STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455999	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Lavaca Nursing and Rehabilitation Center	524 Village Rd Port Lavaca, TX 77979

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 1 of 27 residents (Resident #188) reviewed for advanced directives, in that: The facility failed to ensure Resident #188's Out of Hospital Do Not Resuscitate (OOH-DNR) dated [DATE] was signed by a physician, which made the document invalid. This failure could place residents at risk of having their end of life wishes dishonored, and of having CPR performed against their wishes. The findings included: Record review of Resident #188's face sheet, dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included a wedge compression fracture of T11-T12 vertebrae, essential hypertension (high blood pressure), and chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe. The Advance Directive was identified as DNR (Do Not Resuscitate). Record review of Resident #188's comprehensive care plan, updated [DATE] revealed the focus area indicating the resident was a DNR, date initiated: [DATE]. The goal was the facility will comply with resident/family wishes. Date initiated: [DATE]. Interventions were to ensure a signed DNR was in the resident's medical record. If resident has a cardiac arrest, do not call 911 or initiate CPR. Notify MD/RP and follow instructions after notification. Record review of Resident #188's Order Summary Report, dated [DATE], revealed the following: DNR (Do Not Resuscitate), Communication Method: Verbal, Order status: Active, Order Date: [DATE], no end date. Record review of Resident #188's OOH-DNR revealed it was signed by the resident and two witnesses on [DATE]. Under the section, Physician's Statement the physician's name was printed but there was no signature. In the section, All persons who have signed above must sign below, acknowledging that this document has been properly completed the resident's signature and those of the two witnesses were present; the attending physician's signature line was blank. (continued on next page)

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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:14 AM, MDS LVN F, the OOH-DNR form was out for the physician's signature, it was valid without a physician's signature, but she would need to read the back of the form. During an interview on [DATE] at 11:20 AM, the facility's SW stated the facility knew the resident's desire was DNR, but EMS may choose not to follow that if the form was not signed. The facility always uploaded DNR forms into resident's electronic health records pending physicians' signatures. During an interview on [DATE] at 11:40 AM, the CNC RN stated the physician gave a telephone order for DNR and the facility would honor the resident's desire for DNR even if the OOH-DNR form had not yet been signed by the physician. Record review of Out of Hospital Do-Not-Resuscitate (OOH-DNR) Order form revealed, Instructions for Issuing an OOH-DNR Order .In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses .making an OOH-DNR Order by nonwritten to the attending physician, who must sign in Section D and also the physician's statement section. Record review of Texas Department of State Health Services Frequently Asked Questions for DNR, undated, revealed, Can a physician's assistant or nurse practitioner sign the physician's statement? No. Only the attending physician can sign in this section. Why does everyone have to sign twice? All persons who have signed the DNR form must sign at the bottom of the page to acknowledge that the document has been properly completed. 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. Filling out the Out-of-Hospital Do-Not-Resuscitate Form: Physician's Statement: The patient's attending physician must sign and date the form, print or type his/her name and give his/her license number. Signatures: The statute requires that everyone who signed the form MUST sign the form again in the bottom section to acknowledge that the form has been completed. https://www.dshs.texas.gov/sites/default/files/emstraumasystems/FAQsforDNR.pdf

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on interview, record review, and observation, the facility failed to ensure residents have a right to personal privacy for 1 of 6 resident (Resident #84) reviewed for privacy, in that: CNA A and CNA B did not close Resident #84's privacy curtain while providing incontinent care on 4/17/25. This deficient practice could place residents at-risk of loss of dignity due to lack of privacy. The findings included: Record review of Resident #84's face sheet, dated 04/17/2025, revealed an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Hypertension (High blood pressure), Asthma (Condition making breathing difficult), Dysphagia (Difficulty swallowing) and Heart failure (The heart muscle doesn't pump blood as well as it should). Record review of Resident #84's Significant change MDS assessment, dated 03/21/2025, revealed the resident had a BIMS score of 11, indicating he was moderately impaired. Resident #84 was occasionally incontinent of bladder and always incontinent of bowel. Record review of Resident #84's care plan, dated 03/11/2025, revealed a problem of has bladder incontinence and does not always recognize the need to toilet.,, with a goal of The resident will remain free from skin breakdown due to incontinence and brief use through the review date. Observation on 04/17/2025 at 2:26 p.m. revealed CNA A and CNA B did not completely close the privacy curtain while they provided incontinent care for Resident #84, exposing the resident's genital area during care. The resident's end of the bed was completely uncovered and the resident's roommate was in the room at the time of care. During an interview with CNA A and CNA B on 04/17/2025 at 2:34 p.m., CNA A and CNA B confirmed the privacy curtain was not completely closed while they provided care for Resident #84 but it should have been. They confirmed they received resident rights training within the year. During an interview with the DON on 04/18/2025 at 12:52 p.m., the DON confirmed privacy must be provided during nursing care and Resident #84's privacy curtain should have been closed completely. She confirmed the staff had received training on resident rights within the year and the training was provided by the ADON and herself. They also checked the staff skills annually and as needed. Review of the facility's policy titled Statement of Resident Rights, undated, revealed, You have a right to: privacy, including privacy during visits and telephone calls.

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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** 34788 Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 10 residents (Resident #39) whose assessments were reviewed. Resident #39's significant change MDS assessment incorrectly documented the resident as not using tobacco. This failure could place residents at-risk for inadequate care due to inaccurate assessments. The findings included: 1. Record review of Resident #39's face sheet, dated 04/17/2025, revealed an admitted [DATE] and, a readmitted [DATE] with diagnoses that included: Hepatic encephalopathy (brain dysfunction caused by liver dysfunction), Schizophrenia (mental disorder characterized by abnormal thought processes and an unstable mood), Type 2 diabetes mellitus (high level of sugar in the blood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood) and Bipolar disorder (Mental disorder characterized by periods of depression and periods of abnormally elevated mood). Record review of Resident #39's Smoking safety screen, dated 02/26/2025, revealed Resident is an unsafe smoker. Record review of Resident #39's Significant change MDS, dated [DATE], revealed the assessment indicated Resident #39 did not use tobacco. During an interview with MDS nurse C on 04/17/2025 at 2:45 p.m., the MDS nurse verbally confirmed she had completed the MDS. MDS nurse C confirmed Resident #39's Significant change MDS was coded as the resident not using tobacco when Resident #39 was a smoker. MDS nurse C revealed she did not know why she had not coded the resident as a smoker. The MDS nurse revealed the RAI was used as reference for the MDS and she had access electronically to the RAI on her computer. Record review of, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual,Version 1.19.1, October 2024, revealed, J1300: Current Tobacco Use (cont.)3. [.] Coding Instructions Code 0, no: if there are no indications that the resident used any form of tobacco. Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

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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 41651 Based on interview and record review, the facility failed to create a baseline care plan within forty-eight hours of admission for 1 (Resident #240) of 1 residents reviewed for baseline care plans, in that: Resident #240 admitted to the facility on the evening of 04/14/2025, and her baseline care plan was not in place as of the afternoon of 04/17/2025. This deficient practice could result in newly admitted residents having their needs unmet. The findings included: Record review of Resident #240's clinical record as of 04/17/2025 revealed the resident was admitted to the facility in the evening of 04/14/2025 and a baseline care plan was not present in the record. During an interview with the DON on 04/17/2025 at 12:12 p.m., the DON confirmed Resident #240's baseline care plan had not been initiated and should have been. The DON stated the admitting nurse was generally responsible for initiating the baseline care plan with the ADONs or the DON responsible for checking and completing the document. The DON stated the process was interrupted because the survey began on 04/18/2025. The DON stated her expectation was that baseline care plans be initiated and completed in a timely manner so that the newly admitted resident's needs could be fully addressed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 of 6 medication carts (Hall 600 Medication Cart) reviewed for storage. During medications administration, RN D left Hall 2600 Medication cart unlocked on 1 occasion (04/17/2025). This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed medications. The findings included: Observation on 04/17/2025 at 8:21 a.m. revealed RN D was administering medications to residents. RN D was seen entering room [ROOM NUMBER]. The medication cart was left unlocked and out of sight of RN D who was behind the privacy curtain. Inside the unlocked cart were blister packs, bottles, and vials of medications for the residents. During an interview with RN D on 04/17/2025 at 8:24 a.m., RN D confirmed the medication cart was left unlocked while she was administering medications in the resident's room. RN D confirmed she knew she had to keep the cart locked and had forgotten. During an interview with the DON on 04/18/2025 at 12:52 p.m., the DON confirmed the medication cart should have been kept locked. The DON confirmed the nursing staff received training about drug diversion including keeping their cart locked at all times when not in use to prevent drug diversion. The DON revealed one possible outcome of drug diversion was the resident's missing doses of medications. Record review of the facility's policy titled, Medication carts and supplies for Administering Meds, dated 10/01/2019, revealed The medication cart is locked at all times when not in use.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 36232 Based on observations, interviews, and record review, the facility failed to follow menus for 2 of 2 resident meals reviewed for menus in that: The facility failed to follow the menu for residents on regular and modified diets for the lunch meals on 04/15/2025 and 04/16/2025 This failure could place residents who consume food prepared by the facility kitchen at risk of not having their nutritional needs met and/or weight loss. The findings included: Record review of the weekly menu provided by the facility revealed the lunch meal scheduled for Tuesday, 04/15/2025, Day #23 of the 5-week menu cycle, was peppered pork loin, tricolor spiral pasta, herbed green beans, wheat roll and seasonal fresh fruit. The menu scheduled for Wednesday, 4/16/2025, Day #24 of the menu cycle, was baked fish in lemon butter, baked potato wedges, creamed peas, wheat roll, and strawberries with whipped topping. There was no sign posted indicating any deviations from the daily or weekly menus. Record review of the Menu Substitution Approval Form provided by the facility revealed the following entry only for the lunch meals on 04/15 - 04/16/2025: 4/16 Meal: Lunch, Item on Menu: Mushrooms, Substitution: Sauteed onion & bell peppers, Reason for Substitution: Residents dislike mushrooms. The entry was initialed by the DTR. Observation on 04/15/2025 at 12:10 PM of the lunch meal served to residents in the dining room revealed they were served the lunch meal scheduled for the Monday of that week, Day #22 of the menu cycle, which was Mexican meatballs En Salsa, rice, sauteed mushrooms, wheat bread, and chilled blushing pears. Observation on 04/16/2025 at 12:30 PM of the lunch meal served to residents in the dining room revealed they were served the meal scheduled for the previous day, per the weekly menu (pork loin with pasta, green beans, and seasonal fresh fruit). During an interview on 04/16/2025 at 12:03 PM, the consultant RD stated she discussed how to substitute items and meals with the DM, and the changes would have to be posted properly in the dining room so residents would know what they should be served. During an interview on 04/16/2025 at 12:30 PM, the administrator stated she was not aware the facility was not serving meals as posted on the weekly menu. She was also not aware changes needed to be logged on a menu substitution approval form and approved by either the RD or DTR. During an interview on 04/16/2025 at 1:30 PM, the DTR stated she did not know why the menus had been shifted down one day for both days, but it was important to follow the menu as posted so residents knew what to expect. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 10:40 AM, the DM stated she usually followed the menu and having the lunch meal scheduled for Monday, 04/14/2025 served on Tuesday, 04/15/2025 and the lunch meal scheduled for Tuesday, 04/15/2025 on Wednesday, 04/16/2025, was a mistake. She was unsure how the error occurred but believed it had to do with wanting to serve fish on Friday. She knew she had to log any menu changes on the Menu Substitution Approval Form and she failed to do so for the changes in meals served the week of 04/14/2025. It was her responsibility to ensure meals were served according to the menu posted and signed by the consultant RD or changes documented properly on the form and also in the dining room so residents could be apprised of the changes. Record review of the facility policy, Menu Substitutions, policy number 01.007, revised 06/01/2019, revealed: Policy: The facility believes that a well-balanced menu, planned in advance and served as posted, is important to the well-being of its residents. The menus will be served as planned except for emergency situations when a food item is unavailable. Procedure: 1. The menu will be served as written unless an emergency situation arises. 5. The consultant RD/DTR will review the Menu Substitution Approval form with the dietitian on each visit to determine trends in substitutions and accuracy of substitutions so that the appropriate training can be provided if needed. 6. The dietitian will initial off the Menu Substitution Form after review.

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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 in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to store plastic cups and bowls to allow for air-drying in the dish room. 2. The facility failed to ensure the tabletop can opener blade and base were free of grime and debris. 3. The facility failed to discard a bag of salad mix dated 03/24/2025 containing brown and rotted leaves in the reach-in cooler. 4. The facility failed to ensure an opened bag of grits in the dry storage room was properly sealed. These failures could place residents at risk for food borne illness. The findings included: 1. Observation on 04/15/2025 at 10:41 AM revealed two plastic trays each with approximately 18 overturned plastic drinking cups and four trays each with approximately 12 overturned plastic bowls on the clean side of the dish machine. The plastic trays were damp with moisture and there were no air-drying nets separating the cups and bowls from the trays to allow for air circulation. During an interview on 04/15/2025 at 11:00 AM, the DM stated the wet, plastic cups and bowls should not have been placed face-down on a wet trays without an air-drying net separating them from the trays to prevent the potential accumulation of bacteria which could lead to food borne illness. Staff working in the dish room were trained on how to store clean but damp dishware. They were trained upon hire and periodically throughout there year. The facility used to have an ample supply of air-drying nets and she did not know what happened to them. 2. Observation on 04/15/2025 at 10:42 AM in the kitchen revealed the tabletop can opener was covered with sticky grime that was black and brown in color. The grime covered the blade portion of the can opener, the adjustable bar, and also surrounded the base that was affixed to the table with screws. During an interview on 04/15/2025 at 11:05 AM, the DM stated that the can opener blade, bar, and base were covered in sticky grime and should not have been. The DM stated the cooks were responsible for ensuring the can opener and area surrounding the base remained clean and free of debris, and that failing to do so could result in contamination of food from bacteria lingering on the blade and potential foodborne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 04/15/2025 at 10:48 AM in the reach-in cooler revealed 5-lb. bag of salad mix with a handwritten date of 03/24/2025. The bag was sealed and approximately 15% of the salad leaves had turned brown or were rotten. During an interview on 04/15/2025 at 11:10 AM, the DM stated the salad mix should have been discarded. All dietary staff were responsible for properly labeling and dating food items stored in the cooler and discarding items past their use-by dates. 4. Observation on 04/15/2025 at 10:57 AM in the dry storage room revealed a plastic case containing five 5-lb. bags of quick-cook grits on a rack. The case had been torn open and there was a small pile of loose grits inside the plastic case in front of the bag on the right approximately 4 high that had likely been left from a bag of grits removed from the case. During an interview 04/15/2025 at 11:12 AM, the DM stated the spilled grits should have been cleaned up by dietary staff. All kitchen staff stored food in the dry storage room, and failing to ensure food was properly sealed and the dry storage room was free from debris could result in deterioration in food quality and potential contamination from pests. Record review of facility policy 04.006 Mechanical Cleaning and Sanitizing of Utensils and Portable approved 10/01/2018 revealed, Policy: The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for mechanical cleaning in order to ensure that all utensils and equipment are thoroughly cleaned and sanitized to minimize the risk of food hazards. 9. Air dry all equipment and utensils after sanitizing. Handle cleaned and sanitized equipment and utensils and all single-serve articles in a way that protects them from contamination. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 4-901.11 Equipment and Utensils, Air-Drying Required. Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils. Record review of facility policy 04.009 Can Opener approved 10/01/2018 revealed, Policy: The facility will maintain can openers free of food particles and dirt to minimize the risk of food hazards. Can openers be cleaned after each use. 1. Hand held or table top. a. Remove can opener shank from base. b. Wash shank in sink with warm water and detergent or in the dishwasher. c. Give close attention to the blade and moving parts. d. Rinse in clean, hot water. e. Sanitize with approved sanitizer. Follow manufacturer's instructions for immersion times. f. Air dry. g. Wash base of can opener with clean cloth soaked in warm water and detergent, removing all food particles and dirt. h. Rinse with clean cloth soaked in clear hot water. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. (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 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. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, O. Retail Food Protection Program Information Manual: Recommendations to Food Establishments for Serving or Selling Cut Leafy Greens. Following 24 multi-state outbreaks between 1998 and 2008, cut leafy greens was added to the definition of time/temperature for safety food requiring time-temperature control for safety (TCS). The term used in the definition includes a variety of cut lettuces and leafy greens. Record review of facility policy 03.003 Food Storage revised 06/01/2019 reveled, 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. 1. Dry storage rooms. d. To ensure freshness, store opened and bulk items in tightly covered containers. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455999	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Lavaca Nursing and Rehabilitation Center	524 Village Rd Port Lavaca, TX 77979

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to maintain medical records that were accurate and complete for 1 (Resident #240) of 25 residents reviewed for accuracy and completeness of records in that: Resident #240's facesheet did not include a list of diagnoses. This deficient practice could result in unmet resident needs due to missing information. The findings were: Record review of Resident #240's facesheet, dated 04/17/2025, revealed the resident was admitted to the facility on [DATE]. Further review revealed no diagnoses were listed on the resident's facesheet. During an interview with the DON on 04/18/2025 at 12:50 p.m., The DON stated the admitting nurse was generally responsible for entering diagnoses into the record with the ADONs or the DON responsible for checking and completing the document. The DON stated the process was interrupted because the survey began on 04/18/2025. The DON stated her expectation was that resident records be complete and accurate and updated in timely manner so that the newly admitted resident's needs could be fully addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455999	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Lavaca Nursing and Rehabilitation Center	524 Village Rd Port Lavaca, TX 77979

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41651 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 1 (500 Hall) of 7 hallways reviewed for environment, in that: The storage room on 500 Hall was not secured and contained potentially unsafe items. This deficient practice could result in residents coming into contact with potentially unsafe items. The findings were: Observation on 04/15/2025 at 11:50 a.m. revealed the storage room on 500 Hall was unlocked. Further observation revealed the storage room contained items for use during resident showers including body soap, shampoo, and disposable razors. The soap and shampoo containers were labeled, eye irritant. During an interview with the Housekeeping Supervisor on 04/15/2025 at 11:51 a.m., the Housekeeping Supervisor confirmed the storage room on 500 Hall was unlocked, contained items labeled eye irritant, and should have been secured. During an interview with the DON on 04/18/2025 at 12:50 p.m., the DON stated her expectation was for storage rooms to remain locked when not in use to protect residents from coming into contact with potentially unsafe items. During an interview with the Administrator on 04/18/2025 at 1:30 p.m., the Administrator stated the facility did not have a policy regarding physical environment.