| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455549 | A. Building<br>B. Wing | 11/21/2025 |

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

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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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of their personal and medical records for 1 of 1 resident (Resident #11) reviewed for resident rights. The facility failed to ensure CNAs H and I completely closed Resident #11's privacy curtain while providing perineal care for the resident. This deficient practice could place residents at risk of loss of dignity.The findings were: Record review of Resident #11's face sheet, dated 11/21/2025, revealed an admission date of 12/03/2014, and a readmission date of 10/19/2020. Resident #11 had diagnoses which included: Vascular dementia (decline in cognitive abilities), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Hypertension (High blood pressure), Type 2 diabetes mellitus (high level of sugar in the blood), and Irritable bowel syndrome (chronic disorder affecting the large intestine, causing symptoms like abdominal pain, bloating, gas, constipation, or diarrhea) Record review of Resident 11's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 09, which indicated moderate cognitive impairment, and was indicated to always be incontinent of bowel and bladder. Record review of Resident 11's care plan, dated 09/26/2025, revealed a problem of Impaired Skin Integrity related to history of excoriation on the scrotum due to moisture, friction, or incontinence and an intervention of Maintain proper incontinence care. Observation on 11/20/2025 at 6:33 a.m. revealed CNAs H and I provided incontinent care for Resident #11. During care CNAs H and I did not pull the curtain to offer privacy to the resident. Resident #11 could be seen by his roommate and could have been seen by someone opening the room's door. During an interview with CNAs H and I on 11/20/2025 at 6:35 a.m., CNAs H and I stated the privacy curtain was not closed while they provided care for Resident #11 but should have been. They stated they were nervous and had forgotten. CNAs H and I stated they received resident rights training from the DON within a year. During an interview with the DON on 11/20/2025 at 7:11 a.m., the DON stated privacy must be provided during nursing care and Resident #11's privacy curtain should have been closed completely to prevent loss of dignity for the resident. She stated the staff received resident rights training within the year and skills were checked annually and as needed. Record review of the facility's policy titled, Resident rights dated 2025, revealed, The resident had a right to personal privacy and confidentiality [ .] Personal privacy includes accommodations, medical treatment [ .]. |

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 |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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 the assessment accurately reflected the resident's status for 1 of 4 residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure Resident #1 was coded for a fall with injury that occurred on 09/04/2025, on his admission MDS assessment, signed as completed on 9/11/2025. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: Record review of Resident #1's admission Record, dated 11/18/2025, reflected a [AGE] year-old male. He was admitted to the facility on [DATE]. Record review of Resident #1's Diagnosis Report, dated 11/18/2025, reflected diagnoses included encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor, or stroke), intracranial injury (an injury to the brain caused by an external force) with loss of consciousness of unspecified duration, and dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #1's Fall Assessment-Post Incident, dated 09/04/2025 by LPN A, reflected under reason for assessment, Recent Falls. Resident #1 was noted to have no history of falls, having had agitated behavior occur daily or more, having been confined to a chair and disoriented, and required hands-on assistance to move from place to place. Record review of Resident #1's Post Event Head to Toe Skin Check, dated 09/04/2025 by LPN A, reflected Resident #1 had a superficial pink abrasion on his left iliac crest (pelvic bone). Record review of Resident #1's admission MDS Assessment, dated 09/08/2025 and signed as completed on 09/11/2025, by the MDS Nurse, reflected assessment observation end date of 09/08/2025. Resident #1 had a BIMS score of 08, which indicated he was moderately cognitively impaired. Under Any Falls Since Admission/Entry or Reentry or Prior Assessment, Resident #1 was coded as having had a fall but with no injury since admission/entry or reentry or the prior assessment. The section for fall history was noted to have been signed as completed by the MDS Nuse. Record review of Resident #1's Care Plan Report, dated as last care plan review completed 09/26/2025, reflected Falls: At Risk for falls related to unsteady gait, date initiated 09/11/2025, and revised on 09/12/2025. Interventions included Call light within reach and Place frequently used items within reach, date initiated 09/04/2025. Record review of the facility report Incidents By Incident Type, dated 11/18/2025, for date range 09/01/2025 to 09/30/2025, reflected Resident #1 had an unwitnessed fall incident on 09/04/2025 at 04:50 p.m. During an observation and attempted interview on 11/19/2025 at 01:57 p.m., Resident #1 was observed sitting in his wheelchair with his side table and his call light within reach. Resident #1 did not respond when attempting to interview. During an interview on 11/19/2025 at 02:21 p.m., Resident #1's family member stated he was contacted regarding Resident #1's fall. Resident #1 stated he had no concerns regarding Resident #1's care or treatment. During an interview on 11/20/2025 at 10:28 a.m., the MDS Nurse stated when completing the MDS Assessments, she reviewed a resident's fall assessment and post head-to-toe assessment to determine if a resident had an injury due to a fall. She stated the only reason an injury could have been missed was if it was not in the assessment. The MDS Nurse stated an error on the MDS Assessment would not necessarily impact the resident's care if there was an order to observe or treat the injury. During an interview on 11/20/2025 at 12:56 p.m., the DON stated she would not imagine an error on the MDS Assessment would impact a resident's care. She stated the nursing staff did not look at the MDS Assessment for provision of care. They would look at the orders. During an interview on 11/20/2025 at 01:47 p.m., the ADMIN stated an error on the MDS Assessment would not impact Resident #1's care. She stated the facility staff would look at the doctor's orders and previous documentation on how they should be caring for the resident. She stated the nurses and CNAs did not look at the MDS Assessments. Record review of the facility's policy, Documentation in Medical Record, dated as Copyright 2024, reflected: Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #2) reviewed for quality of care. The facility failed to complete weekly skin assessment for Resident #2 for 2 out of 10 weeks (week of 9/24/2025 and week of 11/06/2025) per the care plan and facility policy. This failure could place residents at risk of not receiving necessary medical care, harm, and hospitalization. The findings included: Record review of Resident #2's admission Record, dated 11/18/2025, reflected a [AGE] year-old male. He was admitted on [DATE]. Record review of Resident #2's Diagnosis Report, dated 11/18/2025, reflected diagnoses which included encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor, or stroke), acute (quickly has become severe) cholecystitis (the swelling and irritation or inflammation of the gallbladder), and sepsis (a condition in which the body's extreme response to an infection become life-threatening). Record review of Resident #2's Quarterly MDS Assessment, dated 10/27/2025, reflected the resident had a BIMS score of 14, which indicated he was cognitively intact. He normally used a wheelchair and required partial/moderate assistance to roll left and right on in the bed, to move from sitting to lying, from sitting to standing, and to transfer from the chair/bed-to-chair. He was noted to be at risk of developing pressure ulcers/injuries, but to not have any present skin ulcers or injuries. Record review of Resident #2's Care Plan Report, dated as last care plan review completed 11/10/2025, reflected pressure ulcer: At risk for PI [Pressure Injury] r/t incontinence, date initiated and revised 09/10/2025. Interventions included Weekly skin assessment per facility protocol date initiated 09/10/2025. Record review of Resident #2's Order Summary Report, dated 11/18/2025 for Active Orders as of 11/18/2025, reflected Resident #2 did not have an order for weekly skin assessments. Record review of Resident #2's Standard Assessments tab in the EMR on 11/18/2025 at 04:14 p.m., reflected Resident #2 did not have a weekly skin assessment for the weeks of 09/24/2025 and 11/06/2025. Record review of Resident #2's Progress Notes, dated 09/17/2025 to 10/01/2025 did not reveal a progress note describing Resident #2's skin status. A progress note entered 09/24/2025 at 12:15 p.m. by LPN B, reflected .requires supervision to extensive assist of one with ADLs. Incontinent of B&B. Res denies pain or discomfort at this time.Caring for JP drains [a think flexible tube that drains fluid away from a wound after surgery] and surgical wounds. Record review of Resident #2's Progress Notes, dated 11/01/2025 to 11/19/2025, did not reflect a progress note describing Resident #2's skin status. Record review of Nursing Staff Assignments titled November 11/3 - 11/9, reflected LPN C was the facility nurse for day shift, 07:00 a. m. to 07:00 p.m. from 11/03/2025 - 11/06/2025 and 11/08/2025 - 11/09/2025. During an observation and interview on 11/20/2025 at 10:35 a.m., Resident #2 was observed lying in bed with no visible injuries. Resident #2 stated the facility staff took care of him and denied having any skin issues. During an interview on 11/20/2025 at 12:35 p.m., LPN C stated she could not recall completing a skin assessment on Resident #2 during the week of 11/06/2025. LPN C stated she knew a resident's skin assessment was due because it would show up on the nurses' Medication Administration Record but could not recall specifically if Resident #2 had one due. During an interview on 11/20/2025 at 12:56 p.m., the DON stated the weekly skin assessment would not show up on the Medication or Treatment Administration Record unless the assessment was ordered. The DON stated she felt the impact of a resident having missed a weekly skin assessment would depend on multiple variables. She stated she did not believe Resident #2 having missed a skin assessment would have been detrimental for him because his incontinence brief was changed as needed, so if he had any skin impairments, there would be someone whose eyes would have been on the skin to notify the appropriate people. During an interview on 11/20/2025 at 01:47 p.m., the ADMIN stated the impact of a resident having missed a skin assessment would depend on the resident, their dietary needs, and their functional needs. She stated for a resident that who had his incontinent brief changed frequently and had received shower assistance, the aides would have seen his skin multiple times per day. The ADMIN stated she did not believe Resident #2 would have been impacted by a missed skin assessment because he was constantly monitored by therapy staff, received incontinent care and shower assistance, and his meal intake was pretty good. Record review of the facility's policy, Skin Assessment, dated as Copyright 2025, reflected: Policy: It is our policy to perform a full body skin assessment as part of our systematic approach to |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and service to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident #11) resident reviewed for incontinent care and catheter care. The facility failed to ensure CNA H retract Resident #11's foreskin (the retractable roll of skin covering the end of the penis) while providing incontinent care . This deficient practice could place residents at-risk for infection and skin break down The findings were: Record review of Resident #11's face sheet, dated 11/21/2025, revealed an admission date of 12/03/2014, and a readmission date of 10/19/2020. Resident #11 had diagnoses which included: Vascular dementia (decline in cognitive abilities), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Hypertension (High blood pressure), Type 2 diabetes mellitus (high level of sugar in the blood), and Irritable bowel syndrome (chronic disorder affecting the large intestine, causing symptoms like abdominal pain, bloating, gas, constipation, or diarrhea) Record review of Resident 11's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 09, which indicated moderate cognitive impairment. Resident #11 was indicated to always be incontinent of bowel and bladder. Record review of Resident 11's care plan, dated 09/26/2025, revealed a problem of Impaired Skin Integrity related to history of excoriation on the scrotum due to moisture, friction, or incontinence and an intervention of Maintain proper incontinence care. Observation on 11/20/2025 at 6:33 a.m. revealed while providing incontinent care for Resident #11, CNA H did not retract the foreskin of the resident, therefore not properly cleaning the head of Resident #11's penis. During an interview on 11/20/2025 at 6:35 p.m. with CNA H, he stated he did not retract the foreskin of Resident #11's penis. CNA H was unclear why he did not retract the foreskin but knew he had to clean underneath it. He stated he received incontinent care training from the DON. During an interview with the DON on 11/20/2025 at 7:11 a.m., she stated that in the case of an uncircumcised male resident, the foreskin should be retracted to provide proper hygiene and prevent infection and skin breakdown. She stated providing incontinent care training for the staff within the year. Skills were checked annually and as needed. Record review of the facility's policy titled Perineal care, dated 2024, revealed, gently retract the foreskin if applicable . |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 2 of 4 residents (Resident #2 and Resident #3) reviewed for clinical records. The facility failed to document 10 occasions for Resident #2 and 1 occasion for Resident #3's medication administration of Cefinir, and antibiotic on multiple occasions. This failure could place residents at risk of not receiving the care and services needed. The findings included: 1. Record review of Resident #2's admission Record, dated 11/18/2025, reflected a [AGE] year-old male. He was admitted to the facility on [DATE]. Record review of Resident #2's Diagnosis Report, dated 11/18/2025, reflected diagnoses which included encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor, or stroke), acute (quickly has become sever) cholecystitis (the swelling and irritation or inflammation of the gallbladder), and sepsis (a condition in which the body's extreme response to an infection become life-threatening). Record review of Resident #2's Progress Notes, dated 10/19/2025 to 10/26/2025 reflected: - An **Alert Charting Note, dated 10/19/2025 at 06:51 a.m. by LPN G, noted reason for charting as PNA/UTI with interventions P.O. ABT Cefdinir. - No progress notes mentioning an antibiotic or Cefdinir from 10/21/2025 through 10/20/2025 prior to 02:00 p.m. daily were documented. Record review of Resident #2's Quarterly MDS Assessment, dated 10/27/2025, reflected the resident had a BIMS score of 14, which indicated he was cognitively intact. He was noted as having taken an antibiotic during the last 7 days or since admission/entry or reentry with an indication noted. Record review of Resident #2's Order Summary Report, dated 11/18/2025 for Active Orders as of 11/18/2025, reflected Resident #2 did not have an active order for Cefdinir. Record review of Resident #2's CMA MAR, dated 11/18/2025 from 10/01/2025 to 10/31/2025, reflected the following order and administrations: - Cefdinir Capsule 300 MG Give 1 capsule by mouth every 12 hours for PNA/UTI for 10 Days - D/C Date- 10/27/2025 0733 with administration times noted as at 0600 (6:00 a.m.) and 1800 (6:00 p.m.). The first scheduled administration was on 10/18/2025 at 06:00 p.m. and was coded for resident hospitalized . The second scheduled administration, on 10/19/2025 at 06:00 a.m., was blank. The third, fourth, and fifth administrations (10/19/2025 and 10/20/2025 at 06:00 p.m., and 10/20/2025 at 06:00 a.m.) were documented as administered. The following six (6) 06:00 a.m. scheduled administrations (10/21/2025 to 10/26/2025) were blank but the 06:00 p.m. administrations were noted as administered. The administration on 10/27/2025 at 06:00 a.m. was the last scheduled administration for the order. CMA D was noted to have administered other medications to Resident #2 on 10/19/2025 and 10/26/2025 during the time of the blanks in documentation. LPN A was noted to have administered other medications to Resident #2 on 10/21/2025 to 10/25/2025 during the time of the blanks in administration documentation. Record review of Resident #2's CMA MAR, dated 11/18/2025 from 11/01/2025 to 11/30/2025, reflected the following order and administrations: - Cefdinir Capsule 300 MG Give 1 capsule by mouth every day and evening shift for PNA/UTI for 10 Days with administration times noted as at 6A TO .2P TO. Three (3) scheduled administrations, on 11/02/2025 for 6A TO .2P TO and on 11/03/2025 for 2P TO, were coded for Other-See Progress Note by LPN E. Other scheduled administrations were documented as administered. Record review of Resident #2's Progress Notes, dated 11/02/2025 and 11/03/2025, reflected no progress notes entered on these dates. During an observation and interview on 11/20/2025 at 10:35 a.m., Resident #2 was observed lying in bed with no visible injuries. Resident #2 stated the facility staff took care of him. When asked about medication administration, Resident #2 stated he had a sore throat the day prior, 11/19/2025 and the nurse gave him liquid medicine that was effective. During an interview on 11/20/2025 at 11:32 a.m., CMA D stated she believed a blank in the medication administration record meant the documentation of the administration was not there. She stated she recalled Resident #2 having a scheduled antibiotic and administered it. During an interview on 11/20/2025 at 11:39 a.m., LPN A stated she believed a blank in the medication administration record meant the medication had not been given. She stated she recalled Resident #2 had his antibiotic in the medication cart and was able to describe the medication. She stated Resident #2 would occasionally initially refuse his medications, but then when she re-offered, he would take them. She stated she believed she must have missed clicking in the medication record that the medication was administered. Attempted interview on 11/20/2025 at 11:46 a.m. with LPN E was unsuccessful. A message was left with call back |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and 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 disease and infection for 1 of 1 resident (Resident #11) reviewed for infection control, in that: 1. The facility failed to ensure CNAs H and I washed their hands before starting to provide incontinent care for Resident #11. 2. The facility failed to ensure CNA H sanitized his hands between change of gloves during incontinent care for Resident #11 . These deficient practices could place residents at-risk for infection due to improper care practices.The findings were: Record review of Resident #11's face sheet, dated 11/21/2025, revealed an admission date of 12/03/2014, and a readmission date of 10/19/2020. Resident #11 had diagnoses which included: Vascular dementia (decline in cognitive abilities), Schizoaffective disorder (mental disorder characterized by abnormal thought processes and an unstable mood), Hypertension (High blood pressure), Type 2 diabetes mellitus (high level of sugar in the blood), and Irritable bowel syndrome (chronic disorder affecting the large intestine, causing symptoms like abdominal pain, bloating, gas, constipation, or diarrhea). Record review of Resident #11's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 09, which indicated moderate cognitive impairment. Resident #11 was indicated to always be incontinent of bowel and bladder. Record review of Resident #11's care plan, dated 09/26/2025 , revealed a problem of Impaired Skin Integrity related to history of excoriation on the scrotum due to moisture, friction, or incontinence and an intervention of Maintain proper incontinence care. Observation on 11/20/25 at 6:33 AM revealed CNAs H and I did not wash their hands after entering Resident #11's room and before providing incontinent care for Resident #11. CNA H did not sanitize his hands between change of gloves, after cleaning the resident's buttocks and before touching the clean briefs. During an interview with CNAs H and I, on 11/20/2025 at 6:35 a.m., they stated they had not washed their hands before starting the care. CNA H stated he changed his gloves before touching the clean briefs but did not use sanitizer between change of gloves. They stated they forgot but knew hand hygiene was important to prevent infection for the residents. They stated they received infection control training at least once a year . During an interview with the DON on 11/20/2035 at 7:11 a.m., she stated staff had to wash their hands before starting to provide care for a resident and had to use sanitizer or wash their hands between change of gloves to prevent the spread of infection. She stated she provided infection control training at least annually and the staff's skills were checked annually and as needed. Record review of the facility's policy, titled Infection control guidelines for all nursing procedures, dated quarter 3 of 2018, revealed Employees must wash their hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents [ .] In most situations, the preferred methos of hand hygiene is with alcohol-based hand rub [ .] use an alcohol-based rub [ .] before moving from contaminated body site to clean body site during resident care [ .] after removing gloves. |