

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineral Wells Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 316 SW 25th Ave Mineral Wells, TX 76067	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722</p> <p>Based on observation, interview, and record review the facility failed to provide services with reasonable accommodation of needs for 1 of 10 (Resident #9) residents reviewed for reasonable accommodation of needs</p> <p>The facility failed to provide a working communication system on 04/15/2025 that was easily at reach and that would allow Resident #9 the ability to safely call for staff for assistance.</p> <p>This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they need support for daily living.</p> <p>The findings included:</p> <p>Record review of Resident #9's face sheet dated 04/17/2025, revealed: an [AGE] year-old-female admitted on [DATE] with a recent readmission on 09/02/2024. Resident #9 had the following diagnosis Dementia, anxiety disorder, Type 2 Diabetes, and respiratory failure.</p> <p>Record review of Resident #9's Quarterly MDS dated [DATE] revealed: Section C-Cognitive Patterns: Resident #9 had a BIMS score of 5, meaning severe cognitive impairment; Section GG- Functional Abilities: Resident #9 required maximal or total assistance for transfers, toileting, dressing, and transferring.</p> <p>Record review of Resident #9's most recent Care Plan revealed:</p> <p>Focus: The resident is risk for falls joint pain and weakness Date initiated on 09/03/2024.</p> <p>Goal: The Resident will be free of falls through the review date.</p> <p>Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.</p> <p>(continued on next page)</p>

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: 455570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineral Wells Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 316 SW 25th Ave Mineral Wells, TX 76067	
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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 04/15/2025 at 3:48 PM Resident # 9 was sitting up in her bed, call light was not in reach. Resident # 9's call light was laying on the floor at the head of her bed, between the headboard and the wall. Resident #9 stated if she needed assistance she would push her button, Resident #9 stated she did not know where her button was.</p> <p>During an interview on 04/15/25 at 4:08 PM MA E stated Resident # 9 was able to use her call light and if she could not find it she will ask her roommate if she needed assistance. MA E stated the call light should have been connected to Resident #9. MA E stated everyone was responsible to ensure resident call lights were in reach.</p> <p>During an interview on 04/16/25 at 10:38 AM LVN D stated she was the charge nurse for the 400, 500 and 600 hall. LVN D stated Resident #9 resided on one of her hall's. LVN D stated Resident #9 was able to use her call light on some days. LVN D stated the call light should not have been behind her bed in the floor. LVN D stated the call light should have been attached to her clothes. LVN D stated the call light not being in reach could have caused harm to resident. LVN D stated she did not know why the call light was not in reach of Resident #9.</p> <p>During an interview on 04/17/2025 at 5:06 PM the MIT stated her expectation was call lights should have been in reach of residents. The MIT stated everyone who entered resident rooms were responsible to ensure call lights were in reach of residents. The MIT stated staff making champion rounds, and charge nurses were responsible to monitor to ensure lights were in reach. The MIT stated if call light was not in reach, it could have caused resident to not have needs met. The MIT stated what led to failure of call light not being reach could have been due to hospice brought in new equipment. The MIT stated they did not have a policy regarding call lights.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineral Wells Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 316 SW 25th Ave Mineral Wells, TX 76067	
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)		
<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44722</p> <p>Based on observation, interview and record review, the facility failed to ensure at the time each resident was admitted, the facility had a physician order for the resident's immediate care for 1 (Resident #47) of 32 residents reviewed for residents receiving necessary care and services upon admission.</p> <p>The facility failed to obtain physician's order prior to placing Resident #47's knee immobilizer to her right leg.</p> <p>This failure could place residents at risk of not having a physician order followed.</p> <p>Findings include:</p> <p>Record review of Resident #47's electronic face sheet dated 04/17/2025 revealed an [AGE] year-old female admitted on [DATE]. Resident #47's diagnosis included Unspecified Fracture of Right Patella (kneecap), Hypertension (high blood pressure), Type 2 Diabetes Mellitus, Unspecified Dementia, Muscle Weakness (generalized)</p> <p>Record review of Resident #47's physician orders revealed an admitted [DATE], and further review revealed no evidence of an order for a knee immobilizer.</p> <p>Record review of Resident #47's care plan dated 03/27/2025 did not address the use of a knee immobilizer.</p> <p>Record review of Resident #47's hospital records dated 03/12/2025 revealed final diagnosis closed nondisplaced fracture of right patella. Hospital course: Right patella fracture non operative treatment as per orthopedic. WBAT (weight bearing as tolerated) in knee immobilizer.</p> <p>Record review of Resident #47's physician progress note dated 03/28/2025 revealed an [AGE] year-old female admitted post right patella fracture. Wear brace on right lower extremity at all times. Review of systems; Musculoskeletal -right patella fracture; knee brace in place. written by facility's medical director.</p> <p>Record review of Resident #47's admission MDS dated [DATE] revealed: Section C - Cognitive Patterns: Resident #47 had a BIMS of 4 (severe cognitive impairment); Section G- Functional Abilities: Resident #47 had functional Limitation in Range of Motion to lower extremity impairment on one side. Section I-Active diagnosis Resident #47: had Fractures and other multiple traumas.</p> <p>During an observation on 04/15/2025 at 11:00 AM Resident #47 was lying in bed with knee immobilizer to right leg.</p> <p>During an observation on 04/16/2025 at 10:22 AM Resident #47 was lying in bed with knee immobilizer on right leg.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineral Wells Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 316 SW 25th Ave Mineral Wells, TX 76067	
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)		
<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 04/17/2025 at 02:30 PM Resident #47 was sitting at a table in the dining area of the secure unit playing cards. Resident #47 was observed wearing a hinged brace (knee immobilizer) to right leg.</p> <p>During in an interview on 04/17/2025 at 03:50 PM LVN C stated there should have been an order for a rResident #47 who had a knee immobilizer. LVN C stated the admitting nurse would have been responsible for putting in the orders from the hospital. LVN C stated if no order on the EMR the resident could possibly not have the knee immobilizer in place as needed. LVN C stated they did not know how this failure occurred.</p> <p>During an interview on 04/17/2025 at 04:05 PM CNA B stated she knew that the knee immobilizer was to be put on rResident #47 because the charge nurse told her the resident needed it.</p> <p>During an interview on 04/17/2025 at 04:10 PM The RCN stated admission orders were put in the EMR by the nurse who had performed the admission assessment. The RCN stated the DON or the ADON reconciled orders the day after a resident was admitted to the facility. The RCN stated there should have been an order for the knee immobilizer. The RCN stated she did not know how this failure occurred. The RCN stated the effect on the resident would have been the resident would not have the needed support for her right knee and this could cause further injury to the resident's knee. The RCN stated the staff would not know the resident needed the knee immobilizer and would not be putting the immobilizer on the resident. The RCN stated she was responsible for monitoring the physician orders when she visits the facility. The RCN stated she visits facility at least one time a month. The RCN stated she did not know how this failure occurred.</p> <p>Record review of the facility's policy titled: Physician Orders without a date revealed:</p> <p>Purpose:</p> <p>To monitor and ensure the accuracy and completeness of the medication orders, treatment orders and ADL order for each resident.</p> <p>Person responsible: Medical Records/Designee</p> <ol style="list-style-type: none"> 1. Physician's monthly consolidated orders must be reviewed by a licensed nurse to assure they reflect all current orders. Any orders not within the monthly physician's order must be added before physician review or being sent out for physician signature. 2. 3. The physician must approve/sign/return the monthly consolidated orders within 30 days. 4. The original paper monthly orders should be returned and placed on the chart within 30 days. <p>Effective June 22, 2015 the white paper copy of the physician's orders is no longer necessary. If a copy is needed, one can be printed from the electronic medical record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineral Wells Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 316 SW 25th Ave Mineral Wells, TX 76067	
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)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>48883</p> <p>Based on interviews and record reviews, the facility failed to ensure nursing staffing information was posted in a prominent place readily accessible to residents and visitors that included: the census, the total number and the actual hours worked by the registered nurses, licensed practical nurses or licensed vocational nurses and certified nurse aides directly responsible for resident care per shift for 1 of 3 days (04/15/2025) reviewed for required postings.</p> <p>The facility failed to ensure the daily staffing information for licensed and unlicensed nursing staff was posted in a prominent location on 04/15/2025.</p> <p>This failure could place residents, their families, and visitors at risk of not knowing how many nursing staff were currently working and the total hours were to be worked by nursing staff to provide care on all shifts.</p> <p>Findings Included:</p> <p>During an observation on 04/15/2025 at 10:11 a.m., the daily staffing posted in hallway was dated 03/06/2025 totaling 40 days of posting not being updated.</p> <p>During an interview on 04/16/2025 at 10:27 a.m., the DON stated her expectation was that the daily staffing be posted daily. The DON stated she was responsible for posting daily nursing staff. She stated she had forgotten to post the staff posting but had kept them in a binder in her office. She stated in the future, she would delegate the staff posting to her ADON. The DON stated the ADMN may monitor that staffing hours were posted but was unsure if he did. She stated staff knew how many staff were on schedule by looking in another binder, but visitors and residents would not know to look in that binder. She stated failing to post nurse staffing could interfere with visitors and residents knowing if the facility had adequate staffed.</p> <p>During an interview on 04/17/2025 at 10:58 a.m., the RCN stated it was the DON who monitored that daily nursing staff was posted. She stated the staffing coordinator was responsible for posting the nursing staff daily and the ADON was the back up if the staffing coordinator was not present. She stated the DON mentioned that she may have just not updated the date on the posting and that may have been the failure. She stated anyone entering the building could ask one of the staff how many people were on shift, and they would tell them about the binder listing staff members scheduled. She did not feel any negative impact occurred from daily nurse staffing not being posted for public to view.</p> <p>During an interview on 04/17/2025 at 11:00 a.m., the interim ADMN stated he expected nurse staffing to be posted daily. He stated he was unsure who monitored or who was responsible for posting the nurse staffing. He stated the DON had come up with a plan for who was responsible and who would monitor the staffing was posted daily. He stated he was unsure why the nursing staffing had not been posted daily. He stated no posting could interfere with visitors and resident knowing how many direct care staff were scheduled. He stated there was no policy other than the mandatory posting check off sheet on required postings.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineral Wells Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 316 SW 25th Ave Mineral Wells, TX 76067	

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)
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Review of facility document titled Mandatory Posting revision date on 05/16/2019 revealed: NAME OF POSTING .Daily Staffing by shift of Licensed and Unlicensed Nursing Staff .POSTED .Yes No.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineral Wells Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 316 SW 25th Ave Mineral Wells, TX 76067	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44722</p> <p>Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed.</p> <p>The facility failed to ensure the temperature of the banana pudding was taken prior to leaving the kitchen.</p> <p>The facility failed to ensure that staff performed hand hygiene while preparing food.</p> <p>These failures could place residents that eat out of the kitchen at risk for food borne illnesses.</p> <p>The findings included:</p> <p>During an observation and interview on 04/15/2025 between 11:00 AM and 12:30 PM the cook failed to take the temperature of the banana pudding, prior to resident's lunch trays being plated, placed on cart and ready to leave the kitchen. [NAME] F stated she had forgotten to take the temperature of the banana pudding. [NAME] F stated the banana pudding should have had temperature taken prior to food being plated. The AD failed to perform hand hygiene, when she entered the kitchen, before she grabbed a can of tomato juice and an empty container. The AD opened the can of tomato juice and poured into the empty container.</p> <p>During an interview on 04/15/2025 at 12:30 PM the DM stated the temperature of food should have been taken prior to leaving the kitchen. The DM stated the [NAME] F was responsible to take temperature of food prior to plating food. The DM stated she was responsible to monitor. The DM stated she had gotten busy and thought [NAME] F had taken the temperature of the banana pudding. The DM stated every time staff walk into the kitchen they should have performed hand hygiene. The DM stated the AD should have washed her hands prior to getting the tomato juice. The DM stated the affect on residents could have been cross contamination. The DM stated she was responsible to monitor. The DM stated she did not have an explanation to why the failure occurred. The DM stated the AD had her food handlers and had been reminded several times.</p> <p>During an interview on 04/17/25 at 5:06 PM the MIT stated her expectation was for food to be tempted prior to leaving the dining room. The MIT stated the DM was responsible to ensure food temperatures were taken before served to residents. The MIT stated residents could have received food that was not prepared appropriately. The MIT stated she was not sure what led to failure of staff not taking the temperature of the banana pudding. The MIT stated her expectation was that hand hygiene be performed by any staff that entered the kitchen. The MIT stated the AD had a food handlers license and was a department head and was responsible to ensure she had performed hand hygiene went entered the kitchen. The MIT stated not performing hand hygiene could have affected residents by cross contamination. The MIT stated what led to failure was the AD's lack of following thru with AD's previous training she had received and in-services she had been provided.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455570	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Mineral Wells Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 316 SW 25th Ave Mineral Wells, TX 76067	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility policy titled Daily Food Temperature Control dated 2012, revealed: Prior to meal service, the cook shall take the temperature of all hot and cold foods.</p> <p>Record review of facility policy titled Hand Washing dated 2012 revealed: Employees are to frequently perform hand washing.</p>		