

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  03/29/2024
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</b></p> <p>Based on observation, interview and record review the facility failed to ensure the resident's had the right to be informed of the risks, and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 3 of 22 residents (Resident #44, Resident #47 and Resident #95) reviewed for resident rights.</p> <ol style="list-style-type: none"> <li>1. The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #44 Representative prior to admitting to a locked unit.</li> <li>2. The facility failed to find and obtain informed consent from Reasonable and Responsible party for, Resident #47, who did not have the cognitive ability to make medical decisions, who was taking medications for psychiatric diagnosis, and resided in the locked unit.</li> <li>3. The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #95's Representative prior to admitting to a locked unit.</li> </ol> <p>This failure could place residents at risk of being unnecessarily confined to a locked unit and receiving medications without their prior knowledge or consent, or that of their responsible party.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Record review of Record review of Resident #44's face sheet revealed a [AGE] year-old female was admitted on [DATE] with diagnosis that included dehydration, dementia, muscle weakness, generalized anxiety disorder, seizures, insomnia, and cognitive communication deficit. The face sheet also revealed Resident #44 had a Responsible Party that was a family member.</li> </ol> <p>Record review of Resident #44's Admission MDS, dated [DATE], indicated Resident #44's cognition was severely impaired. The MDS also indicated Resident #44 was receiving antianxiety medications and antidepressants.</p> <p>Record review of Resident #44's care plan, revised on 03/26/24 did not contain any information about psychiatric diagnosis, the locked unit, or medications for psychiatric diagnosis.</p> <p>Record review of Resident #44's physician orders, dated 03/27/24 revealed orders for:</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-ADMIT TO GENERATIONS UNIT (same as locked unit) DUE TO RESIDENT DOES BETTER IN STRUCTURED ENVIRONMENT R/T DX DEMENTIA, order date 02/23/24.</p> <p>Record review of Resident #44's clinical records revealed the facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #44's Representative prior to admission to a locked unit.</p> <p>During an interview on 03/28/24 at 1:50 p.m. Medical records clerk stated she was behind on uploading consent into the computer. The clerk looked in her stack of papers and could not find a consent for Resident #44 to reside in the locked unit.</p> <p>During an interview on 03/29/24 at 2:33 p.m. the DON stated the facility requires a consent form be signed by the RP for all residents on the locked unit.</p> <p>2. Record review of Record review of Resident #47's face sheet revealed a [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included mood disorder due to known physiological condition with major depressive like episode, bipolar disorder severe with psychotic features (a mood disorder that features extreme shifts in mood, during which psychosis can occur. People with psychosis experience a disconnected view of reality. It can involve hallucinations and delusions.), insomnia (is a common sleep disorder that can make it hard to fall asleep or stay asleep), generalized anxiety disorder, schizophrenia (A mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), mild intellectual disabilities, pseudobulbar affect (A nervous system disorder that causes inappropriate involuntary laughing and crying), schizoaffective disorder (A mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), sleep apnea (a is a potentially serious sleep disorder in which breathing repeatedly stops and starts), and cognitive communication deficit. Resident #47 was noted as the Responsible party. No emergency contact was listed.</p> <p>Record review of Resident #47's Annual MDS, dated [DATE], indicated Resident #47's cognition was severely impaired. The MDS also indicated Resident #47 was receiving antipsychotic medications and antianxiety medications.</p> <p>Record review of Resident #47's care plan indicated, revised on 03/27/24 revealed:</p> <ul style="list-style-type: none"> <li>- Resident #47 has frequent episodes of crying then laughing r/t DX (diagnosis) of PBA (pseudobulbar affect). In addition, she is easily agitated r/t multiple psych DX of Bipolar, Dementia and Psychosis. Risk for complications. Interventions included administer medications per MD orders, monitor for side effects, and refer to psych as needed.</li> <li>- Resident #47 has impaired cognitive function r/t DX of dementia. Risk for complications. Interventions included Administer medications as ordered. Monitor/document for side effects and effectiveness. Cue, reorient and supervise as needed.</li> <li>- Resident #47 has thought process alteration r/t psychological causes aeb res has dx: schizophrenia and schizoaffective d/o (disorder) and takes routine antipsychotic medication.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Resident #47 has a DX of Anxiety. Risk for complications. Interventions included Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT.</p> <p>Record review of Resident #47's physician orders, dated 03/28/24 revealed orders for:</p> <p>- ADMIT TO GENERATIONS UNIT DUE TO RESIDENT DOES BETTER IN STRUCTURED ENVIRONMENT RELATED TO DX SCHIZOPHRENIA, order date 05/14/2018.</p> <p>- Ativan Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth three times a day for ANXIETY GIVE 1 TAB = 1MG PO TID, order date 05/18/23.</p> <p>- Nuedexta Oral Capsule 20-10 MG (Dextromethorphan HBr-Quinidine Sulfate) Give 1 capsule by mouth every 12 hours for PBA GIVE ONE CAPSULE = 20-10MG PO Q12H, order date of 06/09/23.</p> <p>- Exelon Patch 24 Hour 4.6 MG/24HR (Rivastigmine) Apply 1 patch transdermally one time a day related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE WITHOUT BEHAVIORAL DISTURBANCE REMOVE PATCH BEFORE APPLYING AND ROTATE SITES and remove per schedule, order date 08/24/17.</p> <p>During an interview on 03/29/24 at 10:13 a.m. Resident #47 pointed to the nurse when asked if she knew what medications she takes. Resident #47 said she did not sign any medication forms and did not know what medications she took. Resident #47 said no one was in charge of her.</p> <p>During an interview on 03/29/24 at 10:21 a.m. LVN D stated she has worked on the locked unit for a while. LVN D stated Resident #47 resided on the unit because she had wandering and exit seeking behaviors.</p> <p>During an interview on 03/29/24 at 10:38 a.m. the SW stated Resident #47 was her own representative. The SW stated Resident #47 resided in the locked unit to avoid overstimulation. The SW stated she did not know who the person listed as guardian on the consent form for the lock unit was. The SW stated she had never know Resident #47 to have a guardian or have any family visitors. The SW stated the nursing staff fills out the medication consent forms. The SW stated she thinks Resident #47 can make her own decisions and she thinks she knows what you are telling her. The SW stated their legal department would ask them to find someone from the community to sign consent of behalf of residents who cannot make their own medical decisions. The SW stated they had attempted this but did not document it anywhere.</p> <p>During an interview on 03/29/24 at 10:43 a.m. ADON A stated Resident #47 was on the locked unit due to exit seeking behavior. ADON A explained she and another nurse signed a medication consent form on the line for the resident representative because the resident verbally agreed but did not want to sign the document. ADON A stated Resident #47 was her own representative and had never seen anyone else since she was admitted being involved in her care. ADON A stated if they encounter a resident, who was not able to make medical decisions for themselves, they could ask the SW to reach out to the family or an RP but in this case she did not because she knew the resident's history.</p> <p>During an interview on 03/29/24 at 12:38 p.m. MDS E stated Resident #47 has always been her own RP and she has never known anyone else to be involved in her care. MDS E stated Resident #47 multiple psychiatric issues and over the years her cognition has lessened by about 40%.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/29/24 at 12:54 p.m. RN F stated Resident #47 was initially on the locked unit due to exit seeking behavior but more recently was there because of her behaviors and did not exit seek as much anymore. RN F Resident #47 could voice her needs well. RN F said her and another nurse signed the consent form on the Resident Representative line as a way to witness the Resident was informed of the medication change and she verbally agreed to it. RN F stated Resident #47 did not know what medication she took but staff would explain what the medication was for and Resident #47 would say OK. RN F said Resident #47 did not have any memory issues. RN F said she was not familiar with a BIMS score and did not know what Resident #47 BIMS score was.</p> <p>During an interview on 03/29/24 at 2:37 p.m. the DON stated Resident #47 was on the locked unit due to wandering and exit seeking behaviors. The DON stated she will still wander if she was in her wheelchair, and she also gets overstimulated with large groups. The DON stated she has never known anyone else to be involved in her care. The DON stated Resident #47 can give her verbal consent and two nurses witness this by signing on the resident representative line on the consent form. The DON stated Resident #47 had dementia but she was not incompetent and can make decisions. The DON stated a resident on a locked unit can sign their own consent for medications and consent to be on the locked unit. The DON stated they reached out to the ombudsman on 03/29/24 for help with resources for resident who need an RP and was given information. The DON stated if Resident #47 had an RP they would have them sign the consent but because she did not have a RP they had residents or staff sign them.</p> <p>Record review of a document titled Consent for the Generations Unit Placement, dated 08/01/2017, revealed a printed name and the word Guardian in parenthesis. This would indicate that this person consented to Resident #47 being on the locked unit and would have been her guardian.</p> <p>Record review of Resident #47's medical records revealed no guardian, emergency contact, or resident representatives was ever listed for Resident #47.</p> <p>Record review of document titled Informed consent for Psychoactive Medications, dated 06/08/23, revealed a section of the document showed the Resident name was printed on the document and there was no signature on the line for the Residents signature. Another section stated Person authorized to consent on behalf of the resident. The Resident's name was printed on the line labeled Responsible Party &amp; Relationship. Two staff signatures were on the line labeled Responsible Party Signature.</p> <p>3. Record review of Resident #95's face sheet, dated 3/27/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with behavioral disturbance, cognitive communication deficit, lack of coordination, type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), anoxic brain damage (complete lack of oxygen to the brain resulting in death of brain cells due to oxygen deprivation), and chronic kidney disease (longstanding disease of the kidneys leading to kidney failure).</p> <p>Record review of Resident #95's most recent quarterly MDS assessment, dated 3/2/24 revealed the resident was severely cognitively impaired for daily decision-making skills.</p> <p>Record review of Resident #95's comprehensive care plan, revision date 10/26/23 revealed the resident had impaired cognitive function/dementia and resided in the Generations Unit (secure unit).</p> <p>Record review of Resident #95's Order Summary Report, dated 3/27/24, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Admit to Generations Unit due to resident does better in a structured environment due to dementia, with order date 10/4/23 and no end date</p> <p>Observation and interview on 3/26/24 at 12:07 p.m., revealed Resident #95 sitting up in bed eating lunch in the secure unit. Resident #95 was unable to determine how long he had been living in the secure unit.</p> <p>During an observation and interview on 3/28/24 at 5:14 p.m., ADON A revealed Resident #95 had been living in the secure unit since he was admitted to the facility on [DATE]. ADON A revealed Resident #95 was placed in the secure unit due to wandering and the need for a structured environment. ADON A revealed, in order for a resident to reside on the secure unit, a consent and a physician's order needed to be obtained. ADON A revealed she could not find a written consent in Resident #95's electronic record for Resident #95 to be in the secure unit. ADON A revealed she had obtained the order for Resident #95 to reside in the secure unit but had delegated obtaining the consent to a charge nurse. ADON A revealed she could not remember which charge nurse she had told to obtain the consent. ADON A revealed, once the consent was obtained, the document would have been uploaded into the resident's electronic record.</p> <p>During an interview on 3/28/24 at 5:27 p.m., the Medical Records Clerk revealed she was responsible for recovering any resident documents that needed to be uploaded into the resident's electronic record. The Medical Records Clerk revealed, any documents that needed to be uploaded into the electronic record were placed in a basket at the nurse's station. The Medical Records Clerk revealed she made daily rounds to the nurse's station to retrieve those records. The Medical Records Clerk revealed she made it a point to upload consents into the record as soon as they became available to her. The Medical Records Clerk revealed she was at least two months behind in her filing, dating back to January 2024.</p> <p>During an interview on 3/28/24 at 5:35 p.m., the DON revealed, a consent and a physician's order needed to be obtained before a resident was allowed to reside in the secure unit. The DON revealed, a telephone consent could be obtained and any consent, including consent to the secure unit, could be secure by the ADON or the charge nurse. The DON revealed, once consent to the secure unit was obtained, it was uploaded into the resident's electronic record. The DON revealed, Resident #95's family requested the resident reside in the secure unit and the consent should have been in the record. The DON revealed, it was their policy to obtain a consent for Resident #95 to reside in the secure unit because they obtained consents for all the other residents in the secure unit.</p> <p>A policy for Resident Rights was requested and not provided.</p> <p>45857</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39075</p> <p>Based on observation, interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 1 of 24 residents (Resident #95) reviewed for advanced directives, in that:</p> <p>The facility failed to ensure Resident #95's Out-of-Hospital Do Not Resuscitate (OOH DNR) was dated and signed by the physician which made the document invalid.</p> <p>This failure could place residents at-risk of having their end of life wishes dishonored, and of having CPR performed against their wishes.</p> <p>The findings included:</p> <p>Record review of Resident #95's face sheet, dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) with behavioral disturbance, cognitive communication deficit, lack of coordination, type 2 diabetes (a chronic, long-lasting health condition that affects how your body turns food into energy), anoxic brain damage (complete lack of oxygen to the brain resulting in death of brain cells due to oxygen deprivation), and chronic kidney disease (longstanding disease of the kidneys leading to kidney failure). Further review of Resident #95's face sheet revealed the resident was identified as DNR status.</p> <p>Record review of Resident #95's most recent quarterly MDS assessment, dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills.</p> <p>Record review of Resident #95's comprehensive care plan, dated [DATE] revealed the resident was DNR status with interventions which included to ensure a signed DNR was in the medical record.</p> <p>Record review of Resident #95's Order Summary Report, dated [DATE] revealed the following:</p> <p>- DNR (Do Not Resuscitate), with order date [DATE] and no end date</p> <p>Record review of Resident #95's OOH DNR, dated [DATE] revealed the Physician's Statement section which required the physician's signature, printed name, date, and license number were blank. Further review of Resident #95's OOH DNR document revealed the section requiring the physician's signature indicating it was acknowledged the document had been properly completed was blank.</p> <p>During an interview on [DATE] at 8:53 a.m., ADON B revealed, the SW initiated the OOH DNR paperwork and was completed as soon as the resident admitted to the facility. ADON B revealed, DNR orders were obtained by nursing staff, but the SW was responsible for obtaining the OOH DNR.</p> <p>During an interview on [DATE] at 9:05 a.m., the DON revealed the SW was solely responsible for completing the OOH DNR paperwork and nursing staff was in charge of putting the orders into the electronic record.</p> <p>(continued on next page)</p>		

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<p>F 0578</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 [DATE] at 9:09 a.m., the SW revealed she was responsible for ensuring the OOH DNR was completed prior to uploading the document into the electronic record for those residents who requested DNR status. The SW stated, after reviewing Resident #95's electronic record, Resident #95 is a DNR, it's a recent code status and I know that because I handled it. The SW confirmed, Resident #95's OOH DNR was missing the physician's signature, printed name, license number and date. The SW stated, it was me that uploaded Resident #95's OOH DNR document and I take full responsibility for that. The SW revealed, the OOH DNR was invalid because of the missing physician information and resulted in Resident #95 would be identified as full code status and would be going against the family's wishes.</p> <p>During an interview on [DATE] at 4:04 p.m., the Administrator revealed, the SW was responsible for ensuring the OOH DNR documents were filled out completely and correctly. The Administrator revealed, not following the OOH DNR would be going against the resident/family's wishes.</p> <p>Record review of the Texas Health and Human Services webpage titled, Out of Hospital Do Not Resuscitate Program, updated [DATE], revealed, Frequently Asked Questions for DNR: What happens if the form is not filled out correctly or EMS has doubts about any of the information? Health professionals can refuse to honor a DNR if they think: The form is not signed twice by all who need to sign it or is filled out incorrectly.</p> <p>Record review of the facility policy and procedure, titled Communication of Code Status, date implemented [DATE] revealed in part, .It is the policy of this facility to adhere to resident's rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information .</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45307</p> <p>Based on record review and interviews, the facility failed to complete an accurate assessment which reflected the resident's status for 1 of 5 residents (Resident #78) reviewed for unnecessary medications.</p> <p>The facility failed to ensure Resident #78's diagnosis of depression was included in the residents annual MDS assessment on 01/31/2024.</p> <p>This failure could result in inadequate care due to an incomplete assessment of the resident's psychological condition.</p> <p>The findings included:</p> <p>Record review of Resident #78's face sheet, dated 3/28/2024, reflected a [AGE] year-old male resident initially admitted on [DATE], with a primary diagnosis of Type 2 Diabetes (the bodies inability to regulate sugars).</p> <p>Record review of Resident #78's Annual MDS Assessment, dated 1/31/2024, reflected that the resident did not have depression under the section Active Diagnosis. The MDS Assessment further reflected that Resident #78 was cognitively intact.</p> <p>Record review of Resident #78's Order Summary Report, dated 3/28/2024, reflected the resident had an order for Paroxetine 20 mg (an antidepressant used to treat depression) with a start date of 1/12/2024 for treating depression.</p> <p>Record review of Resident #78's Comprehensive Person-Centered Care Plan, dated 3/28/2024, reflected, [Resident #78] uses anti-depressant medication [refer to] insomnia and adjustment disorder.</p> <p>Interview on 3/28/2024 at 1:48 PM, RN H stated Resident #78 was taking Paroxetine for the purpose of treating depression. RN H stated that during a review of Resident #78's MDS Assessment, depression was not identified as an active diagnosis. RN H further stated that the MDS Assessment was completed by the MDS Coordinators and as a charge nurse he did not review them for their accuracy.</p> <p>Interview on 3/28/2024 at 2:00 PM, MDS Coordinator I stated she had reviewed and completed Resident #78's MDS Assessment on 1/12/2024 and had missed indicating Resident #78's depression due to a clerical error. MDS Coordinator I stated the risk associated with insufficiently completing resident assessments could result in residents' actual diagnosis going untreated and a change in condition being missed.</p> <p>Interview on 3/28/2024 at 2:07 PM, the DON stated she was not aware of Resident #78 being treated pharmaceutically for a diagnosis that Resident #78 was not assessed to have. The DON stated this practice has a risk of residents not being assessed adequately and having missed changes in condition.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy titled, Psychotropic Medication, dated 8/15/2022, reflected, 12. Use of psychotropic medications in specific circumstances: . B. Enduring condition (i. e., non-acute, chronic, or prolonged) I. The resident symptoms and therapeutic goals shall be clearly and specifically identified and documented.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45857</p> <p>Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments person-centered care plan to reflect the current condition for 1 of 22 residents (Resident #44) reviewed for care plan revisions.</p> <p>1. The facility failed to ensure Resident #44's care plan was comprehensive and updated to reflect Resident #44 resided on a locked unit, listed her allergies, listed her code status, and contained interventions for her dementia diagnosis.</p> <p>This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs.</p> <p>The findings included:</p> <p>1. Record review of Record review of Resident #44's face sheet revealed a [AGE] year-old female was admitted on [DATE] with diagnosis that included dehydration, dementia, muscle weakness, generalized anxiety disorder, seizures, insomnia, and cognitive communication deficit.</p> <p>Record review of Resident #44's Admission MDS, dated [DATE], indicated Resident #44's cognition was severely impaired. The MDS also indicated Resident #44 was receiving antianxiety medications and antidepressants.</p> <p>Record review of Resident #44's care plan indicated, revised on 03/26/24 did not contain any information about psychiatric diagnosis, the locked unit, allergies, code status or medications for psychiatric diagnosis. The care plan stated she had dementia but did not contain any interventions.</p> <p>During an interview on 03/29/24 at 2:33 p.m. the DON stated the care plan was missing information and should contain all of the residents needs so staff can provide appropriate interventions.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Pearsall Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  169 Medical Dr Pearsall, TX 78061	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy, titled Comprehensive Care Plans, dated 10/24/22, stated Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate. g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45857</p> <p>Based on observation, interview, 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 for 1 of 3 resident (Resident #47) reviewed for incontinent care, in that:</p> <p>The facility failed to ensure CNA G properly cleaned Resident #47 vaginal area after an incontinent episode.</p> <p>This deficient practice could place residents at-risk for infection and skin break down due to improper care practices.</p> <p>The findings were:</p> <p>Record review of Record review of Resident #47's face sheet revealed a [AGE] year-old female initially admitted on [DATE] and readmitted on [DATE] with diagnosis that included mood disorder due to known physiological condition with major depressive like episode, bipolar disorder severe with psychotic features (a mood disorder that features extreme shifts in mood, during which psychosis can occur. People with psychosis experience a disconnected view of reality. It can involve hallucinations and delusions.), insomnia (is a common sleep disorder that can make it hard to fall asleep or stay asleep), generalized anxiety disorder, schizophrenia (A mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior), mild intellectual disabilities, pseudobulbar affect (A nervous system disorder that causes inappropriate involuntary laughing and crying), schizoaffective disorder (A mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), sleep apnea (a is a potentially serious sleep disorder in which breathing repeatedly stops and starts), and cognitive communication deficit. Resident #47 was noted as her own Responsible party.</p> <p>Record review of Resident #47's Annual MDS, dated [DATE], indicated Resident #47's cognition was severely impaired. The MDS also indicated Resident #47 was always incontinent for urinary and required substantial maximal assistance for toileting.</p> <p>Record review of Resident #47's care plan, revised on 03/27/24 revealed: The resident has bladder incontinence related to confusion with interventions to Clean peri-area with each incontinence episode.</p> <p>Observation on 03/27/24 04:08 p.m. revealed, while providing incontinent care for Resident #47, CNA G cleaned the vaginal area and did not separate and clean between the vaginal folds.</p> <p>During an interview on 03/27/2024 at 4:27 p.m. CNA G revealed she was supposed to open and clean the labia (labia minor-inner fold) and confirmed she did not. CNA G stated she was supposed to clean between the folds to remove germs and prevent infections.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on 03/29/2024 at 02:31 p.m., the DON confirmed that during incontinent care the vaginal folds need to be cleaned to make sure they are properly cleaned and to remove any bacteria in the area.</p> <p>Review of annual skills check for CNA G revealed CNA G passed competency for Perineal care/incontinent care on 10/22/2020.</p> <p>Review of facility document, titled Incontinent Care Skills Checklist, no date, revealed . For women</p> <p>Use ONE WIPE PER STROKE. Cleanse labia majora (outer labia.) Repeat until clean. o Cleanse each side of vulva using a different wipe for each stroke. Repeat until clean. Once outer area is satisfactorily clean, separate labia and wipe down center (labia minora) FRONT TO BACK ONLY. Repeat as needed.</p> <p>Record review of the facility's policy titled Perineal Care, dated 10/24/2024, stated: Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Definition Perineal care refers to the care of the external genitalia and the anal area . 11. Females: a. Assist resident in bending her knees slightly and spreading her legs. b. Wet washcloth and apply perineal cleanser. If using prepackaged product, open package and obtain the wet cloth. 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). d. Repeat on opposite side using separate section of washcloth or new disposable wipe. e. Clean urethral meatus and vaginal orifice using clean portion of washcloth or new disposable wipe with each stroke. f. Pat dry with towel. g. Turn the resident on her side .</p>

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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>47611</p> <p>Based on interview and record review the facility failed to ensure 1(NA A) of 1 Nurses' Aides were not working in the facility longer than four months without being enrolled in or having completed an approved training course.</p> <p>The facility failed to ensure NA G was a certified nursing aide (CNA) within the required time frame.</p> <p>This failure place residents at risk for receiving care from an individual whose skill level was not known.</p> <p>Findings included:</p> <p>Record review of the facility staff roster provided upon entrance revealed:</p> <p>Nurses' Aide G was listed as a Nursing Assistant with an 04/24/2023 hire date.</p> <p>During an interview with HR on 03/29/2024 at 12:15 p.m., HR stated Nurses' Aide G did have a start date of employment at the facility on 04/24/2023 and she did not know if he had taken any type of CNA test for certification but did know Nurses' Aide G was listed on the staff list.</p> <p>During an interview with LVN C on 03/29/2024 at 1:15 pm, she stated that the nurse aide had completed his skills checklist, but she did not know why he had not taken the certification test.</p> <p>During an interview with the DON on 03/29/2024 at 1:18 p.m., she stated that she did not know why the nurse aide had not taken his certification test. She stated that they had been trying to contact the nurse aide, but he was not answering his phone.</p> <p>Nursing facilities must ensure that their temporary nurse aides register for testing and maintain documentation of registration and test dates on file. Any existing temporary nurse aides not certified before May 1, 2024, must complete a traditional Nurse Aide Training and Competency Evaluation Program (NATCEP) to be approved to take an exam and become certified.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45307</p> <p>Based on record review and interviews, the facility failed to administer a psychotropic medication to treat a specific, diagnosed condition for 1 of 5 residents (Resident #78) reviewed for unnecessary medications.</p> <p>Resident #78 was being administered a psychotropic medication (Paroxetine, an antidepressant used to treat depression) since 01/12/2024 without having an active and current diagnosis of depression.</p> <p>This failure could result in residents receiving unnecessary medications.</p> <p>The findings included:</p> <p>Record review of Resident #78's face sheet, dated 3/28/2024, reflected a [AGE] year-old male resident initially admitted on [DATE], with a primary diagnosis of Type 2 Diabetes (the body's inability to regulate sugars).</p> <p>Record review of Resident #78's Annual MDS Assessment, dated 1/31/2024, reflected that the resident did not have depression, insomnia, or adjustment disorder under the section Active Diagnosis. The MDS Assessment further reflected that Resident #78 was cognitively intact.</p> <p>Record review of Resident #78's Order Summary Report, dated 3/28/2024, reflected the resident had an order for Paroxetine 20 mg (an antidepressant used to treat depression) with a start date of 1/12/2024 for treating depression.</p> <p>Record review of Resident #78's Comprehensive Person-Centered Care Plan, dated 3/28/2024, reflected, [Resident #78] uses anti-depressant medication [refer to] insomnia and adjustment disorder.</p> <p>Interview on 3/28/2024 at 1:48 PM, RN H stated Resident #78 was taking Paroxetine for the purpose of treating depression. RN H stated that during a review of Resident #78's MDS Assessment, depression was not identified as an active diagnosis. RN H further stated that the MDS Assessment was completed by the MDS Coordinators and as a charge nurse he did not review them for their accuracy.</p> <p>Interview on 3/28/2024 at 2:00 PM, MDS Coordinator I stated she had reviewed and completed Resident #78's MDS Assessment on 1/12/2024 and had missed indicating Resident #78's depression due to a clerical error. MDS Coordinator I stated the risk associated with insufficiently completing resident assessments could result in residents' actual diagnosis going untreated and a change in condition being missed.</p> <p>Interview on 3/28/2024 at 2:07 PM, the DON stated she was not aware of Resident #78 being treated pharmaceutically for a diagnosis that Resident #78 was not assessed to have. The DON stated this practice has a risk of residents receiving unnecessary medications.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy titled, Psychotropic Medication, dated 8/15/2022, reflected, 12. Use of psychotropic medications in specific circumstances: . B. Enduring condition (i. e., non-acute, chronic, or prolonged) I. The resident symptoms and therapeutic goals shall be clearly and specifically identified and documented.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45857</p> <p>Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 4 medication cart (100 hall and 500 Hall medication cart) reviewed for storage of drugs.</p> <p>The Facility failed to provide change direction labels for 2 medications packages which had their medication orders changed.</p> <p>This deficient practice could place residents at risk of medication misuse and diversion.</p> <p>The findings were:</p> <p>Observation on 03/28/24 at 08:04 a.m. revealed a package in the 500-hall medication cart contained medication for Resident #39 with a label for Divalproex and instructions for 250 mg give 1 tab twice daily and 1 tablet of 125 mg to equal 375 mg.</p> <p>Observation on 03/28/24 at 08:16 a.m. revealed a package in the 100-hall medication cart contained medication for Resident #82 with a label for Divalproex and instructions for 125 mg, give 2 capsules to equal 250 mg every 12 hours.</p> <p>During an interview on 03/28/24 at 8:16 a.m., CMA J stated the medication package in the 500 cart for Resident #39's divalproex and the medication package in the 100 cart for Resident #82's divalproex did not match the current dosage orders. CMA J stated they usually use change order stickers to alert staff to the change, but they were out of stickers.</p> <p>Record review of Resident #39's physician orders, dated 03/29/24, revealed an order for Divalproex Sodium Oral Tablet Delayed Release 250 MG Give 1 tablet by mouth two times a day.</p> <p>Record review of Resident #82's physician orders, dated 03/29/24, revealed an order for Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG Give 1 capsule by mouth every 12 hours.</p> <p>During an interview on 03/29/24 at 2:22 p.m. the DON stated staff should place a change in direction sticker on any medications with a change in the order. The DON stated they had run out of stickers and staff should have notified her in advance to order more prior to running out. The DON stated the stickers help to alert staff the order has been changed and to prevent them from giving the wrong dose.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy titled Labeling of Medication, dated 10/01/2019, stated: Policy All drugs and biological in the Facility are labeled in accordance with all Federal and State regulations. The Facility will comply with the standards established by the pharmacy. Only the dispensing pharmacy/registered pharmacist can modify, change, or attach prescription labels. Procedure .1. Prescription drugs will be kept in container labeled by a Pharmacist or in the original manufacturer's container. Drugs will not be transferred into any other container. Single doses prepared for immediate administration are the exception</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45307</p> <p>Based on observation, interview, and record review, the facility failed to ensure all dietary staff were confirmed to have appropriate competencies and skillsets to carry out the functions of food and nutrition service for 1 of 1 facility (Activity Director) reviewed for food preparation.</p> <p>The activity director was concluded on [DATE] to be preparing food for resident use without having evidenced a food handlers' certificate to the facility.</p> <p>This failure could place all residents who consume food prepared during activities at increased risk of food-borne illness and not receiving adequate nutrition.</p> <p>Findings included:</p> <p>Observation on [DATE] at 2:45 PM revealed 2 reach-in refrigerator/freezer combination units and a deep freezer which contained: 3 dozen eggs, 2 gallons of whole milk, 1 bottle of caramel drizzle dated [DATE], 1 bottle of chocolate syrup dated ,d+[DATE], 1 bottle of mustard dated [DATE], 1 frozen non-alcoholic [NAME] mixer dated [DATE], and 4 large gallon sized bag containers of unlabeled, undated meat. Additionally revealed was a lock on the 2nd reach in refrigerator/freezer combination unit as well as deep freezer.</p> <p>Interview on [DATE] at 2:54 PM, the Activity Director stated she had been working at the facility as the Activity Director for the last two years. The Activity Director stated the deep freezer and first reach in refrigerator/freezer unit was only accessible by herself and her activity aides, and not by any of the nursing or dietary staff. The Activity Director further stated the foods stored in these refrigerators and freezers was exclusively for the purpose of preparing meals for residents and during staff community events and had done this for the last year. The Activity Director stated the locks existed due to a historic problem of facility staff stealing food stored. The Activity Director stated she prepares food from these refrigerator/freezer units during activity events and will cook raw meats such as chicken on an electric skillet that she has. The Activity Director stated that she equips a hairnet and temperature checks the meat after cooking and before serving to residents but did not obtain a food handlers' certificate. The Activity Director stated she was never required by facility administration to present evidence of a food handlers' training certificate. The Activity Director further stated she was unaware of the expired, past-dated, and unlabeled food items in the activities deep freezer and reach in refrigerator/freezer units. The Activity Director stated her activity aides audit the activities refrigerator and deep freezer once weekly but did not audit their work nor require documentation of these inspections since inspections started when she started at the facility.</p> <p>Observation on [DATE] 3:01 PM revealed an electric skillet that reaches a maximum temperature of 500 degrees Fahrenheit. Additionally revealed a storage of hairnets behind the activity director's desk.</p> <p>Record review of the staff certifications obtained by facility kitchen staff reflected that the AD did not have a food handlers' certificate.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 11:32 AM, the Administrator stated he was aware of the Activity Director preparing food for residents' consumption during activities. The Administrator further stated he did not request the activity director to complete a food handlers' certificate due to him believing she did not require one based on her not being a dietary staff member. The Administrator stated the potential risk associated with staff preparing food without first being food handler trained included a potential for food-borne illness.</p> <p>Record review of facility policy titled, Food Preparation and Handling, dated [DATE], reflected to ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and US Food Codes and HACCP guidelines.</p> <p>Record review of facility policy titled, Food Storage, dated [DATE], reflected, date, label, and tightly seal all refrigerated foods using clean, non-absorbent, covered containers that are approved for food storage.</p>		

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(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 - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45307</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 facility reviewed for kitchen sanitation.</p> <p>The facility failed to discard all past dated food in the activities refrigerators, and ensure all food items contained a label in the activities freezer and kitchen Freezer #5 as observed on [DATE].</p> <p>This failure could place all residents who consume food prepared by facility staff at increased risk of food-borne illness and not receiving adequate nutrition.</p> <p>The findings included:</p> <p>Observation on [DATE] at 10:45 AM revealed reach-in freezer unit #5 to contain the following items: 1 bag of diced meat, unlabeled; 1 bag of meat tenders, unlabeled; 1 bag of meat balls, unlabeled; 3 bags of meat cutlets, unlabeled.</p> <p>Interview on [DATE] at 11:25 AM, the DM stated she was unaware of the unlabeled food items observed within reach-in freezer unit #5 and stated it was her expectation that all items in her kitchen have a label but stated the cooks likely missed this item in the last two days and forgot to place a label. The DM stated the nutrition rooms in the facility are not a part of the dietary departments responsibilities and are inspected and audited by the nursing department.</p> <p>Observation on [DATE] at 2:45 PM revealed 2 reach-in refrigerator/freezer combination units and a deep freezer which contained: 3 dozen eggs, 2 gallons of whole milk, 1 bottle of caramel drizzle dated best by [DATE], 1 bottle of chocolate syrup dated best by ,d+[DATE], 1 bottle of mustard dated use by [DATE], 1 frozen non-alcoholic [NAME] mixer dated use by [DATE], and 4 large gallon sized bag containers of unlabeled meat. Additionally revealed there were locks on the 2nd reach in refrigerator/freezer combination unit and deep freezer.</p> <p>(continued on next page)</p>		

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  03/29/2024
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.

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 2:54 PM, the Activity Director stated the deep freezer and first reach in refrigerator/freezer unit was only accessible by herself and her activity aides, and not by any of the nursing or dietary staff. The Activity Director further stated the foods stored in these refrigerators and freezers was exclusively for the purpose of preparing meals for residents and during staff community events. The Activity Director stated the locks existed due to a historic problem of facility staff stealing food stores. The Activity Director stated she prepares food from these refrigerator/freezer units during activity events and will cook raw meats such as chicken on an electric skillet that she has. The Activity Director stated that she equips a hairnet and temperature checks the meat after cooking and before serving to residents but did not obtain a food handlers' certificate. The Activity Director stated she was never required by facility administration to present evidence of a food handlers' training certificate. The Activity Director further stated she was unaware of the expired, past-dated, and unlabeled food items in the activities deep freezer and reach in refrigerator/freezer units. The Activity Director stated her activity aides audit the activities refrigerator and deep freezer once weekly but did not audit their work nor require documentation of these inspections since inspections started when she started at the facility.</p> <p>Record review of the facility food handling certifications obtained by the facility kitchen staff on [DATE] reflected that the AD did not have a food handlers' certificate.</p> <p>Interview on [DATE] at 11:32 AM, the Administrator stated he was not aware of the unlabeled or past dated items stored in the kitchen or nutrition room. The Administrator stated it was his expectation that all food in the facility be labeled and discarded once the printed date was past. The Administrator stated the potential risk associated with past dated and unlabeled items being retained included a potential for food-borne illness.</p> <p>Record review of facility policy titled, Food Preparation and Handling, dated [DATE], reflected to ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and US Food Codes and HACCP guidelines.</p> <p>Record review of facility policy titled, Food Storage, dated [DATE], reflected, date, label, and tightly seal all refrigerated foods using clean, non-absorbent, covered containers that are approved for food storage.</p>