STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455797	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearsall Nursing and Rehabilitation Center	169 Medical Dr Pearsall, TX 78061

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview and record review the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #92) of 8 residents reviewed for baseline care plans. The facility failed to include Resident #92's use of antipsychotic medication in his baseline care plan. This failure could result in residents not receiving needed care and treatment. Findings Included: Record review of Resident #92's Admission Record dated 05/09/2025 revealed he was a [AGE] year-old man admitted [DATE] with diagnoses which included dementia (general term for loss of memory, language, problem-solving and other thinking abilities) and unspecified psychosis (when a person has trouble telling the difference between what's real and what's not). Record review of Resident #92's entry MDS assessment dated [DATE] revealed a BIMS score of 2 indicating severe cognitive impairment, and was assessed as taking an antipsychotic medication. Record review of Resident #92's Baseline Care Plan initiated 4/1/2025 revealed a problem area for uses antipsychotic medications r/t psychosis with an initiated date of 05/06/2025. Record review of Resident #92's Medication Administration Record for May 2025 revealed an order for OLANZapine Oral Tablet 2.5MG (Olanzapine). Give 1 tablet by mouth at bedtime for psychosis give 1 tablet to equal 2.5mg po at hs. This order for Olanzapine had a start date of 04/01/2025. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MDS Nurse-D on 05/08/2025 at 11:57 a.m., MDS Nurse-D stated Resident #92 had an order for Olanzapine, an antipsychotic medication on the day he was admitted [DATE], but this was not addressed on his Baseline Care Plan, and was not added to his Care Plan until 05/06/2025. MDS Nurse-D stated Baseline Care Plans should be completed within 48 hours, and include essential information such as fall risk, and Physician Orders which would include the different type of medications taken. She stated it was important to have this information in the Baseline Care Plan to provide staff with all the information needed to meet his needs after his admission. MDS Nurse-D stated that the admitting Nurse was responsible for completing baseline care plans. Interview on 05/09/2025 at 09:13 a.m. with the DON revealed that the admitting Nurse was responsible for completing Baseline Care Plans, and that Resident #92's Baseline Care Plan should have included his use of an antipsychotic medication. The DON stated that the facility was monitoring for side effects of the anti-psychotic medication and providing good care, but through oversight, it just did not make it onto the Baseline Care Plan within the 48 hours, but had been added later. Record review of the facility policy titled Baseline Care Plan reviewed 10/05/2023 revealed The baseline care plan will: a. be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. initial goals based on admission orders. ii. Physician Orders .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the 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 comprehensive assessment for 1 of 8 residents (Resident #89) reviewed for care plans: The facility failed to ensure Residents #89's Care Plan reflected he should receive PASRR services. This deficient practice could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. The findings included: Record review of Resident #89's admission record, dated 5/9/25, revealed a [AGE] year-old male resident was admitted to the facility on [DATE] and readmitted last on 10/1/24 with diagnoses including major depressive disorder, schizoaffective disorder, insomnia, anxiety disorder, and unspecified psychosis not due to a substance or known physiological condition. Record review of Resident #89's quarterly MDS assessment, dated 2/5/25, revealed Resident #89's cognition was fully intact for daily decision making. Record review of Resident #89's Care Plan, revealed a problem area, initiated on 6/13/24 and revised on 2/17/25, for the resident used antipsychotic medication related to schizoaffective, bipolar type, and a history of psychosis with interventions to be evaluated and treated by a mental health service, and monitor/document/report any adverse reactions of antipsychotic medications. The care plan did not indicate if the resident was receiving PASRR services. Record review of Resident #89's document titled PASRR Evaluation, dated 1/17/25, revealed he was evaluated for qualifying mental illness by a qualified mental health professional. During an interview on 5/9/25 at 12:33 p.m. MDS D stated Resident #89 stated she believed the resident had refused PASRR services. MDS D stated she would need to check but if the resident had refused services, they would still need to add it to the care plan, so people are aware that he was positive for services but refused them and the facility had addressed it. During a follow up interview on 5/9/25 at 12:45 p.m. MDS D stated Resident #89 had not refused PASRR services, and they were waiting for services to be implemented after his recent evaluation. MDS D stated he was receiving psychiatric services in the meantime. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, titled Comprehensive Care Plans, dated 10/22/24, 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 . Policy Explanation and Compliance Guidelines: 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 . 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 i:'etlise treatment c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for 1 of 2 residents (Resident #61) reviewed for pressure injuries. The facility nurse did not provide wound care to Resident #61 on the evening of 05/07/2025 as ordered. This failure could place residents at risk of improper wound management, deterioration in existing pressure injuries, infection, and pain. Findings included: Record review of Resident #61's admission record dated 05/08/2025 revealed he was a [AGE] year-old-man initially admitted on [DATE], and readmitted on [DATE] with diagnosis which included: Pressure ulcer of sacral region Stage 4 (most severe type of pressure injury, characterized by full-thickness skin loss located at base of spine, just above buttocks). Record review of Resident #61's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 indicating intact cognition. He was assessed as being dependent (helper does all the effort) for transfers and having a diagnosis of Pressure Ulcer of sacral region, Stage 4. Record review of Resident #61's Comprehensive Care Plan initiated 11/19/2021, revealed a problem area for stage 4 pressure ulcer to sacrum . with interventions which included Administer treatments as ordered and monitor for effectiveness:. Record review of Resident #61's Physician Order Summary dated 05/08/2025 revealed an order to CLEANSE SACRAL STAGE IV PRESSURE ULCER WITH VASHE [cleansing wound solution]. PAT DRY WITH 4X4 GAUZE. APPLY SKIN PREP TO PERI WOUND. PLACE VASHE SOAKED GAUZE IN NEGATIVE SPACE OF SACRAL PRESSURE WOUND. COVER WITH ABD [abdominal] PAD AND SECURE WITH KERLIX TID AND PRN UNTIL HEALED. Order date 05/02/2025. Record review of Resident #61's Treatment Administration Record (TAR) for May 2025 revealed an order to Cleanse sacral stage IV pressure ulcer with VASHE [cleansing wound solution]. Pat dry with 4x4 gauze. Apply skin prep to peri wound. Place VASHE soaked gauze in negative space of sacral pressure wound. Cover with ABD pad and secure with Kerlix [bulky gauze bandage] TID and PRN until healed with start date of 5/2/2025. Further review revealed Resident #61 was to receive this wound treatment at 0800 [8:00a.m], 1400 [2:00p.m.] and 2000 [8:00 p.m.] every day. On 5/7/2025 at 2000 [8:00p.m.], there were no initials to indicate the wound treatment had been completed. Observation on 05/08/2025 at 08:42 a.m. of wound care for Resident #61 provided by LVN-E revealed that Resident #61 had a dressing dated 5/7/2025 over a wound he had on the back of his upper left thigh, but there was no dressing observed over the Stage IV wound on his sacrum. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN-E on 05/08/2025 at 09:48 a.m., LVN-E stated she had removed the dressing over his sacral wound just prior to the State Surveyor observing his wound care, because she had checked to see if he was clean, and found the sacral wound dressing to be soiled with drainage from his wound and she wanted to clean that up before the State Surveyor observed his wound care. LVN-E stated that Resident #61's had orders for his Stage 4 sacral wound to be cleaned and dressed three times a day, and that the dressing that she had removed earlier had been dated 05/07/2025, but had no time on the dressing and had been heavily soiled with drainage. She reviewed Resident #61's treatment record for May and stated that there was no entry for the 2000 [8:00p.m.] dressing change on 05/07/2025, but could not say if that was a documentation error, or the wound care had not been done. Interview with the DON on 05/08/2025 at 11:46 a.m. revealed that she had contacted the Nurse, LVN-F who had been assigned to provide Resident #61's wound care treatment on the evening of 05/07/2025, and LVN-F told her she had not completed his wound care that night because she had gotten busy and forgot, and the DON stated that she had never done that before. The DON stated she notified Resident #61's Physician of this medication error and that he would be going to see the Wound Care Doctor the next day. The DON stated that by not providing wound care to Resident #61's sacral wound as prescribed, it could result in his wound because worse or slowing healing. Telephone interview on 05/08/2025 at 6:00 p.m. with LVN-F revealed she was Resident #61's assigned Nurse on the evening of 05/07/2025, and had not completed his prescribed wound care at 2000 [8:00p.m.] that evening because she had gotten very busy and did not have time to complete. She stated this was the only time she had not been able to complete his wound care as scheduled, and that not providing his wound care as prescribed could result in his pressure ulcer getting worse. Record review of facility policy titled Topical Administration reviewed 10/01/2019, revealed Apply topical treatment (medication and dressing if indicated) as per physician's order

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45857 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 1 of 3 medication cart (300 Hall medication cart) reviewed for storage of drugs. The Facility failed to provide change direction labels for Resident #86's medication package of sertraline (Sertraline is an SSRI (serotonin reuptake inhibitor) that increases serotonin levels between neurons (nerves) by blocking serotonin from being absorbed.) which had medication order change from 150 mg to 50 mg. This deficient practice could place residents at risk of medication misuse and diversion. The findings were: Observation on 5/8/25 at 08:32 a.m. revealed a package in the 300-hall medication cart contained medication for Resident #86 with a label for 50 mg of sertraline, and instructions to give 1 tab by mouth daily with 100 mg to equal 150 mg. MA J administered 50 mg of sertraline to Resident #86. Record review of Resident #86's physician orders, dated 5/9/25, revealed an order for sertraline 50 mg give 1 tab by mouth one time a day with a start date of 4/4/25 and no end date. During an interview on 5/9/25 at 10:11 a.m. the DON stated staff should place a change in direction sticker on any medications with a change in the order so staff with be altered and not give the wrong amount of medication to the resident. 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 . A. When there is a change to a physician order, the nurse receiving the order will affix a Direction Change sticker or equivalent to the label if there is no change in the medication. This sticker will be placed so as not to obliterate any other required information on the medication label. B. When such label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physician's order for current information. C. The dispensing pharmacy is informed prior to the next refill of the prescription so the new container will contain an accurate label .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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. 36232 Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 facility reviewed for dietary requirements. The FSS did not have the appropriate certification, education, or qualifications to serve as the Director of Food and Nutrition Services. This deficient practice could place the residents who consume food prepared from the kitchen at risk of food borne illness and not receiving adequate nutrition. Findings included: During an interview on 05/06/2025 at 11:07 AM, the FSS was hired 06/30/22 and stated she was not a certified dietary manager or certified food service manager, and she did not have an associate's or higher degree in food service management or in hospitality. She had 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting but had not completed a course of study in food safety management that included topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving. She attempted to become certified but the facility had gone through several consultant RDs and there had not been one assigned to the facility long enough to serve as a preceptor. During an interview on 05/08/2025 at 10:37 AM, the consultant RD stated did not work at the facility full time. She provided approximately 12 - 16 hours of consultative hours to the facility per month. During an interview on 05/08/2025 at 2:20 PM, the Administrator stated he was aware the FSS was not a certified dietary manager, certified food manager and could not produce evidence she completed a course of study including topics integral to maintaining dietary operations and stated he would take care of it. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 1-201.10.10(B) Accredited Program. (1) Accredited program means a food protection manager certification program that has been evaluated and listed by an accrediting agency as conforming to national standards for organizations that certify individuals. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2-102.12.

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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. 36232 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. 1. The facility failed to maintain the temperature of reach-in cooler #1 at or below 41 degrees F. 2. The facility failed to ensure a package of pork sausage and a package of sliced salami were discarded by their use-by dates. 3. The facility failed to record the temperature of reach-in cooler #1 on the Refrigerator Temperature Record on 05/08/2025. 4. The facility failed to properly sanitize the compartments of the blender used to puree food for modified diets in accordance with manufacturer's instructions. These failures could place residents at risk for food borne illness. The findings included: 1. Observation on 05/06/2025 at 11:12 AM of reach-in cooler #1 revealed the digital display outside the cooler indicated a temperature of 52 degrees F. Further observation inside the cooler revealed an analogue thermometer indicating a temperature of 51 degrees F. The Dietary Refrigerator and Freezer Temperature Record posted on the side of the cooler indicated the internal temperature of the cooler was 40 degrees F on 05/06/2025. There was no time noted on the log. During an interview on 05/06/2025 at 11:13 AM the FSS stated the internal temperature of reach-in cooler #1 was not good, it should be at or below 41 degrees F, and she would speak to the maintenance supervisor. She did not know what time the temperature was taken that morning, but it was taken by the early DA. All kitchen staff was responsible for keeping an eye on the temperatures of the coolers. Staff was trained during meetings twice a month. During an interview on 05/06/2025 at 11:14 AM, DA A stated she had noted the temperature of reach-in cooler #1 was 40 degrees F and recorded this temperature on the log at 5:00 AM that morning. During an interview on 05/06/2025 at 11:32 AM, the Administrator stated all food from reach-in cooler #1 had been discarded and the cooler would not be in use until it was repaired and maintaining the proper temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy 03.003 Food Storage revised 06/01/2019 revealed, Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. 2. Refrigerators. a. Keep fresh meat, poultry, seafood, dairy products and most fresh fruit and vegetables in the refrigerator at an internal temperature of 41 F or less. h. Place a thermometer inside refrigerators near the door where the temperature is warmest. Check the temperature of all refrigerators using the internal thermometer to make sure the temperature stays at 41 F or below. Temperatures should be checked each morning and again on the PM shift. Record the temperatures on a log that is kept near the refrigerator. i. Record review of Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (2) At 5 C (41 F) or less. 2. Observation on 05/06/2025 at 11:16 AM in the kitchen revealed inside reach-in cooler #2 a package 5 lb. package of pork chorizo sausage that had been opened and was stored in a sealed zip-locked bag. Written in black marker on the zip-locked bag was, Received 4/11/25 and Opened 4/12/25. Observation on 05/06/2025 at 11:25 AM in the reach-in stand-alone refrigerator revealed a package of uncured sliced salami that had been opened and was stored in a sealed zip-locked bag. Written in black marker on zip locked bag was, 12/22/24. During an interview on 05/06/2025 at 11:26 AM, the FSS stated the opened packages of pork sausage and salami should not have been in the cooler and refrigerator and should have been discarded by dietary staff. All staff was trained on proper storage of food upon hire and during bi-monthly training classes. Record review of facility policy 03.003 Food Storage revised 06/01/2019 revealed, e. Use all leftovers within 72 hours. Discard items that are over 72 hours old. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. 3. Observation on 05/08/2025 at 10:00 AM revealed there was no entry on the Dietary Refrigerator and Freezer Temperature Record posted on the outside of reach-in cooler #1. During an interview on 05/08/2025 at 10:02 AM, the FSS stated DA B worked the early shift that morning and was responsible for recording the temperature on the log. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/2025 at 10:05 AM, DA B stated she noted the internal temperature of reach-in cooler #1 at 5:00 AM when she arrived for duty in the kitchen and it was 40 degrees F. She failed to record the temperature on the log because she was in a hurry. She understood the importance of recording the internal temperatures of the cooler on the log, especially since that particular cooler was discovered to have malfunctioned at some point in the morning of 05/06/2025. 4. Observation on 05/08/2025 at 10:20 AM in the kitchen revealed [NAME] C blended spinach in the high-speed blender for residents ordered a pureed-texture diet. Observation on 05/08/2025 at 10:25 AM revealed [NAME] C emptied the contents of the blender in a pan and took the blender and a measuring cup to the three-compartment sink. [NAME] C used a Quaternary Test Kit to test the concentration of sanitizing solution in the third sink. The test strip revealed a concentration of approximately 200 ppm, indicating an adequate concentration of chlorine to sanitize equipment and dishes. [NAME] C washed the measuring cup and blender components (blade, lid, and container) in the first sink, rinsed the cup and blender components in the second sink, and submerged the cup and blender components in the third sink containing the sanitizing solution. [NAME] C removed the measuring cup and blender components from the third sink containing the sanitizing solution immediately after submersion. [NAME] C then took all items back to the preparation table in the kitchen to puree the next menu item. During an interview on 05/08/2025 at 10:30 AM, [NAME] C stated equipment and dishes needed to be submerged in the sanitizing solution for ten seconds. During an interview on 05/08/2025 at 10:38 AM, the FSS stated equipment and dishes needed to be submerged in the sanitizing solution for 30 seconds to absorb the sanitizer. During an interview on 05/08/2025 at 2:00 PM, the administrator stated equipment and dishes needed to be submerged in the sanitizing solution for 60 seconds or per manufacturer's instructions. Record review of the label on the container of Auto-Clor System Solution QA used by the facility revealed, Directions for use: Treated surfaces must remain wet for 60 seconds. Drain thoroughly and allow to air dry before reuse. Record review of facility policy 04.005 Manual Cleaning and Sanitizing of Utensils and Portable Equipment updated 10/10/2018 revealed, Policy: The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for manual cleaning in order to ensure that all utensils and equipment are thoroughly cleaned and sanitized to minimize the risk of food hazards. b. Immerse for at least 60 seconds in a clean sanitizing solution containing: i. A minimum of 50 parts per million of available chlorine at a temperature not less than 75 F, or iii. Any other chemical sanitizing agent which has been demonstrated to be effective and non-toxic under use conditions and for which a suitable field test is available. Such other sanitizing agents, in-use solutions, shall provide the equivalent sanitizing effect of a solution containing at least 50 parts per million of available chlorine at a temperature not less than 75 F. The concentration and contact time for quaternary ammonium compounds shall be in accordance with the manufacturer's label directions. C. Be sure to cover all surfaces of the utensils and/or equipment with hot water or the sanitizing solution and keep them in contact with it for the appropriate amount of time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455797	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearsall Nursing and Rehabilitation Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 of 8 residents (Residents #69 and #45) reviewed for infection control. 1. The facility failed to ensure CNA -G, after completing peri and foley care for Resident #69, did not replace a bed wedge that had fallen on the floor back onto Resident #69's bed without cleaning/sanitizing it first. 2. The facility failed to ensure RN I changed his gloves and sanitized his hands after removing an old bandage and placing a new bandage, while performing peg tube (an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) site care for Resident #45. These failures could place residents at risk for cross contamination and infection. The finding included: 1. Record review of Resident #69's Admission Record revealed she was an [AGE] year-old woman admitted on [DATE] with diagnoses which included: cerebral infarction (also known as a stroke, which occurs when blood flow to brain is blocked causing brain tissue to die) and neuromuscular dysfunction of bladder (occurs when signals from nervous system to the bladder are disrupted leading to issues with bladder control and emptying). Record review of Resident #69's 5-day MDS assessment dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment and was assessed as being dependent for transfers and toileting hygiene. Record review of Resident #69's Care Plan initiated revealed problem areas which included: need for Enhanced Barrier Precautions due to foley catheter and ulcers, and is at risk for infection (initiated 3/19/2025). Record review of Resident 369's Order Summary dated 05/08/2025 revealed orders including: Foley cath care q shift and PRN Observation on 05/08/2025 at 8:25 a.m. of foley and peri-care for Resident #69 revealed CNA-G and CNA-H both sanitized their hands, put on gown and gloves and then CNA-G prepared the area by unharnessing and removing an oblong wedge that had been attached to the side of Resident #69's mattress with straps, midway along the length of the bed. The wedge dropped onto the floor and CNA-G was then observed to kick the wedge under the bed to clear it from where she was standing. CNA-G and CNA-H then provided foley and peri-care for Resident #69. After completing the peri-care and repositioning Resident #69, CNA-G picked up the wedge from floor underneath Resident #69's bed and placed it back on the bed, midway along the side of the bed, and attached it back to the mattress with harness straps without cleaning or sanitizing the mattress. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA-G on 05/08/2025 at 8:38 a.m., CNA-G stated that normally the bed wedge just hung over the side of the bed by the harness straps after she removed it for peri-care, not touching the floor, but this time the straps released completely and the wedge fell to the floor. She stated she should have cleaned and sanitized the wedge before replacing it on the bed next to Resident #69 because it had come into contact with dirt and germs on the floor. She stated that by not cleaning the wedge after it was on the floor, it could have caused the spread of germs from the floor to Resident #69. During an interview with the DON on 05/08/2025 at 11:46 a.m., the DON stated that CNA-G should have cleaned and sanitized the bed wedge before placing it back on the bed, noting that Resident #69 was on Enhanced Barrier Precautions, which indicated an increased risk of infection, and that placing the dirty wedge back on the bed could increase the risk for spread of infection. The DON stated CNA-G had worked at the facility a long time, and had been trained on infection control. 2. Record review of Resident #45's admission record, dated 5/9/25, revealed a [AGE] year-old female resident was initially admitted on [DATE], and readmitted on [DATE] with diagnoses including dementia, cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes.), and dysphagia (difficult swallowing) following cerebral infarction. Record review of Resident #45's Quarterly MDS Assessment, dated 4/2/25, revealed she had severely impaired cognition for daily decision making. Section K revealed the resident had a feeding tube. Record review of Resident #45's Care Plan revealed a problem area, initiated on 4/18/24, the resident required tube feeding related to dysphagia with interventions to Monitor/document/report PRN any signs and symptoms of: aspiration- fever, SOB (shortness of breath), tube dislodged, infection at tube site, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, and dehydration. Record review of Resident #45's Order Summary, dated 5/7/25, revealed an order to cleanse PEG tube site with normal saline and pat dry with 4x4 gauze. Paint with skin prep and leave open to air one time a day, with a start date of 3/10/25, and no end date. During an observation on 5/8/25 at 2:11 p.m. RN-I removed Resident #45's gauze pad from her PEG tube site. The bandage was dated 5/7/25. RN-I discarded the old gauze bandage, with the same gloves, RN-I opened a new package of split gauze, placed it around the residents PEG tube and secured it to the residents abdomen with tape. RN-I did not change his gloves or sanitize his hands after removing the old gauze bandage and applying the new one. During an interview on 5/8/25 at 2:32 p.m. RN-I stated he should have changed his gloves and sanitized his hands after he removed the old bandage and before he applied the new bandage. RN-I stated his hand sanitizer was in his pocket and not accessible during care. RN-I stated he needed to change his gloves and sanitize his hands because you do not know what was on the old bandage, they can get an infection, and become septic (Sepsis occurs when your immune system has a dangerous reaction to an infection. It causes extensive inflammation throughout your body that can lead to tissue damage, organ failure and even death.). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/25 at 12:24 p.m. The DON stated staff should remove their gloves, sanitize their hands, and apply new gloves when removing an old bandage and placing a new one on, to prevent infection to the resident. Record review of the facility policy titled Infection Prevention and Control Program implemented 5/13/2023 revealed This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Further review revealed all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. Record review of the facility policy titled Hand Hygiene, dated 10/24/22, stated All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR) .1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice . 6. Additional considerations: a. The use of gloves does not replace band hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . 45857