

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Jourdanton Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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)

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement for 1 of 5 Residents (Resident #1) whose records were reviewed for pharmacy services. 1.Nursing staff failed to contact the pharmacy to ask about the status of the pending order for Lyrica and consult with Resident #1's PCP to obtain a one-time order for Lyrica (pain medication) pending pharmacy delivery of the medication from 10/10/25 until 10/15/25. 2.LVN A failed to contact and consult with Resident #1's PCP and the pharmacy when Lyrica (pain medication) was not available for administration for Resident #1 per physician orders. This failure could place residents at risk of a decline in health status. The findings were: Review of Resident #1's face sheet, dated 10/15/25, revealed he was admitted to the facility on [DATE] with primary diagnoses including unspecified cirrhosis of the liver (permanent scarring that damages your liver and interferes with its functioning) and type 2 diabetes (a progressive, long-term condition that affects how the body regulates blood glucose levels) without complications. Review of Resident #1's quarterly MDS assessment, dated 9/22/25, revealed he did not complete his BIMS to establish a level of cognitive function. Further review revealed he frequently experienced pain and received PRN medication for pain. Review of Resident #1's Care Plan, dated 7/2/25, revealed COGNITION: Impaired cognitive function thought processes r/t pain. Administer medications as ordered by physician. Notify physician as needed. PAIN: I (Resident #1) have potential for altered comfort r/t Pain. I (Resident #1) will have complaints of pain relieved in timely fashion at all times daily through next 90day review. Monitor for s/s e.g.a) verbal c/o painb) guarding (defending, safeguarding, protecting)c) facial grimacingd) refusal to participate in ADL's or therapiese) agitationf) restlessness Notify MD as needed Pain Management Therapy. Review of Resident #1's consolidated physician orders for October 2025 revealed an order Lyrica Oral Capsule 50 MG (Pregabalin) Give 1 capsule by mouth two times a day for Pain management. Active 05/16/2025 and Gabapentin Oral Capsule 300 MG (Gabapentin) Give 1 capsule by mouth three times a day related to PAIN, UNSPECIFIED (R52); POLYNEUROPATHY, UNSPECIFIED (G62.9); GENERALIZED ABDOMINAL PAIN. In addition, Resident #1 had the following PRN orders for pain, Acetaminophen-Codeine Tablet 300-30 MG Give 1 tablet by mouth every 6 hours as needed for pain, and HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain. Review of Resident #1's medication administration record for October 2025 revealed he did not receive Lyrica according to physician orders on 10/10/25, 10/11/25/ 10/12/25, 10/13/25, 10/14/25 and on 10/15/25. On 10/10/25 there were no initials to indicate the medication was administered. On 10/11/25 through 10/15/25, there was a code 19=Other-See Progress Note. Further review revealed that Resident #1 received HYDROcodone-Acetaminophen on 10/10/25, 10/13/25 and 10/14/25. It was noted as being effective for each date it was administered. Review of Resident #1's progress notes from 10/11/25 through 10/15/25 reflected Lyrica Oral Capsule 50 MG Give 1 capsule by mouth two times a day for Pain management, pending delivery. Further review revealed LVN A wrote the progress note for 10/15/25. Observation and interview on 10/14/25 at 1:22 PM Resident #1 was sitting on his bed. Resident #1 stated he often had pain related to swelling to the side of his face. Resident #1 stated he fell earlier this year in the bathroom, and his back would hurt, and he had a hernia that often caused a lot of pain. Resident #1 stated he received pain medications, but he had to beg for them, he had to keep asking staff for the medications. He stated the medications helped. Interview on 10/15/25 at 5PM the ADON revealed nursing staff should re-order a medication at least 7 days prior to the medication being out. He stated the pharmacy usually delivered medications on the same date or the day after being ordered. The ADON stated nursing staff should have called the pharmacy on 10/11/25 after the request for the refill was placed on 10/10/25 to determine why the medication had not been delivered because it had been days since it was ordered. In addition, nursing staff should let him and the DON know if there were any problems so they could assist with the process as needed. The ADON stated he learned it was not until 10/14/25 that one of the nurse's called for an update. He stated the pharmacy needed a new script for the Lyrica. He stated the same nurse should have also called Resident #1's PCP to obtain a one-time order to dispense the medication from the facility's Pyxus. He stated it had been days since the Lyrica was re-ordered. The ADON stated LVN A should have followed this same process on this date, 10/15/15, especially because Resident #1 had not received the medication in days. He stated LVN A should have called Resident #1's PCP to</p>		