

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/27/2026
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 0690 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #1) reviewed for incontinence care. The facility failed to ensure while providing incontinent care to Resident #1 on 07/27/2026, CNA-A cleaned the resident's suprapubic area (the area of the abdomen located below the umbilical region) and separated the labia when cleaning the resident's genital area. This failure could place residents who require incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: Record review of Resident #1's face sheet, dated 07/27/2026, revealed Resident #1 was a [AGE] year-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with the diagnoses of type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), chronic kidney disease-stage 2 (a long-term condition where the kidneys are damaged and lose the ability to filter waste and fluid out of the blood), and muscle weakness. Record review of Resident #1's annual MDS, dated [DATE], revealed the resident's BIMS was 15 out of 15, which indicated the resident was cognitively intact, the resident was dependent (Helper does all of the effort) for most activities of daily living, such as sit to stand and chair to bed transfer, and the resident was always bladder and bowel incontinent. Record review of Resident #1's comprehensive care plan, dated 06/08/2026, revealed the resident had the care plan of Incontinence of bowel and bladder mixed incontinence - Assist to toilet at his/her requests, reminded as needed. Monitor for dark, foul-smelling urine, burning/frequency with urination, and fever/chills. Observation on 07/27/2026 at 2:06 p.m. revealed CNA-A washed her hands with water, put on gloves, opened the old and dirty brief of Resident #1, then cleaned the resident's right and left groin areas and cleaned the resident's genital area without separating labia. CNA-A did not clean the resident's suprapubic area and turned the resident to side. When CNA-A turned Resident #1 to side, CNA-A cleaned the resident's rectum, right, and left buttock area, then put the new brief under the resident after changing gloves and closed the new brief. Interview on 07/27/2026 at 2:10 p.m., CNA-A stated she did not clean Resident #1's suprapubic area and did not separate the resident's labia when cleaning the resident's genital area because she was nervous so forgot it. CNA-A said she should have cleaned the resident's suprapubic area because that area was folded with belly fat and should have separated labia when cleaning the resident's genital area to prevent possible infection. Interview on 07/27/2026 at 3:23 p.m., the DON stated CNA-A should have cleaned Resident #1's suprapubic area and should have separated the resident's labia when cleaning the resident's genital area to prevent possible infection. Record review of the facility policy, titled Perineal Care, undated, revealed . 10. Re-position (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident in supine position. Change gloves if soiled and continue with perineal care. 11. Female: . c. Separate the resident's labia with one hand, and cleanse perineum with the other hand by wiping in direction from front to back (from pubic area toward anus).		

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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 interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #2) out of 3 residents reviewed for medical records. The facility did not ensure nurses document accurately on Resident #2's Treatment Administration Record on 07/03/2026 and 07/16/2026 regarding the resident's wound care. This failure could place residents at risk for missed treatments which could result in decline in healing and well-being. Findings included: Record review of Resident #2's face sheet, dated 07/27/2026, revealed the resident was a 49-years-old female and admitted to the facility on [DATE] with diagnosis of spastic diplegic cerebral palsy (primarily affects movement in the legs and it causes muscle stiffness, tightness, and jerky movements that make walking and balance difficult), muscle weakness, and neuromuscular dysfunction of bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should). Record review of Resident #2's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 13 out of 15, which indicated the resident was cognitively intact. Section GG (Functional Abilities), the resident was dependent (Helper does all of the effort) for most activities of daily living, such as chair to bed transfer, and Section M (Skin Conditions) indicated the resident had applications of ointments/medications other than to feet. Record review of Resident #2's comprehensive care plan, dated 02/03/2026, revealed [Resident #1] has PRESSURE ULCER RISK: At risk for pressure injury related to decreased bed mobility/transfers, bowel incontinence. For intervention - Keep skin clean and dry; use mild soap and water. Record review of Resident #2's physician order, dated 02/25/2026, revealed the resident had the order of wound care: triad cream to sacral redness daily, and as needed, every shift for redness to bottom. Record review of Resident #2's Treatment Administration Records from 07/01/2026 to 07/31/2026 revealed the resident received triad cream to her buttock area two times a day and scheduled at 7 am and 7 pm. Further record review of the resident's Treatment Administration Records revealed there were blanks (empty - no document) on 07/03/2026 at 7 am and 07/16/2026 at 7 pm. Interview on 07/27/2026 at 1:05 p.m., the DON said the nurses who worked 07/03/2026 at 7 am and on 07/16/2026 at 7 pm applied triad cream to Resident #2's buttock area, but they forgot documenting on the resident's Treatment Administration Record. The DON provided the nurses' telephone numbers. Interview on 07/27/2026 at 1:43 p.m., attempted to call the nurse who worked on 07/03/2026 at 7 am, no answer left voice message. Interview on 07/27/2026 at 2:05 p.m., LVN-B who worked on 07/16/2026 at 7 pm said that she applied triad cream to Resident #2's buttock area on 07/16/2026 at 7 pm, but she forgot to document on the resident's Treatment Administration Record because she was very busy. LVN-B stated it was her mistake and she should have documented on the resident's Treatment Administration Record after applying the cream to the resident to provide accurate information to other nurses. She said an inaccurate medical record could cause staff to provide incorrect care to the resident. Interview on 07/27/2026 at 3:23 p.m., the DON said the nurse who worked on 07/03/2026 at 7 am applied the cream to Resident #2 as ordered because the nurse conducted skin assessment on 07/03/2026 and administered the cream to the resident after skin check. The DON stated the nurses should have documented accurately on Resident #2's Treatment Administration Record because inaccurate medical record staff could provide the incorrect care to the resident. Record review of the facility policy, titled Documentation in Medical Record, undated, revealed Each resident's medical (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	records shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 2. Documentation shall be completed at the time of services, but no later than the shift in which the assessment, observation, or care service occurred. b. Documentation shall be accurate, relevant, and complete containing sufficient details about the resident's care and/or responses to care.		