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	06/19/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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 3 of 18 residents (Residents #2, #7 and, #24) reviewed for infection control: 1. The facility failed to ensure MA B sanitized the blood pressure cuff in between use with Residents #24 and #7 on 06/18/2026.2. The facility failed to ensure LVN C sanitized the blood pressure cuff before using it on Resident #2 on 06/18/2026 These failures could place residents at-risk for infection due to improper care practices. The findings included: 1. Record review of Resident #24's face sheet dated 06/18/2026 revealed an admission date of 07/03/2025 with re-admit on 08/02/2025 and with diagnoses which included: Cerebral infarction (death of brain tissue due to lack of blood flow), Major depressive disorder (severe and persistent low mood, profound sadness, or a sense of despair), Alcoholic cirrhosis of liver (liver disease caused by alcohol), Vascular dementia (problems with blood flow to the brain, leading to cognitive decline) and Hypertension (Hight blood pressure). Record review of Resident #24's Physician orders, for June 2026, revealed an order for Lisinopril-hydrochlorothiazide Oral Tablet 20-25 MG (Lisinopril & Hydrochlorothiazide) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) HOLD FOR SBP (systolic blood pressure) LESS THAN 100, DBP (diastolic blood pressure) LESS THAN 50. Record review of Resident #7's face sheet, dated 06/18/2026, revealed an admission date of 06/11/2024 with re-admit on 03/14/2026, with diagnoses which included: Chronic kidney disease (Gradual loss of kidney function), Cellulitis (bacterial skin infection), Type 2 diabetes mellitus (elevated blood sugar level) and Hypertension (high blood pressure). Record review of Resident #7's Physician orders, for June 2026, revealed an order for Metoprolol Tartrate Oral Tablet 25 MG(Metoprolol Tartrate) Give 0.5 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) *GIVE 0.5 OF 25MG TAB TO EQUAL 12.5MG; HOLD FOR SBP LESS THAN 100 AND/OR DBP LESS THAN 50; HOLD FOR HR LESS THAN 60. Observation of medication pass on 06/18/2026 at 8:42 a.m. revealed MA B checked Resident #24's blood pressure prior to administering her oral medications, and then proceeded to Resident #7's room, where she sanitized her hands, but did not sanitize the blood pressure cuff before checking Resident #7's blood pressure with the same cuff she had checked Resident #24's blood pressure with. During an interview with MA B on 06/18/2026 at 08:45 a.m., MA B stated she knew she was supposed to sanitize the blood pressure cuff in between uses with different residents but just forgot. She stated that by not sanitizing equipment in between uses with different residents it could spread infection. MA B stated she had received training in infection control. 2. Record review of Resident #2's face sheet, dated 06/18/2026, revealed an admission date of 05/31/2024 with re-admit on 03/24/2026, with diagnoses which included: Hemiplegia (paralysis on one side of the body), Aphasia (language disorder), Dysphagia (difficulty swallowing), Type 2 diabetes mellitus (high level of sugar in the blood), Hyperlipidemia (high level of fats, also known as lipids, in the blood) and, Hypertension (high blood pressure). Record review of Resident #2's Physician orders, for June 2026, revealed an order for Metoprolol Tartrate Oral Tablet 50 MG(Metoprolol Tartrate) Give 1 tablet enterally two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) hold if sbp is less than 110 and/or pulse is (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	less than 60. Observation of medication pass on 06/18/2026 at 8:53 a.m. revealed LVN C checked Resident #2's blood pressure prior to administering his enteral medications. LVN C was observed prior to providing care for Resident #2, coming from another room with the Blood pressure cuff in hand. LVN C sanitized her hands but did not sanitize the blood pressure cuff before checking Resident #2's blood pressure. During an interview with LVN C on 06/18/2026 at 08:57 a.m., LVN C stated she had used the blood pressure cuff on another resident before using on Resident #2. She knew she was supposed to sanitize the blood pressure cuff in between uses with different residents but just forgot. She stated that by not sanitizing equipment in between uses with different residents it could spread infection. LVN C stated she had received training in infection control. Interview with the DON on 06/18/2026 at 4 p.m. revealed all blood pressure cuffs need to be sanitized in between uses with each resident to prevent the spread of infection. She stated all staff received infection control training within the current year. Record review of the facility policy titled Infection prevention and control program , dated 05/13/2023, revealed All reusable items and equipment requiring cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedure governing the cleaning and sterilization of soiled or contaminated equipment

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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** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident 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 #24) whose records were reviewed. The facility failed to include Resident #24's diagnosis of vascular dementia in her comprehensive care plan including care and services the facility would provide between the dates of 8/1/2025 and 6/17/2026. This deficient practice could result in residents not receiving the care and services needed.The findings include: Record review of Resident #24's admission sheet dated 6/18/2026 revealed she originally admitted to the facility on [DATE] and readmitted on [DATE]. She was a [AGE] year-old female with primary cerebral infarction (ischemic stroke caused by a blockage in brain blood vessels, leading to tissue damage without a specified location or cause) and vascular dementia, mild, with mood disturbance (disrupts cognitive and emotional functioning including depression, apathy, and emotional lability). Record review of Resident #24's Quarterly MDS assessment dated [DATE] documented a BIMS score of 15 of 15 indicating the resident was cognitively intact and an active diagnosis of non-Alzheimer's dementia (e.g. lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-[NAME] diseases). Record review of Resident #24's care plan dated 6/2/2026 revealed the lack of the diagnosis of vascular dementia with the focus, goals, and Interventions. During an interview on 6/19/2026 at 11:11 AM, the MDS Nurse #1 stated the diagnosis of vascular dementia was added to the EMR on 8/1/2025. She said the care plan should have been updated on 8/1/2025. She said the care plan was updated on 6/18/2026. She stated I can't tell you why at that time. I know I have a process of what I update. Possibly just overlooked. The dashboard has a diagnosis notification. When somebody adds the diagnoses, we should not clear the notification without verifying the care plan has been updated. We also look at the meds to determine CP additions. MDS Nurse #1 said regarding the impact to a resident was It is very important for resident care like medications and the idiosyncrasy. She said the impact to staff wound be The staff know where the diagnosis area so they will still be informed.Record review on 6/18/2026 of the facility policy Comprehensive Care Plans with an implemented date of 10/24/22 revealed: 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. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being; andPolicy Explanation and Compliance Guidelines:3. The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment.5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who needed tracheostomy care were provided such care, consistent with professional standards of practice, for tracheostomy care for 1 of 1 residents (Resident #4) reviewed for tracheostomy care. The facility failed to ensure RN A provided tracheal care and suctioning according to professional standards for Resident #4 on 06/18/2026. These deficient practices could result in the residents not receiving the care and services ordered by the physician and a decline in health status and infection. Findings included: Record review of Resident #4's face sheet, dated 06/18/2026, revealed an admission date of 08/29/2023 and, a readmission date of 11/16/2024, with diagnoses that included: Anoxic brain damage (damage caused to the brain due to a lack of oxygen), Contractures (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), Aphasia (result of a Stroke or Brain injury that affects a person's ability to communicate), Vascular dementia (memory and cognitive impairments related to decreased blood flow to parts of the brain), Chronic respiratory failure (condition where there's not enough oxygen or too much carbon dioxide in the body), Quadriplegia (symptom of paralysis that affects all a person's limbs and body from the neck down), Hypertension (High blood pressure) and, Tracheostomy status (surgically created hole, or stoma, in the trachea (windpipe) that allows air to pass directly into the lungs). Record review of Resident # 4's Quarterly MDS assessment dated [DATE], revealed Resident #4 was nonverbal. Resident #4 was dependent of the staff for all of her activities of daily living; she had an indwelling catheter and was always incontinent of bowel . Resident #4 was coded as having a tracheostomy (opening in the trachea (windpipe) to facilitate breathing) care. Record review of Resident #4's care plan, dated 09/29/2023, revealed a problem of has a tracheostomy r/t (related to) anoxic brain damage. and, an intervention of Provide trach care as ordered. Record review of Resident #4's physician orders for June 2026 revealed TRACH: Change disposable trach SHILEY/SIZE 6 inner cannula every day shift. Observation on 06/18/2026 at 2:15 p.m. revealed while providing tracheostomy care for Resident # 4, RN A placed the sterile field on the side table and positioned the normal saline used to clean the tracheostomy of the resident on the top left of the sterile field. By doing so every time she reached for saline the non-sterile part of her arms crossed over the sterile field, as a result breaking the sterile field. Further observation revealed RN A had rolled up the sleeves of her PPE gown exposing her arms and Resident #4 was on enhanced barrier precaution due to the tracheostomy and indwelling Catheter. During an interview with RN A, on 06/18/2026 at 2:28 p.m., RN A stated she had broken the sterile field but did not realize she was doing it. She stated she had received training for tracheostomy care and infection control with the year. During an interview with the DON, on 6/18/2026 at 4 p.m., the DON stated tracheostomy care should be done using sterile procedure and not maintaining sterile technique could result in respiratory tract infection. The DON stated crossing the sterile field with the non-sterile part of the arms constituted breaking the sterile field. The RN was qualified to do tracheostomy care, and her skills were checked annually by the DON. Record review of the facility policy, titled Tracheostomy care competency assessment, dated 12/21/2025, revealed remove the inner cannula and place it in the container of sterile water (discard inner cannula if disposable and replace with new one using sterile technique). Review of Nursing Skills - 2e Copyright (C) 2023 at https://wtcs.pressbooks.pub/nursingskills/chapter/4-4-sterile-fields/ revealed Open sterile kits away from your body first, touching only the very edge of the opening flap.Using the same technique, open each of the side flaps one at a time using only one hand, being careful not to allow your body or arms to be directly above the opened drape. Take care not to allow already-opened corners to flip back into the sterile area again.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen (Kitchen 1) reviewed for food safety requirements. The facility failed when a sink for hand washing was not accessible at all times when the food service staff placed rolling carts for clean dishes in front of the hand sink dish room used by kitchen staff making the sink inaccessible for use on 6/16/2026 and 6/19/2026.ˆ These failures could place residents at risk for the spread of infections, food contaminations, food-borne illnesses, and diminished quality of life.The findings included: During an observation on 6/16/2026 at 11:11 AM, the hand sink in the dish room was blocked by two rolling carts making the only hand sink in the food preparation room inaccessible. During an observation on 6/18/2026 at 9:17 AM, the hand sink in the dish room was blocked by two rolling carts making the only hand sink in the food preparation room inaccessible. During an interview on 06/19/2026 at 11:21 AM, the [NAME] stated the hand sink should be accessible at all times. She stated the reason the sink was blocked was When they are doing dishes, they are running out of space. She said the impact to a resident was There is cross-contamination that can occur from not handwashing. Record review of the facility's policy, Hand Washing dated October 1 2018 with Policy Number 04.002 revealed: Policy:The facility recognizes that food-borne illness has the potential to harm elderly and frail residents. All Nutrition & Foodservice employees will practice good hand washing practices in order to minimize the risk of infection and food borne illness.Procedure:1. Hand-washing Stationsa. Make sure hand washing stations are located in food preparation areas to encourage employees to wash their hands frequently.b. Make sure there are hand-washing stations in all areas that employees' hands may become contaminated, including food preparation areas, service areas, dishwashing areas and rest-rooms. Record review of the FDA Food Code 2022, https://www.fda.gov/food/retail-food-protection/fda-food-code,ˆaccessed 6/9/2026 revealed: 5-205 Operation and Maintenance5-205.11 Using a Handwashing Sink.(A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use. Pf(B) A HANDWASHING SINK may not be used for purposes other than handwashing. Pf

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, interviews, and record reviews, the facility failed to ensure the safe and sanitary storage of residents' food items in 1 of 5 residents' refrigerators reviewed. The personal refrigerator in the resident's #84 room contained an unlabeled, undated food item. This deficient practice could put residents at risk of foodborne illness from consuming spoiled food. The findings were: Record review of Resident #84's face sheet, dated 6/16/2026, revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: Chronic obstructive pulmonary disease (lung disease, which causes breathing difficulties due to obstructed airflow), and major depressive disorder (is a mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems) and Alcohol-related dementia (is a type of brain damage caused by years of heavy drinking. It happens when alcohol harms the brain's nerve cells, making it harder to think, remember, and move). Record review of Resident #84's BIMS assessment, completed 2/10/26, revealed a BIM score of 12, which indicated cognition was moderately impaired. Observations on 6/16/2026 at 10:20 a.m. revealed that the personal refrigerator for Resident #84 contained an unlabeled, undated container with grilled chicken and Spanish rice. Further observations on 6/16/2026 at 11:00 a.m. of the personal refrigerator of Resident # 84 revealed that the unlabeled, undated storage container was still present. An interview with Resident #84 on 6/16/2026 at 11:15 a.m. revealed she was unaware the unlabeled, undated container containing grilled chicken and Spanish rice was in her personal refrigerator. She recalled that on 6/13/2026, the family came to visit and must have dropped off the food. Resident #84 stated, She stored snacks in her personal refrigerator but forgot the container was even there . Interview on 06/16/2026 at 11:20 p.m. with CNA D, who stated she was assigned to resident #84 and stated that the personal refrigerator in Resident #84's room contained an undated container containing grilled chicken and Spanish rice. She did not know who was responsible for checking the president's personal refrigerator for expired food but would check with the charge nurse. Interview with LVN C on 6/16/2026 at 11:35 a.m. revealed she was the assigned nurse for resident # 84 and stated the presence of an unlabeled/undated container containing grilled chicken and Spanish in Resident 84's personal refrigerator. She added that nursing and administrative staff assisted Residents in removing undated and unlabeled food items from residents' personal refrigerators daily; she did not check them today. Resident # 84 risked some form of food-borne illness by possibly consuming food that was unlabeled and undated. During an interview with the DON on 06/16/26, at 12:30 p.m., the DON stated that perishable food and drinks in residents' personal refrigerators should be labeled and dated to prevent residents from consuming spoiled food. The DON stated that all nursing and administrative staff were responsible for removing undated, unlabeled food items from residents' refrigerators daily, including assisting families in labeling and dating food items brought in. The DON stated that families sometimes bring food for residents without notifying the nursing staff. She added that her charge nurses were responsible for overseeing this task, and her ADONs would be monitored at random. Record review of the facility policy, Food Brought in by Family / Visitors , dated 1/27/2023, revealed: All food items that are prepared by the family or visitor must be labeled with content and dated

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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** Number of residents sampled: Number of residents cited: Based on the interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, that medical records were accurately maintained for each resident, as documented for 1 of 4 residents (Resident #83) whose medical records were reviewed for accuracy. The facility failed to ensure the accuracy of Resident #83's clinical record. Review of the medical record revealed a diagnosis of benign prostatic hyperplasia (BPH) despite the resident being female. The presence of inaccurate diagnoses in the medical record has the potential to affect clinical decision-making, care planning, and treatment interventions. Findings included: Record review of Resident #83's face sheet, dated 6/18/2026, revealed a [AGE] year old famale admitted to the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease (a long-term respiratory condition that progressively limits airflow, making it difficult for affected individuals to fully exhale, often leading to shortness of breath, chronic cough, and wheezing), heart failure (a chronic condition in which the heart is unable to pump blood effectively to meet the body's needs), and cirrhosis of the liver (a chronic condition in which healthy liver tissue is gradually replaced by scar tissue, leading to impaired liver function and eventual liver failure). Record review of Resident #83's face sheet on 6/18/2026 revealed a diagnosis of BPH (benign prostatic hyperplasia), a condition affecting only males that involves enlargement of the prostate gland. Record review of Resident #83's BIMS assessment, completed 3/3/26, revealed a BIMS score of 7, indicating severe impairment. Interview with Resident #83 on 6/18/2026 revealed she identified as female and was assigned female at birth. Interview with the MDS nurse on 6/19/26 at 9:05 a.m. revealed that the admitting nurse, who no longer works at the facility, must have entered the diagnosis incorrectly. The MDS nurse stated she had audited the resident's face sheets for accuracy, but this one must have fallen through the cracks. She added that the BPH diagnosis should not have been on the face sheet and that its presence may have resulted in Resident #83 not receiving proper care. During the interview on 6/19/2026 at 10:25 a.m., the DON stated that audits are assigned by corporate MDS nurses and that she was unaware why Resident #83's face sheet contained inaccurate information. The DON noted that listing BPH on Resident #83's face sheet could cause confusion among other providers and may result in the resident not receiving appropriate care. She explained that MDS nurses are responsible for conducting these audits, with ADONs performing random monitoring. Record review of the facility's policy documentation in the medical record, dated 10/24/2022, revealed: Documentation shall be factual, objective, and resident centered.