

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

Printed: 07/18/2026
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 01/16/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: A bag of broccoli in the freezer was opened. A tub of peanut butter had peanut butter around the rim of the bucket. A bin of flour was opened. A box with oranges had mold. These failures could place residents who received food and/or snacks from the kitchen at risk for food borne illness. Observation on 1/13/2026 at 9:41AM the freezer revealed a box folded close with the corners of the four flaps tucked under one another that allowed a gap in the center that revealed an open bag of broccoli, exposing it to air in the freezer. Observation on 1/13/2026 at 9:46AM the dry food storage was used as an office. There was a closed tub of peanut butter with peanut butter around the rim of the tub. There was a bin of flour with the top not secured and opened. There was a box with that had been used with the remainder of the oranges in the bottom that had mold on 5 of the oranges. Interview on 1/14/2026 at 12:03PM DM said it was important to store food properly in the freezer to maintain the food's integrity and prevent freezer burn and cross contamination. He said the bin of the flour needed to be secured to prevent insects from getting inside and contaminating the food and the containers of food like the peanut butter needed to be clean after use to prevent pest or rodents. He said food that was expired or not fit for consumption due to mold, can cause food borne illness and needed to be discarded. Interview on 1/15/2026 at 2:28 PM The RD said food should be stored properly to prevent cross contamination and food borne illness to the residents. She said food that was rotten or moldy should not be kept or served to the residents because it could cause food borne illness to the residents. Record review of the facility policy titled, Food Safety Requirements dated 2025 stated in part: It is the policy of this facility food to be stored, prepared, distributed, and served in accordance with professional standards for food service safety. Under Policy Explanation and Compliance Guidelines b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms.		

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations, interviews, and record reviews, the facility failed to dispose garbage and refuse properly for 1 of 2 dumpsters (dumpster #1) on the premises. Three doors on dumpster #1 were opened. This failure could place the facility at risk of pests and rodents that could cause contamination of the foods stored in the kitchen and place the residents at risk of infection and illness. Observations and interview on 1/13/2026 at 10:00AM revealed dumpster #1 had 2 sliding doors opened on the sides and one of the black doors that closed on the top of the dumpster was opened. The [NAME] said she knew the doors should be closed so animals could not get into the dumpsters and garbage pickup was every Monday. Interview on 12/14/2026 at 12:03 PM the DM said it was important to keep the doors of the dumpsters closed because it could bring rats and roaches to the facility that could get into the food and cause food borne illness to the residents. Interview on 1/15/2026 at 2:28 PM the RD said it was important to keep the dumpsters closed to prevent rodents and pest contamination that could cause food borne illness if they get into the food supply. Record review of the facility policy titled, Disposal of Garbage and Refuse dated 12/1/2025 stated: 7. Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 8 Residents (Resident #23) who was reviewed for call light placement. Nursing staff failed to ensure Resident #23's call light was within reach. Resident #23 asked for water and was not able to locate his call light because it was under the fall mat. This deficient practice could result in residents not being able to ask for assistance as needed. The findings were: Review of Resident #23's face sheet, dated 1/16/26, revealed he was admitted to the facility on [DATE] with diagnoses including Dementia (characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). Review of Resident #23's quarterly assessment, dated 12/26/25, revealed his BIMS score was 99 indicating staff was unable to interview him. Further review revealed he was severely cognitively impaired, and he was dependent for most ADLs by 1 staff. Observation and interview on 1/13/26 at 10:33 AM revealed Resident #23 was lying in a low bed with a floor mat on the right side of the bed. Resident #23 asked for water. He was asked how he usually asked staff for assistance. Resident #23 stated he did not know the location of the call light. Further observation revealed the call light was on the floor underneath the floor mat. Observation and interview on 1/13/2026 at 11:25 AM revealed Resident #23's call light was on the floor underneath the floor mat. CNA D stated Resident #23's call light was underneath the floor mat. She stated it should be on top of the bed and clipped to the sheet. CNA D stated she did not put him to bed but had checked on the Resident and asked if he needed to get changed. She stated she should have checked for placement but did not check it. CNA D stated the call light should be within reach so Resident #23 could call for assistance otherwise he might not get the help he needed. Interview on 1/16/26 at 5PM with the DON revealed nursing staff should constantly check the placement of the call light so residents could ask for assistance, otherwise they would not be able to get staff's attention, and not get their needs met. Review of a facility policy, Resident Right, copyright date 2025, read in relevant part The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to manage and account for the personal funds of the resident deposited with the facility for 1 of 1 Resident (Resident #41) reviewed for personal funds. The facility failed to disburse Resident #41's personal funds so that she could purchase incontinent supplies. This could contribute to feelings of frustration and helplessness for the residents. The findings were: Review of Resident #41's face sheet, dated 1/16/26, revealed she was admitted to the facility on [DATE] with diagnoses including hemiplegia, and hemiparesis (paralysis) following cerebral infarction (an ischemic stroke, occurs when blood flow to a part of the brain is interrupted, leading to tissue death due to lack of oxygen and nutrients) affecting left non-dominant side and borderline personality disorder (is a mental health condition that affects the way people feel about themselves and others, making it hard to function in everyday life.) Review of Resident #41's quarterly MDS assessment, dated 12/18/25, revealed her BIMS score was 15 out of 15 reflecting she did not have cognitive impairment and she was incontinent of bowel and bladder. Review of Resident #41's Care Plan, revised on 12/19/25, revealed Focus area: Urinary incontinence: I have history of bladder incontinence related to Dementia. Goal: I will remain free from skin breakdown due to incontinence and brief use through the review date. Observation and interview on 1/13/26 at 10:43 AM revealed Resident #41 was lying in bed. Resident #41 stated she had diarrhea during the last two weeks. She stated it was a chronic condition. Resident #41 stated she had not received her allowance for this month with which she planned to buy incontinence supplies She stated she talked with the BOM about withdrawing \$250 last week to buy incontinence supplies. Interview on 1/16/26 at 4:10 PM with the BOM revealed Resident #41 requested to withdraw \$250 last Wednesday (1/7/26). She stated the MS used to cash the trust fund checks and was supposed to cash the check on Friday (1/9/26) but he told her he forgot. The BOM stated he quit his job on 1/12/26 and she did not have anyone else to cash the check. She stated she mentioned it to the ADM but there was not a plan to cash the check. The BOM stated Resident #41 had the \$250 dollars available in her account and had the right to have access to her funds as soon as possible. She stated because Resident #41 asked for more than most residents it took a day or two to get her funds. The BOM stated she had not talked to Resident #41 but was sure the Resident was probably upset and maybe even felt like they did not care about how she might be feeling or about her needs. Interview on 1/16/26 at 4:50 PM with the ADM stated she did not know the BOM was having problems with cashing the trust fund until today (1/16/26). She stated usually one of the employees had to cash the trust fund check because the corporation did not bank with any of the local banks. The ADM stated the MS used to cash the check but they did not have anyone else to do it. She stated they hired another MS and a housekeeping/laundry supervisor and would assign them to cash the trust fund check so this would not happen again. The ADM stated Resident #41 had a right to her funds and she was probably upset because they had not provided her with any monies and probably felt like she was not important. Review of a facility policy, Resident Right, copyright date 2025, read in relevant part The resident has a right to a dignified existence, self-determination, and communication with and access to person's and services inside and outside the facility.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure that each resident has a right to secure and confidential personal and medical records for 1 of 1 facility reviewed for confidentiality: in that: The facility staff left the laptop open, unlocked, and unattended on the MA cart with the screen turned on and the EMAR visible to resident records and medications. This deficient practice could place residents at risk for having their medical information being unnecessarily exposed and their personal privacy violated. The findings included: In an observation and interview on 1/13/26 at 9:15 a.m. the MA cart was at the nurse's station facing outward toward people passing through the area. There was a laptop computer on the MA cart facing away from the nurses station, and the screen was on and open to resident EMARs. The computer was unattended. There was a resident standing to the right of the cart talking on the phone at the nurse's station, another resident standing to the left of the cart talking to LVN A who was seated behind the nurse's station. LVN A stated the cart and computer were MA B's. In an observation and interview on 1/13/26 at 9:16 a.m. MA B approached and closed the laptop screen. MA B stated she should not have left it open and unattended. In an interview on 1/16/26 at 10:05 a.m. the DON stated MA B should not have left the computer screen on and unattended. The DON stated MA B had been trained previously on resident records privacy. The DON stated the staff were re-trained the same day on 1/13/26. The DON stated the possible consequences of leaving the computer screen on and the EMAR open could possibly compromise private resident information. Review of HIPAA Privacy Rule Pre/posttest for MA B dated 9/22/25 revealed . 1. Protected health information includes any identifiable health information that is in electronic format, written on paper, and communicated verbally. Review of in-service training report dated 1/13/26 for all departments on HIPAA and leaving secured information unattended reflected summary of training any applications with secured and private patient information should be protected when away from working station. Laptops and kiosks should be locked, any patient information at nurses' station should be kept confidential and had the policy attached. Review of the facility policy for HIPAA sanctions with copyright 2025 indicated . 6. Examples of violations include, but are not limited to . e. leaving a secured application unattended while logged on.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 2 of 6 residents (Residents #11, and #49), reviewed for quality of care. The facility failed to ensure Resident #11's nebulizer mask and mouthpiece attachment was enclosed in a container or bag when it was not in use. The facility failed to ensure Resident #49's oxygen concentrator filter was clean. This failure could place residents at risk of illness, allergies, and worsening of respiratory symptoms. The findings were: 1. Record review of Resident #11's face sheet dated 1/15/26 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with readmission on [DATE]. Resident #11's diagnoses included 3. COPD (Chronic Obstructive Pulmonary Disease - lung disease restricting airways, making breathing difficult), and Vitamin B12 deficiency (the level of vitamin B12 in the blood is insufficient to maintain proper health), and legal blindness in the USA (visual acuity of 20/200 or less in the better eye with best correction, or a visual field of 20 degrees or less (tunnel vision), even with glasses/contacts, for a condition expected to last at least a year). Record review of Resident #11's quarterly MDS dated [DATE] indicated the resident was usually understood, could usually understand, and had a BIMS of 9 indicating the resident was moderately cognitively impaired. Record review of Resident #11's undated care plan revealed a problem for COPD initiated 4/21/25 with a goal the resident will remain free from signs of respiratory infection through the next review date. Interventions included pulmonary program exercises, monitor for signs of infection, and to notify the physician. Record review of Resident #11's physician orders revealed an order with a start date of 12/23/25 for Budesonide Inhalation Suspension 0.5 mg/2 ml, inhale orally every shift (twice daily). (a liquid medication used with a nebulizer for daily, long-term control and prevention of wheezing, coughing, and chest tightness by reducing airway inflammation). Record review of Resident #11's EMAR for December 2025 revealed Budesonide Inhalation Suspension 0.5 mg/2 ml, inhale orally every shift was refused by Resident #11 on the day shift on 12/26/25, and 12/28/25 through 12/31/25. And he received all evening doses from 12/23/25-12/31/25. Record review of Resident #11's EMAR for January 2026 revealed Budesonide Inhalation Suspension 0.5 mg/2 ml, inhale orally every shift was administered 4 days on the day shift (1/3/26-1-4/26, 1/7/26, and 1/12/26), all other day shift doses were refused. And the resident received all doses on the evening shift but refused his evening doses on 1/12/26 - 1/13/26. In an observation on 1/13/26 at 10:25 a.m. In Resident #11's room a nebulizer machine was plugged in and sitting on nightstand on the right side of the resident's bed. The oxygen tubing leading from the nebulizer machine was in the drawer of the nightstand and the nebulizer mask was laying loose in drawer with a knit hat half on top of it and was not in a container or bag. On the left side of the resident's bed was another nightstand with the drawer closed and two sets of oxygen tubing connection points were sticking up out of nightstand drawer on each end of the drawer and was being held in the air by the closed drawer. A nebulizer machine was inside the drawer with a nebulizer mouthpiece laying loose in drawer and was not in a container or bag. In an observation and interview on 01/13/2026 10:37 a.m. LVN A stated the nebulizer masks should be in bags and not loose in the drawers and the oxygen tubing ends should not be sticking out of the drawer. LVN A stated Resident #11 refused his Nebulizer treatment today and she was unsure when the resident last received it, she would have to look. In an interview on 1/16/26 at 10:05 a.m. the DON stated the nebulizer masks should be in bags. The DON stated the nurses were trained and were aware. The DON stated the possible consequences of the nebulizer mask or mouthpiece not being in bags could cause cross contamination issues. Review of the facility policy on nebulizer therapy with a copyright of 2025 indicated It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions. 7. Once completely dry store the nebulizer cup and the mouthpiece in a zip lock bag. 2. Review of Resident (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#49's face sheet, dated 1/16/26, revealed she had a diagnosis including Chronic Obstructive Pulmonary Disease (A progressive lung disease characterized by persistent airflow limitation). Review of Resident #49's admission MDS assessment, dated 11/21/25, revealed her BIM score was 13 of 15 indicative of no cognitive impairment and she received oxygen therapy on a regular basis. Review of Resident #49's consolidated physician orders for January 2026 revealed an order for continuous oxygen at 2 to 4 liters. Further review revealed to maintain the oxygen concentrator and change out the tubing and humidifier bottle per facility policy. Observation and interview on 1/13/26 at 11:10 AM revealed Resident #49 sitting in a recliner receiving continuous O2 via nasal cannula at 2 liters per minute. Further observation revealed a vent cover full of white build up on the back of the oxygen concentrator. Resident #49 stated staff changed out the tubing and plastic bottle a day or so ago, but she did not see them clean the vent cover. Observation and interview on 1/14/26 at 1:30 PM revealed Resident #49 sitting in recliner receiving continuous O2 via nasal cannula at 2 liters per minute. Further observation revealed a vent cover full of white build up on the back of the oxygen concentrator. LVN A stated it looked like lint and that Hospice had provided the concentrator. She stated she had not checked it. LVN A stated night nurses who worked on Sunday's were responsible for changing out the tubing, humidifier and for cleaning the filters. LVN stated in this case the filter was an internal filter and the Hospice company would be responsible for ensuring the concentrator was serviced. However, nursing staff was responsible for letting the Hospice company know the filter needed cleaning. LVN stated it was important the filter was cleaned regularly because Resident #49 was receiving oxygen into her lungs. It could cause infections if the filter was dirty. Interview on 1/16/26 at 1:30 PM with the DON revealed night nurses were responsible for changing the oxygen tubing, the humidifier bottle and the filter. She stated if the filter was located internally then the MS would service the concentrator and clean the filter unless the resident was on Hospice services. The Hospice company would be responsible for servicing the concentrator, but their nursing staff would have to let Hospice know the concentrator needed servicing. The DON stated if the filter was dirty, it could cause the resident to get an infection or could cause other respiratory complications. Review of the facility policy titled oxygen concentrator with a copyright date of 2025 read in relevant part Care of concentrator: a. follow manufacturer's recommendations for the frequency of cleaning filters and servicing the device. B. Only trained individuals such as the Maintenance Director or supplier shall service the device.		

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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 safeguard medical record information against loss, destruction, or unauthorized use to maintain accurate medical records for 1 of 4 (Resident #2) residents reviewed for change in condition The facility failed to document the of change of condition and transfer to the hospital for Resident #2. These failures could place the residents at risk of inadequate care and a diminished quality of life.The findings were: Record review of Resident #2's face sheet dated 01.14.2026 revealed a [AGE] year-old female was re-admitted to the facility on 1.13.2026 with diagnoses: depression, traumatic brain injury, chronic obstructive pulmonary disease (difficulty breathing due to progressive lung disease), and anxiety. Record review of Resident #2's Quarterly MDS dated 11.03.2025 revealed she had a BIMS score of 15, indicative of cognitively intact. Record review of Care Plan dated 12.10.2025 revealed she was care planned for heightened perception of events, deep vein thrombosis (blood clot), antidepressants, traumatic brain injury, and falls. Record review of Resident #2's progress notes reviewed for dates January 1-16, 2026, did not reveal the transfer to the hospital nor was there a change of condition done to explain the reason for the transfer. The only documentation noted was the call from RP due to her concern about Resident #2's behavior after she called her with complaints about someone was hurting her and people were trying to get her. Observation on 1.13.2026 at 10:00AM revealed Resident #2 was not in the facility during observations. CNA C said Resident #2 went out to the hospital. Interview and observation on 1/13/2026 at 4:20PM Resident #2's RP said Resident #2 was sent to the hospital 1.6.2026 because she called her confused and afraid that someone was hurting or trying to get her. She said she called the facility to inform them of her concerns, and she was then sent out to the hospital where she was treated for her symptoms. The RP said Resident #2 was much better. Resident #2 was in her electric wheelchair, clean and groomed. She was encouraged by her family member that it was okay to speak with the surveyor, and she said she felt fine. Interview on 1/15/2026 at 12:15PM the DON said Resident #2 was transferred to the hospital for a change in mental status. She confirmed there was no documentation in the Resident's record on why she was not in the facility and there was no change in condition in the record. She said it was important to document the condition of a resident, the disposition of a resident if transferred out of the facility, why they may have gone out to the hospital, and documentation of all who were notified of the transfer. She said it was important to have accurate documentation to update the resident's care plan as well if a resident returned to the facility with a new diagnosis. The DON said the RP was notified of the transfer. Record review of facility policy titled, Documentation in Medical Record dated 2025 stated: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide the resident's progress through complete, accurate, and timely documentation. Policy explanation and compliance guidelines stated: :1. Licensed staff shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.		