

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455797	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/08/2024
NAME OF PROVIDER OR SUPPLIER Pearsall Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 169 Medical Dr Pearsall, TX 78061	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41651</p> <p>Based on observations, interview and record reviews, the facility failed to ensure the resident environment was as free of accident and hazards as possible for 3 of 5 halls (100 hall, 200 hall, and 300 hall) reviewed for accident and hazards, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to prevent a container of unsecured bleach wipes from being found on the 100 hallway. 2. The facility failed to ensure the door to the utility area was locked and the room housing hazardous material was locked on the 200 hallway. 3. The facility failed to ensure the supply room containing small objects and food items was unlocked on the 300 hallway which was a secure unit for residents with cognitive concerns. <p>These deficient practices could result in residents coming into contact with dangerous materials which could place them at risk of injury or death.</p> <p>The findings were:</p> <ol style="list-style-type: none"> 1. Observation on 02/08/2024 at 1:32 p.m. of the incontinent care cart on 100 hallway revealed a container of bleach wipes labeled, Danger and Keep Out of Reach of Children. <p>During an interview with CNA A on 02/08/2024 at 1:35 p.m., CNA A stated, I haven't been told if it is or isn't allowed to be stored there and confirmed that the container of bleach wipes was usually stored on the incontinent care cart.</p> <p>During an interview with LVN B on 02/08/2024 at 1:50 p.m., LVN B stated the container of bleach wipes was usually stored on the incontinent care cart and when asked if a resident could come into contact with the wipes and potentially harm themselves, LVN B confirmed it was possible and stated, I had not thought of that.</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Observation on 02/08/2024 at 2:00 p.m., revealed the utility area was unlocked and contained a room marked hazardous material, which was also unlocked, on the facility's 200 hallway. Further observation revealed the room did not contain hazardous material at the time of the observation, but did contain supplies to store hazardous material.</p> <p>During an interview with RN D on 02/08/2024 at 2:00 p.m., RN D confirmed the utility area was unlocked and contained a room housing hazardous material, which was also unlocked on the facility's 200 hallway. RN D confirmed residents, staff, or visitors could come into contact with potentially harmful materials via the unlocked doors and unsecured hazardous materials storage area.</p> <p>3. Observation on 02/08/2024 at 1:55 p.m. revealed the supply room containing small objects (gambling chips) and food items (potato chips and salsa) was unlocked on the facility's 300 hallway which was a secure unit for residents with memory concerns.</p> <p>During an interview with LVN C on 02/08/2024 at 1:56 p.m., LVN C confirmed the supply room containing small objects and food items was unlocked and confirmed it contained small objects and food items, including potato chips and salsa, which could potentially be choking hazards for the residents of the secure memory care hallway.</p> <p>Record review of the facility clinical records system revealed that twenty-five residents lived in the 300-hallway secure unit and fourteen of those residents required a mechanical soft or puree diet to prevent aspiration and/or choking.</p> <p>During a joint interview with the Administrator and DON on 02/08/2024 at 4:30 p.m., the Administrator and DON confirmed that the above listed items could potentially be dangerous for residents, staff, and/or visitors, such items should be secured, and all staff were responsible for securing potentially hazardous items. The Administrator stated that the facility did not have a policy regarding physical environment.</p>		