monitoring device via testing machine every day, every shift, with order date 4/29/25 and no end date. - Signaling Device: Visually check electronic monitoring device every shift for Elopement risk, with order date 4/29/25 and no end date. - Skin monitoring - Monitor skin at the site of Wander guard device and surrounding area for any redness, bruising, swelling, circulation issues, and/or any breakdown. Report. If Observed Skin Integrity Changes, Notify ADON/DON, Provider, and Change Placement of Wander guard every shift, with order date 6/20/25 and no end date. Record review of Resident #1’s TAR for July 2025 revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455549	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jourdanton Nursing and Rehabilitation	1504 Highway 97e Jourdanton, TX 78026

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LVN A documented the resident was visually checked during the 7:00 p.m. to 7:00 a.m. shift on 7/9/25 and documented the resident was wearing the electronic monitoring device on the right upper extremity. - LVN B documented the resident was visually checked during the 7:00 a.m. shift to 7:00 p.m. shift on 7/10/25 and documented the resident was wearing the electronic monitoring device on the right upper extremity. During an observation and interview on 7/9/25 at 8:27 a.m., Resident #1 would not acknowledge or confirm he had used a wander guard. Resident #1 was not observed wearing a wander guard on his person and the wander guard was not seen on the wheelchair he was sitting on. During an observation and interview on 7/10/25 at 10:27 a.m., LVN B stated Resident #1 was not wearing the wander guard because the resident had “ripped it off.” LVN B stated she knew Resident #1 was not wearing the wander guard since last night, 7/9/25 because the night shift nurse, LVN A had given the wander guard to her at shift change. LVN B stated she had marked on Resident #1’s TAR that the resident was seen wearing the wander guard, but stated, “I wasn’t really paying attention, I’ll go back and fix it.” LVN B stated, because she had documented Resident #1 was visually seen wearing the wander guard but was not, was considered false documentation and could have resulted in the resident eloping and nobody knowing about it because he was not wearing the wander guard. An attempt at a telephone interview on 7/10/25 at 10:51 a.m. with LVN A was unsuccessful. During an interview on 7/10/25 at 4:17 p.m., the DON stated, Resident #1 was considered an elopement risk and had to wear a wander guard. The DON stated LVN B should not have documented Resident #1 was wearing the wander guard because it was false documentation. The DON stated since she had only been employed by the facility for less than a month, she had implemented an in-service for the wander guard system due to inconsistencies. The DON stated, in the event the wander guard was not in place, the facility was supposed to be putting the resident on 15-minute checks until the wander guard was replaced. The DON stated, if the nurse documented the resident had the wander guard on when he didn’t, the resident could elope, and nobody would know about it and the resident could get hurt. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #3’s face sheet, dated 7/9/25, revealed a [AGE] year-old male resident admitted on [DATE] and discharged on 2/17/25 with diagnoses of encounter for surgical aftercare following surgery on the nervous system (his back), partial traumatic amputation of two or more right lesser toes (two toes were surgically removed), type 2 diabetes mellitus with unspecified complications (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. Insulin is a hormone that regulates blood glucose.), intraspinal abscess (collection of pus and infectious material in the spine, often resulting from a bacterial infection) and granuloma (localized area of inflammation that forms around an infection often as a response to the immune system’s attempt to clear the infection), depression, osteomyelitis of vertebra- thoracolumbar region (an infection of the vertebrae in the spine), discitis (inflammation or infection that develops between the intervertebral discs of your spine), spondylosis without myelopathy or radiculopathy (degeneration of the vertebral column), schizophrenia (a chronic mental health condition characterized by symptoms of hallucinations (seeing or hearing things that are not there), delusions (false beliefs), disorganized thinking, and difficulty distinguishing reality from imagination.), and methicillin susceptible staphylococcus aureus infection (a type of bacterial infection caused by staphylococcus aureus). Record review of Resident #3’d discharge MDS assessment, dated 2/17/25, revealed the resident memory was severely impaired for daily decision making. Record review of Resident #3’s admission and baseline care plan/summary, dated 2/13/25, revealed the Resident had an IV PICC to the left arm and had staples on his back from prior surgery. Record review of Resident #3’s comprehensive care plan, dated 7/9/25, revealed he had impaired cognitive function process related to disease process with interventions to monitor/document/report physician changes in cognitive function, specifically changes in: a) decision making ability b) memory, recall and general awareness c) difficulty expressing self d) difficulty understanding others e) level of consciousness f) mental status, and notify the physician with an initiated date of 2/20/25. Record review of Resident #3’s physician orders, dated 7/9/25, revealed an order for Cefazolin sodium injection solution reconstituted 2 grams, use 2 grams intravenously three times a day related to methicillin susceptible staphylococcus aureus infection until 5/2/25 to be given three times a day for 11 weeks. The order had a started date of 2/14/25 and an end date of 5/2/25. Record review of Resident #3’s February MAR, dated 7/9/25, revealed an order for Cefazolin three times a day. The MAR reflected there was no documentation for the administrator of the medication on 2/14/25 for the 2:00 p.m.- 6:00 p.m. dose. Record review of nursing progress notes, dated 7/9/25 revealed a note written by the ADON on 2/17/25 at 6:18 p.m. for 2/14/25 at 3:16 p.m. which stated “cefazolin 2g given over 5 min slow push in L brachial via midline, flushed with 10 mlns [sic] slow push”. During an interview on 7/10/25 at 1:30 p.m. LVN B stated she was not the nurse who did the admission assessment for Resident #3 and was not aware of what his admission orders were. LVN B stated since then the facility implemented the use of an admission check list form to track and communicate new admission orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/25 at 3:33 p.m. the ADON stated she entered the order herself the on 2/14/25. The ADON stated she discovered on 2/14/25 that LVN D had not input the order for the resident’s IV antibiotic. The ADON stated LVN D told her she had questions about the order and the administration of the medication. The ADON stated she put the order in and ordered the antibiotic from the pharmacy. The ADON stated she then went to the automated medication dispensing system, pulled the medication from their back up supply, and administered it. The ADON stated she forgot to document the medication had been at administered on 2/14/25 at 3:16 p.m. The ADON stated she documented it on 2/17/25 at 6:18 p.m. in a nursing note. The ADON stated she should have documented on the MAR at the time she administered the medication as proof she gave it. The ADON stated if you do not document at the time of administration the resident could receive a 2nd dose from another nurse who was not aware the resident already received the medication. Record review of the facility’s policy titled “Resident Alarms”, dated 6/10/25, stated “it is the policy of this facility to utilize resident alarms in limited circumstances, in accordance with resident needs, goals, and preferences, so the resident would be able to attain his or her highest practical level of physical, mental, and psychosocial well-being… policy explanation and compliance guidelines: 1. The use of alarms does not eliminate the need for adequate supervision of the resident. Types of alarms include…e. Wander/ elopement alarms- includes devices such as bracelets, pins/ buttons worn on the resident’s clothing, sensors in the shoes, or building/unit exit sensors worn/attached to residents that alert the staff when residents nears or exits an area or the building. This includes devices that are attached to the residence assisted devices…6. Monitoring and modification…b. when alarms are utilized, additional monitoring shall be provided, including but not limited to: i. Verifying alarms are used in accordance with the resident’s care plan. ii. Verifying alarms are working properly at least once per shift, per facility protocol…” Record review of the facility’s policy titled “Medication Administration”, dated 5/7/25, stated “…Policy Explanation and Compliance Guidelines…11. Review MAR to identify medication to be administered. 12. Compare medication source…with MAR to verify resident name, medication name, form, dose, route, and time .17. Administer medication as ordered in accordance with manufacturer specifications…20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR…”