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	07/16/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 6 residents (Resident #17) reviewed for resident assessments.The facility failed to ensure Resident #17's MDS assessment dated [DATE] correctly assessed the resident received dialysis treatments.These failures could place residents at risk for inadequate care and services.The findings included:Record review of Resident #17's face sheet dated 7/13/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included diabetes (condition in which the body has trouble controlling the amount of sugar in the blood), hyperlipidemia (too much fat in the blood; high cholesterol), peripheral vascular disease (poor circulation, usually in the legs, because the blood vessels have become narrowed by fatty deposits), chronic kidney disease stage 5 (kidney failure; the kidneys have lost nearly all their ability to filter the blood, and dialysis or a kidney transplant may be needed to keep the person alive).Record review of Resident #17's most recent MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making skills and was diagnosed with kidney disease. Resident #17's MDS assessment under Section O, Special Treatments, Procedures, and Programs did not reflect the resident required dialysis treatments.Record review of Resident #17's Order Summary Report dated 7/13/26 reflected the following:- Dialysis, check shunt to left upper arm for signs and symptoms of infection or bleeding every shift with order date 6/3/26 and no end date- Dialysis provided by dialysis clinic Monday, Wednesday, and Friday at 4:00 p.m. with order date 6/3/26 and no end dateRecord review of Resident #17's comprehensive care plan initiated 6/3/26 and revised on 6/24/26 reflected the resident required dialysis treatments related to end stage renal disease with the goal to ensure the resident did not have signs or symptoms of complications from dialysis.During an interview on 7/13/26 at 2:35 p.m., MA A stated Resident #17 had only been admitted to the facility a short time ago, but as far as she knew the resident had been getting dialysis treatments since he had been admitted . MA A stated she was not sure what days or times Resident #17 had dialysis treatments.During an interview on 7/14/26 at 8:11 a.m., Resident #17 stated he was admitted to the facility about three weeks ago and stated he had been receiving dialysis treatments for the past 3 1/2 years. Resident #17 stated he continued with dialysis treatments while at the facility and had a dialysis appointment yesterday, 7/13/26. During an interview on 7/15/26 at 10:20 a.m., LVN B stated Resident #17 had been admitted into the facility for restorative care related to an injury to his right leg. LVN B stated, Resident #17 had been receiving dialysis treatments prior to his admission and continued with treatments while a resident at the facility. LVN B stated Resident #17 had dialysis treatments scheduled on Monday, Wednesday, and Friday and nursing was responsible for obtaining vital signs and filling out the proper documentation prior to the resident going to dialysis treatments. During an interview on 7/15/26 at 10:27 a.m., the MDS nurse, after she reviewed Resident #17's MDS assessment dated [DATE] stated dialysis should have been triggered on the MDS assessment and basically it was an oversight; a data entry error. The MDS nurse stated the accuracy of the MDS was important because it provided an overall picture of the resident, which was then translated into developing the care plan, which helped as a guide for the staff on how to care for the resident.During (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 7/15/26 at 10:37 a.m., the DON stated, the importance of the MDS was that it provided a picture of the resident which was used to develop the care plan. The DON stated that the MDS and the care plan help to identify health issues and resident needs and instructs the staff on the type of care they should be providing. The DON stated the facility followed the guidance of the RAI to develop and complete the MDS assessments. Record review of the CMS's RAI Version 3.0 User's Manual dated October 2025, Section O0110: Special Treatments, Procedures, and Programs, O0110J1, Dialysis reflected in part, .Code peritoneal or renal dialysis which occurs at the nursing home or at another facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. 1 of 6 residents (Resident #97) reviewed for pharmaceutical services. LVN B did not prime (a safety test used prior to injecting a patient with insulin in which the dosage selector is dialed to waste at least 2 units of insulin and if insulin solution is seen at the tip of the needle it ensures an accurate dose is injected) the insulin pen prior to injecting Resident #97 with insulin. This deficient practice could affect residents who received insulin by a flex pen in the facility by not receiving the intended therapeutic benefit of their medication.The findings included:Record review of Resident #97's face sheet dated 7/16/26 reflected a [AGE] year old male admitted into the facility on [DATE] and re-admitted on [DATE] with diagnoses that included acquired absence of left toes, diabetes (condition in which the body has trouble controlling the amount of sugar in the blood), peripheral vascular disease (poor circulation, usually in the legs, because the blood vessels have become narrowed by fatty deposits), and acquired absence of right leg below the knee.Record review of Resident #97's most recent comprehensive MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills, had a diagnosis of diabetes and was treated with insulin.Record review of Resident #97's Order Summary Report dated 7/16/26 reflected the following:- Lantus 100 unit/ML insulin, inject 30 units subcutaneously two times a day related to diabetes with order date 2/12/26 and no end dateRecord review of Resident #97's comprehensive care plan with revision date 10/31/23 reflected that the resident had diabetes and was at risk for complications with interventions that included administering medications as ordered by the doctor.During an observation on 7/15/26 at 8:31 a.m., LVN B obtained Resident #97's Lantus insulin from the medication cart and inserted a needle into the rubber seal without cleaning it first. LVN B then took the Lantus insulin pen, did not prime the insulin pen, and dialed the dosage to 30 units and injected the resident with the insulin.During an interview on 7/15/26 at 8:54 a.m. LVN B stated he was not familiar with priming an insulin pen and stated, I don't fully know the technology behind priming the (insulin) pen. LVN B stated he had skills training within the year, including training on the use of insulin. During an interview on 7/15/26 at 3:55 p.m., The DON stated that an insulin pen should be primed prior to administering insulin and should be checked for air bubbles because it could cause an adverse effect on the resident and priming the insulin pen ensures the resident received the appropriate dose.Record review of LVN B's Medication Pass Competency Assessment, dated 1/4/26 reflected he had satisfied the requirements for administering insulin injections. Record review of the Lantus package insert, Instruction Leaflet, with revision date 11/2018 reflected in part, .Follow these instructions completely each time you use.to ensure that you get an accurate dose. If you do not follow these instructions you may get too much or too little insulin, which may affect your blood glucose.Always perform the safety test before each injection.Performing the safety test ensures that you get an accurate dose by ensuring that pen and needle work properly.removing air bubbles.Select a dose of 2 units by turning the dosage selector.Hold the pen with the needle pointing upwards.Press the injection button all the way in. Check if insulin comes out of the needle tip.You may have to perform the safety test several times before insulin is seen.Check that the dose window shows ?0' following the safety test.Select your required dose.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review the facility failed to provide special eating equipment for residents who needed them and appropriate assistance to ensure that the resident could use the assistive devices when consuming meals for 1 of 1 resident (Resident #24) reviewed for special eating equipment and assistance when consuming meals.The facility failed to ensure Resident #24 received the physician-ordered slow-flow adaptive drinking cup during the noon meal on 07/13/2026.The failure placed Resident # 24 at risk for aspiration and/or aspiration pneumonia.Record review of Resident #24's face sheet dated 06/11/2024 revealed Resident #24 had a diagnosis including dysphagia (medical term for difficulty swallowing) and a history of stroke (a medical emergency that happens when blood flow to part of the brain stops, causing brain cells to die from lack of oxygen).Record review of Resident #24's physician orders dated 06/11/2024 revealed order for slow-flow adaptive drinking cup with fluids.Record review of Resident #24's care plan dated 11/11/2025 revealed the need for the adaptive drinking cup to promote safe swallowing and reduce the risk of aspiration.Record review of Resident #24's meal ticket revealed Resident #24 required a slow-flow adaptive drinking cup with meals.Observation of meal service on 07/13/26 at 12:15 pm revealed CNA D served Resident #24 cranberry juice in a regular drinking cup. Resident #24 independently lifted the regular drinking cup, drank the cranberry juice, and immediately coughed after swallowing.During an interview with CNA D on 07/13/26 at 12:17 pm CNA D stated Resident #24 should have been provided a slow-flow adaptive drinking cup during the meal. CNA D acknowledged the resident was served the incorrect drinking cup. CNA D stated he could cough and drink too fast.During an interview with LVN C on 07/13/2026 at 12:23pm, LVN C stated she has worked at facility for about 4 years. She stated I look at the slip and make sure it's correct if it's not, I'll ask the kitchen to make the changes or get what is needed. I reviewed [Resident #24's] meal ticket. I didn't see if he had a sippy cup. He should have had a sippy cup. I'm the one responsible for making sure the residents have what is ordered from the doctor for the residents. The order should have been followed. He could aspirate or something.During an interview with SLP on 07/15/2026 at 3:30 pm, SLP stated Resident #24 requires thin liquids with small sips when drinking. I made those recommendations because the smaller the sips are the more the muscles have control to assist with the swallowing process. The SLP stated that due to Resident #24's diagnosis of dysphagia, he should be monitored and have small sips while drinking or he could cough or potentially aspirate and the fluids could go into his lungs. Interview with Director of Nursing on 07/15/26, at 4:45 p.m., the DON stated Resident #24 should have received the physician-ordered slow-flow adaptive drinking cup. The DON stated staff are educated regarding resident's adaptive equipment needs and explained the purpose of the slow-flow adaptive drinking cup is to regulate the rate of fluid intake and promote safer swallowing. The DON further stated failure to provide the ordered slow-flow adaptive drinking cup could increase the resident's risk for aspiration and aspiration pneumonia.Record review of the facility's undated policy titled Adaptive Equipment documented:6. Staff are required to provide adaptive equipment as ordered and ensure residents receive care and services necessary to maintain safety and meet identified needs and individualized care plans to promote resident safety during meals. Staff are expected to provide adaptive devices as ordered and to follow physician orders and individualized care plans to promote resident safety during meals.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 1 resident (Resident #23) reviewed for hospice services, in that: The facility failed to ensure Resident #23's hospice documents including: The hospice election form and the physician certification and recertification of the terminal illness specific to each patient were present in the hospice binder in the facility. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation. Record review of Resident #23's admission Record dated 07/15/26 revealed a [AGE] year old female admitted to facility 04/01/26. Resident #23's diagnoses included schizophrenia (a chronic brain disorder where individuals interpret reality abnormally), malignant neoplasm of unspecified site of right female breast (a cancerous tumor originating in the right breast), secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes (metastatic cancer meaning cancer cells from a primary tumor have spread to the armpit and upper limb lymph nodes) and mild intellectual disabilities (characterized by an IQ typically between 50 and 70 and significant limitations in adaptive daily living skills). Record review of Resident #23's Significant Change MDS dated [DATE] revealed a BIMS score of 5 indicating severe cognitive impairment. Record review of Resident #23's comprehensive care plan revealed she was placed on hospice services with the date initiated on 06/15/26. Record review of Resident #23's Physician Order Summary as of 07/16/26 revealed she was admitted to [Hospice Company] services for malignant neoplasm of the right breast with an order date of 06/12/26. Record review of the hospice binder for Resident #23 on 07/15/26 at 3:00 pm revealed that there were no forms under the tab for Form 3071 and 3074. During initial rounds on 07/13/26 at 10:45 am, Resident #23 was observed visiting with a hospice employee in her room. During an interview on 07/15/26 at 10:55 am, Resident #23 confirmed she had a visitor from hospice. Resident #23 indicated during her conversation that she was pleased with services from the facility and hospice and that she received help when she needed it. During an interview on 07/15/26 at 3:30 pm, DON stated she would have to ask the hospice company why Forms 3071 (Individual Election/Cancellation/Update) and 3074 (Physician's certificate of terminal illness) were not in the hospice binder under the tab marked for these forms since they are responsible for the binder. The DON called the hospice company and they faxed the forms to her. Record review of Hospice Policy revised December 2017 revealed:Our facility contracts for hospice services for residents who wish to participate in such programs. Our facility has entered into a contractual arrangement for hospice services to make sure that residents who wish to participate in a hospice program may do so. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency is developed. The resident's care plan should be revised and updated with changes. All hospice services are provided under contractual arrangement.

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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** Based on observation, interview, and record review, the facility failed to maintain 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 disease and infection for 1 of 5 residents (Residents #97) reviewed for infection control:During the medication pass, the facility failed to ensure LVN B did not touch the water faucet with his bare hand after washing his hands and wiped the rubber seal to Resident #97's insulin pen with an alcohol swab prior to administering insulin.These failures could place residents at-risk for infection due to improper care practices.The findings included:Record review of Resident #97's face sheet dated 7/16/26 reflected a [AGE] year old male admitted into the facility on [DATE] and re-admitted on [DATE] with diagnoses that included acquired absence of left toes, diabetes (condition in which the body has trouble controlling the amount of sugar in the blood), peripheral vascular disease (poor circulation, usually in the legs, because the blood vessels have become narrowed by fatty deposits), and acquired absence of right leg below the knee.Record review of Resident #97's most recent comprehensive MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills, had a diagnosis of diabetes and was treated with insulin.Record review of Resident #97's Order Summary Report dated 7/16/26 reflected the following:- Lantus 100 unit/ML insulin, inject 30 units subcutaneously two times a day related to diabetes with order date 2/12/26 and no end dateRecord review of Resident #97's comprehensive care plan with revision date 10/31/23 reflected that the resident had diabetes and was at risk for complications with interventions that included administering medications as ordered by the doctor.During the observation of the medication pass on 7/15/26 at 8:31 a.m., LVN B went into Resident #97's bathroom, washed his hands with soap and water and turned off the faucet with his bare hand. After LVN B obtained an accu-check (finger-stick blood glucose test used to measure a person's blood sugar level) from Resident #97, LVN B returned to the medication cart, obtained the resident's insulin pen and inserted a needle into the rubber seal without cleaning the rubber seal first. During an interview on 7/15/26 at 8:54 a.m., LVN B stated after you wash your hands, you should use a paper towel to turn off the faucet because the surface of the handle was contaminated and basically it was reintroducing germs and germs could come in contact with the hands. LVN B stated that the spread of germs could potentially transfer to a resident and make them sick. LVN B stated he did not realize he had washed his hands and turned off the faucet with his bare hand. LVN B stated he believed, since Resident #97's Lantus insulin pen was new, he was not sure the rubber seal had to be cleaned with an alcohol prep. LVN B stated he had skills training within the year, including training on the use of insulin. During an interview on 7/15/26 at 3:55 p.m., the DON stated, when the nurses used an insulin pen to administer insulin to a resident, her expectation was for the nurse to wipe the rubber seal with an alcohol prep before introducing a needle into the seal to prevent spread of infection. The DON stated that LVN B should have turned off the water faucet after washing his hands with a paper towel because it was cross contamination and a break in infection control. The DON stated the nurse could pass an infection to the resident when providing care, in this case administering an insulin injection. The DON stated that the use of gloves did not take the place of washing the hands. Record review of LVN B's Medication Pass Competency Assessment, dated 1/4/26 reflected he had satisfied the requirements for administering insulin injections. LVN B's Medication Pass Competency Assessment included procedures for injections, The rubber septum of the medication vial, whether unopened or previously accessed, is disinfected with alcohol prior to piercing.Record review of the facility document titled Hand Hygiene, date implemented 10/24/22 reflected in part, .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.Hand Hygiene is a general term for cleaning your hands by handwashing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub.The use of gloves does not replace hand hygiene.