

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/28/2024
NAME OF PROVIDER OR SUPPLIER  Cuero Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1310 E Broadway Cuero, TX 77954	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50531</b></p> <p>Based on interviews, and record review, the facility failed to ensure the right to be free from re misappropriation of funds was provided for 1 of 5 residents (Resident # 4), reviewed for misappropriation.</p> <p>The facility failed to ensure that Resident #4 was free from misappropriation of property when [NAME] D took \$100 from the resident to buy Resident #4 a refrigerator and did not return.</p> <p>This failure could affect residents by putting them at a greater risk exploitation and diminished quality of life.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 07/03/2024 and ended on 07/04/2024. The facility had corrected the noncompliance before the survey began.</p> <p>The Findings Included:</p> <p>Review of the facility's Face Sheet, Resident #4 was admitted to the facility on [DATE] with diagnosis that included but was not limited to Genetic Torsion dystonia(A genetic disorder resulting in a defect in a protein called Torsin A affecting muscle control). Resident #4 has not discharged and was a current resident of this facility.</p> <p>During interview with Resident #4 on 10/26/24 at 1:14 p.m., Resident #4 stated she had given [NAME] D the sum of \$100.00 when she offered to purchase a refrigerator for her.</p> <p>During interview with ADMIN on 9/24/24 at 1:00 p.m., ADMIN confirmed that [NAME] D had acknowledged she had taken the money, never returned to work and would not respond to further phone calls &amp; messages to contact her. ADMIN confirmed that police were notified Case # 24-002402. ADMIN confirmed [NAME] D's employment was terminated on 07/04/24.</p> <p>Review of Petty Cash Log revealed that facility reimbursed Resident #4 \$100.00 on 7/3/24.</p> <p>Interview with Resident #4 on 9/26/24 at 1:14 p.m. confirmed that she received \$100.00 from facility.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Abuse, Neglect and Exploitation Policy implemented 8/15/22 reflected that was the policy of the facility to 1.a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; II.A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation; II. B. Existing staff will receive annual education through planned in-services and as needed; and IV. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.</p> <p>Review of Employee file revealed [NAME] D held a current Texas Food Handlers Certification, completed orientation on 8/17/23 to include Maintaining resident rights including dignity, mail, visitors, personal property and telephone. Background Profile 8/11/23 reflected clear public records; Misconduct Registry 1/26/24 reflected no Results found; and Criminal History Conviction search reflected no search results found date?.</p> <p>Record review of facility investigation report dated 7/4/24, reflected the Administrator reported incident to appropriate state agency, suspended [NAME] D pending investigation, completed Abuse, Neglect &amp; Exploitation in-service 7/3/24 with emphasis on misappropriation, completed resident interviews, notified police, validated Resident #4 allegation, and terminated [NAME] D on 07/04/2024.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>47564</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 2 of 4 residents (Resident #1 and #3) reviewed for accidents and supervision.</p> <p>1. The facility failed to ensure Resident #1 did not elope from the facility without staff knowing on the evening of 1/26/2024.</p> <p>The noncompliance was identified as PNC. The IJ began on 1/26/2024 and ended on 1/26/2024. The facility had corrected the noncompliance before the survey began.</p> <p>2. Nurse Aide-E transferred Resident #3 from the bed to the resident's wheelchair using a gait belt by herself and lower the resident to the floor on 02/04/2024. It caused skin abrasion to Resident #3's back. On 02/08/2024, CNA-F transferred Resident #3 into the resident's wheelchair utilizing a mechanical lift without another CNA, and it caused the resident slid out of his wheelchair and no injury noted.</p> <p>This deficient practice could place residents at-risk of harm, serious injury, or death.</p> <p>The findings included:</p> <p>1. Record review of Resident #1's admission record, dated 09/26/2024, reflected that Resident #1 was a [AGE] year-old female initially admitted on [DATE], with diagnoses that included unspecified dementia (group of thinking and social symptoms that interferes with daily functioning), chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 11/17/2023, reflected that Resident #1 had a BIMS score of 14, indicating cognitively intact. Resident #1 was assessed for using a wheelchair and a walker in the 7 days prior to assessment and was assessed as, supervision or touching assistance for the ability to walk at least 50 feet and make 2 turns, and Not applicable for, the ability to walk at least 150 feet in a corridor or similar space. The MDS assessment further reflected that wandering behavior was not exhibited by Resident #1.</p> <p>Record review of Resident #1's care plan dated 9/26/2024, reflected 1/26/24 - Eloped from facility from 100 hall (therapy dept door) into parking lot. Continued to exit seek numerous times with interventions including, Behavior monitoring for exit seeking behaviors, Deer Oaks to provide psychological services, Memory Care Unit, with date initiated 1/27/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's elopement assessment from 11/8/2023 reflected her not to have wandered previously and to have been oriented with a short attention span.</p> <p>Record review of Resident #1's nursing note, dated 1/26/2024, revealed, [6:45 PM] RES NOTED SITTING UP IN W/C AT FRONT EXIT PUSHING ON EXIT DOOR. [Visitor] WAS TALKING TO RESIDENT AND REPORTED TO I CHARGE NURSE THAT RES WAS OUTSIDE IN THE PARKING LOT NEXT TO HER CAR. RES CONT TO PUSH ON DOOR TRYING TO EXIT FACILITY STATING SHE WANTED TO GO HOME. DOOR ALARM WORKING PROPERLY AT THIS TIME. REDIRECTION AT THIS TIME INEFFECTIVE. ADMINISTRATOR IN FACILITY AND WAS IMMEDIATELY NOTIFIED. WHILE SHE WAS TALKING TO RESIDENT REDIRECTING HER TO NOT LEAVE NO VISIBLE INJURIES NOTES FROM EXITING FACILITY. NO C/O OF PAIN OR DISCOMFORT. RES KEPT CRYING SAY SHE WANTED TO GO HOME. UPON PHYSICAL ASSESSMENT NOTED SMALL AMOUNT OF BLOODY DRAINAGE FROM PINPOINT SIZE AREA TO LT UPPER CHEEK. RES UNAWARE OF SITE. WHEN ASKED IF SHE SCRATCHED HERSELF SHE REFUSED TO SAY. RES REFUSED TO HAVE VITALS TAKEN. I CHARGE NURSE CALLED [PHYSICIAN] ON CALL TO REPORT INCIDENT. [PHYSICIAN] ORDERED TO PLACE RESIDENT IN MEMORY CARE UNIT FOR PERSONAL SAFETY AND ALLOW PINPOINT AREA TO SCAB OVER NO TREATMENT NEEDED. SON NOTIFIED AND CAME TO FACILITY TO HELP WITH RESIDENT. RECEIVED PERMISSION FROM SON TO PLACE IN MCU. SON ALSO HELPED PERSUADE RESIDENT TO LET US DO A FLU SWAB TEST THAT WAS ORDER ON PREVIOUS SHIFT. RES ALSO TOOK HER HS MEDS.</p> <p>Record review of Facility Provider Investigation Report, undated, reflected that on 1/26/2023 at around 6:40 PM, resident #1 exited the 100-hall door. Staff responded to the alarm but did not see anyone outside. A visitor stated Resident #1 exited the facility through the 100 hall door and they located Resident #1 by their car. The visitor aided Resident #1 back into the facility. Resident assessment reflected resident was returned unharmed.</p> <p>Observation of door used for exit by Resident #1 was approximately 20 feet from the front door of the facility.</p> <p>Interview on 9/24/2024 at 10:24 AM, the DON and Admin stated neither of them were employed at the facility at the time of the incident, both having begun their employment at the building in June of 2024.</p> <p>Interview on 9/24/2024 at 11:43 AM, Resident #1 stated she was just upset at the time and did not have a plan to go anywhere, just wanted to go outside. Resident #1 stated she has not done it again, does not want to leave, and likes it at the facility.</p> <p>Interview on 9/24/2024 at 11:45 AM, ADON I stated that Resident #1 was confused and upset at the time, but that Resident #1 stated she did not have a plan to go anywhere and just wanted to go outside. ADON I stated that Resident #1 had been offered to discharge with home health with her son, but she declined and stated she preferred to stay at the facility. ADON I stated that Resident #1 was allowed to sign herself out on pass at the time, though that was revoked with her son's permission when the change in cognitive condition was recognized.</p> <p>The Administrator was notified on 9/26/2024 at 11:45 AM, a past non-compliance IJ situation had been identified due to the above failure.</p> <p>The facility implemented the following interventions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review reflected that the facility enhanced Resident #1's care plan to include a risk for elopement, psychological services, including family in care when resident is feeling emotional to help calm them, and moving the resident to the memory care unit for more specialized care.</p> <p>Record review of the facility's in-service records dated 1/27/2024 revealed all staff members across all departments and work shifts had signed and documented they received the trainings on elopement protocol and the new changes made after Resident #1's elopement. All new hires were also in-serviced as part of the new hire on-boarding process.</p> <p>Record review reflected that after the incident, regular elopement drills were in place once a month since January 2024 for 6 months and were being done at the time of survey. Review also reflected the drills were completed quarterly on different shifts.</p> <p>Interview on 9/25/2024 at 4:25 PM, CNA J stated she received elopement training when she began at the facility in the beginning of August and was able to explain the procedure to enact if a door alarm went off.</p> <p>Interview on 9/25/2024 at 4:31 PM, NA K stated she began the job recently and got extensive elopement training. She stated she knew and felt confident on what she would do if a door alarm went off and was able to easily re-direct residents if they attempt to elope, even if it is just going through the door to the main facility area from the memory care.</p> <p>Interview on 9/26/2024 at 4:53 PM, RN M stated she has worked here for about a year and has had elopement training multiple times, including in January 2024 after Resident #1 eloped. RN M was able to describe how to check the facility, indoor and outdoor, if there is a suspected elopement, and what to do if any fire door alarms are heard.</p> <p>Facility policy titled, Elopements and Wandering Residents, dated revised 11/21/22, reflected, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive the adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The Facility Elopements and Wandering Residents Policy then detailed the procedures for monitoring residents at risk for elopement, locating a missing resident, and procedure for post-elopement.</p> <p>2. Record review of Resident #3's face sheet, dated 09/27/2024, reflected the resident was [AGE] years old, male, and originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of Alzheimer's disease (destroy memory and thinking skills), contracture to right ankle (shortening of muscles), type 2 diabetes mellitus (not control blood sugar levels), hemiplegia and hemiparesis (weakness or paralysis on one side), and muscle wasting and atrophy (thinning or loss of muscle tissue).</p> <p>Record review of Resident #3's quarterly MDS, dated [DATE], reflected the resident's BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident required substantial/maximal assistance (helper does more than half the effort) to sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #3's care plan, dated 01/17/2024, reflected Resident #3 required Chair/bed-to-chair transfer: the resident is dependent on the assistance of 2 staff using a Mechanical Hoyer Lift to transfer to and from a bed to a chair (or wheelchair).</p> <p>Record review of Resident #3's incident report, dated 02/04/2024, reflected Nurse was called to [Resident #3]'s room and noted the resident sitting on his buttock on the floor leaning against his wheelchair. Assessed the resident noted an abrasion to his back measuring approximately 14 centimeters. [Nurse Aide-E] stated she asked if the resident wanted to be a Hoyer lift [mechanical lift], he stated no, she [Nurse Aide-E] attempted to transfer when the resident's leg gave out, and [Nurse Aide-E] lowered the resident to the floor. The resident had usual range of motions noted to all four extremities without any complaint of pain or deformities.</p> <p>Record review of the facility in-service training report, dated 02/04/2024, reflected the facility provided in-services to Nurse Aide-E and all CNAs (total 34 CNAs) regarding all residents must have two employees when transferring a resident with a mechanical lift, if resident is care planned as a mechanical lift transfer, we must follow plan of care, never ask resident how they want to be transferred - if resident is requesting other form of transfer and/or care - Report to charge nurse immediately.</p> <p>Record review of the Nurse Aide-E's employee profile reflected the facility suspended the Nurse Aide-E on 02/04/2024 and terminated the employment on 05/02/2024.</p> <p>Record review of Resident #3's incident report, dated 02/08/2024, reflected [CNA-F] reported that [Resident #3] slid out of wheelchair onto floor landing on buttocks. The resident sitting on floor. Assessment done for injuries and reddish-purple discoloration present to outer aspect of left elbow. Skin intact. No swelling present.</p> <p>Record review of facility investigation report dated 02/08/2024, reflected [CNA-F] stated she [CNA-F] utilized the Hoyer lift [mechanical lift] to transfer [Resident #3] from his bed to his wheelchair without another staff. The resident began to slide once he was in the wheelchair, and [CNA-F] assisted the resident to the floor.</p> <p>Record review of the facility in-service training report dated 02/08/2024, reflected the facility provided in-services to CNA-F and all CNAs (total 40 CNAs) regarding Residents are to be transferred according to what in Kiosk. Hoyer lift transfers always require 2 training people. If a resident has declined and you feel the way of transferring need to change, let DON, ADON or case management know so it can be looked into and addressing.</p> <p>Record review of the CNA-F's employee profile reflected the facility suspended the CNA-F and terminated the employment on 02/08/2024.</p> <p>Observation on 09/25/2024 at 1:05 PM revealed CNA-G and CNA-H transferred Resident #3 from the wheelchair to the bed with a mechanical lift as the care plan (two persons with mechanical lift) without any issue.</p> <p>Interview on 09/25/2024 at 8:42 AM with Resident #3 stated two staff transferred the resident with a lift machine from the wheelchair to the bed or from the bed to the wheelchair all the time.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 09/25/2024 at 10:24 AM with ADON-I stated the DON and Administrator working in February 2024 quit their job after 02/04/2024 incident and 02/08/2024 incident. Current DON and Administrator did not know regarding these incidents. However, ADON-I could remember these incidents because she worked on 02/04/2024 and 02/08/2024. The ADON-I acknowledged on 02/04/2024, Nurse Aide-E transferred Resident #3 without a mechanical lift, and on 02/08/2024, CNA-F transferred the resident with a mechanical lift by herself. Resident #3 required a mechanical lift with two staff all the time for transfer. The facility terminated Nurse Aide-E and CNA-F, and no incidents reported since 02/08/2024 when the facility completed providing in-services to all CNA (Certified Nurse Aide)s.</p> <p>Interview on 09/25/2024 from 09:29 AM to 4:37 PM with 11 CNAs who stated Resident #3 had a mechanical lift with two persons all the time for transfer, and they should look at Kardex of care plan to find out what kinds of transfer facility residents needed. If resident refused, they should notify it to charge nurses immediately.</p> <p>Interview on 09/27/2024 at 9:37 AM with DON who stated the DON did not know regarding Resident #3's 02/04/2024 incident and 02/08/2024 incident because she was hired on 06/19/2024. However, if the care plan said Resident #3 needed to have a mechanical lift with 2 staff for transfer, Nurse Aide-E and CNA-F should have transferred Resident #3 utilizing a mechanical lift with 2 staff. All nursing staff should follow the plans of care, and the potential harm was it might cause Resident #3's fall and result in serious injury, such as fracture.</p> <p>Record review on the facility policy and procedure, titled Mechanical Lift, date implemented 08/11/2022, reflected The portable lift required 2 people assist, that have completed competency training on the lift.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services for 1 of 4 residents (Residents #3) reviewed for infection control, in that:</p> <p>CNA-G touched Resident #3's clean brief with dirty gloves after cleaning the resident's bowel movement while providing incontinent care to Resident #3 on 09/25/2024 at 1:12 PM.</p> <p>These deficient practices could place residents at-risk for infection due to improper care practices.</p> <p>The findings included:</p> <p>Record review of Resident #3's face sheet, dated 09/27/2024, reflected the resident was [AGE] years old, male, and originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of Alzheimer's disease (destroy memory and thinking skills), contracture to right ankle (shortening of muscles), type 2 diabetes mellitus (not control blood sugar levels), hemiplegia and hemiparesis (weakness or paralysis on one side), and muscle wasting and atrophy (thinning or loss of muscle tissue).</p> <p>Record review of Resident #3's quarterly MDS (Minimum Data Set</p> <p>), dated 06/20/2024, reflected the resident's BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was dependent to toilet hygiene and shower/bathe self. Further record review of the MDS indicated Resident #3 was always incontinent to bladder and bowel.</p> <p>Record review of Resident #3's care plan, dated 12/14/2018, reflected [Resident #3] has total incontinent of bladder and bowel; intervention for decreased risk of septicemia to prevent urinary tract infection - clean peri-area with each incontinence episode.</p> <p>Observation on 09/25/2024 at 1:12 PM revealed while CNA-G and CNA-H were providing incontinent care to Resident #3, CNA-G and CNA-H rolled the resident to right, and CNA-G cleaned the resident's buttock because the resident had bowel movement. CNA-G finished cleaning the bowel movement, then touched Resident #3's clean brief with the dirty gloves and put the clean brief under the resident's buttock area, then closed the new brief.</p> <p>Interview on 09/25/2024 at 1:30 PM with CNA-G who stated she touched Resident #3's new brief with dirty gloves after cleaning the resident's bowel movement. The CNA-G should have changed the dirty gloves to new gloves after sanitizing her hands because CNA-G's gloves became dirty after cleaning the resident's bowel movement before touching the resident's new brief. CNA-G was nervous so forgot changing gloves.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47622</p> <p>Based on interviews and record reviews, the facility failed to ensure residents received food provided and prepared in a from designated to meet individual needs for 1 of 3 residents (Resident #2).</p> <p>The facility failed to ensure Resident #2 received the correct diet texture to prevent a choking hazard when Resident #2 was served a regular texture diet despite being prescribed a pureed texture diet.</p> <p>This failure to follow dietary orders could place residents at risk of harm, serious injury, or death.</p> <p>The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.</p> <p>The findings included:</p> <p>Record review of Resident #2's face sheet revealed an admitted [DATE] with an original admitted [DATE] with the diagnoses: Alzheimer's with late onset; heart failure; vascular dementia with psychotic disturbance; and dysphagia.</p> <p>Resident #2's Quarterly MDS dated [DATE] revealed max assist with ADLs,a mechanically altered diet, and had to be fed by staff. Resident #2 had a BIMS score of 1.</p> <p>Resident #2's Care Plan dated [DATE] revealed swallowing difficulties related to impaired cognition with interventions included, Provide, serve diet as ordered. With a date initiated of [DATE], and intervention, Diet as ordered with date initiated of [DATE]. of pureed texture food with honey thickened liquids consistency and must be fed.</p> <p>Record review of diet order dated [DATE] revealed Resident #2 was prescribed a pureed diet texture with a honey thick texture.</p> <p>Record review of Resident #2's progress note, dated [DATE] at 10:39 AM, revealed Resident slept through breakfast. When he woke up hungry and the aide gave him a Pimiento Cheese sandwich. Resident choked on sandwich and this nurse was able to do the Heimlich on the resident and he spit the food out without any complications. Resident has no C/O pain or distress. [Physician] is aware of the incident and the RP has been notified.</p> <p>Record review of Resident #2's hospital clinical record revealed an admitted to the regional hospital on [DATE] with a history of present illness that read, Chest x-ray showing right lower lobe pneumonia. Patient does have fairly advanced dementia has had some ongoing issues with swallow dysfunction associated with progressive cognitive decline. There was also concern that this may be attributed to aspiration, but no clear episode noted .Patient meeting sepsis criteria but no evidence of acute organ dysfunction. Further hospital record review reflect Resident #2 reportedly had a fever of 102 earlier in the day of [DATE] and an O2 saturation of ,d+[DATE] without supplemental oxygen.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/28/2024
NAME OF PROVIDER OR SUPPLIER  Cuero Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1310 E Broadway Cuero, TX 77954	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of nurses' notes revealed Resident # 2 expired [DATE]. Resident # 2 was admitted on hospice for services on [DATE] with terminal diagnosis of Alzheimer's dementia. Record review revealed he had a life expectancy of 6 months with decline with feeding and swallowing difficulties which resulted in recurrent lower lobe pneumonia secondary to aspirations.</p> <p>The facility implemented the following interventions:</p> <p>Record review of in-services done on [DATE] for Abuse &amp; Neglect and Dietary Textures were done for , d+[DATE] employees received the in-service for dietary texture and following dietary orders, and not follow what residents' family does.</p> <p>During an interview on [DATE] at 9:05AM the DON stated a pimento cheese sandwich was not appropriate for a pureed diet. The DON stated the bread was difficult and could present as a choking hazard and the pieces in the pimento cheese could also cause choking.</p> <p>During an interview on [DATE] at 9:35AM, CNA C stated Resident #2 was hungry and she asked LVN B what she could give him and she told her a peanut butter and jelly or pimento cheese sandwich. CNA C stated Resident #2 was doing fine for a while and then he started choking. CNA C stated either her or LVN B tried to take away the sandwich and Resident #2 began to shove the food in his mouth. CNA C stated LVN B had to do the Heimlich maneuver once and dislodged the food. CNA C stated she was aware of his pureed diet but thought it was fine to give him the sandwich. CNA C stated his family would give him cookies and other things that were not a part of his diet. CNA C stated they had in-service on that if a family provides food that does not follow diet orders, it does not mean the staff should do the same. CNA C stated she now understands the reason why she should not give a resident the incorrect diet texture. CNA C stated she understood pimento cheese and bread is not safe because it was not pureed and that not adhering to the diet could lead to choking. CNA C stated she had not seen anyone else give the wrong diet and they multiple in-services on diet textures.</p> <p>Interview on [DATE] at 9:48 AM, LVN B stated that she knew Resident #2 was on a pureed diet and his family gave him solid food and thin liquid. LVN B stated that Resident #2 kept stating he was hungry, so she thought that because the family gave Resident #2 solid foods, he would be able to eat a pimento cheese sandwich. LVN B told CNA C to provide Resident #2 a pimento cheese sandwich cut into quarters and to only give him one quarter at a time. LVN B stated she heard Resident #2 coughing and went over and stood next to him. This was when LVN B asked CNA C if she cut up the sandwich and CNA C informed LVN B that she forgot. When Resident #2 stopped coughing, LVN B performed the Heimlich maneuver and dislodged the piece of food from Resident #2's throat. LVN B stated that she believed pimento cheese could be pureed, but was not sure, and that she thought it was safe for him to eat the sandwich slowly and with supervision.</p> <p>During an interview on [DATE] at 10:29AM, the Dietician stated that a pimento cheese sandwich was not appropriate to give a resident on a pureed diet because they cannot form a bolus and they were not able to swallow safely. The bread was not pureed and the pimento cheese was not pureed which does not make it safe for a pureed diet.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:10AM, the DM stated the pimento cheese was pre-made and delivered with other food items. DM stated she was told about the incident with Resident #2. The DM was told that Resident #2 was given a sandwich on the unit and he choked and the nurse was able to remove it. DM stated she asked who gave him the sandwich and was told that it was not dietary that gave him the sandwich. DM stated she, nor her staff, would give a resident on a pureed diet the pimento cheese sandwich because it was not the correct consistency for a pureed diet. DM stated it had to be more of a baby food consistency to facilitate swallowing and to prevent choking. The DM stated staff was in-serviced for correct diet consistencies.</p> <p>On [DATE] at 11:30AM the investigator received and observed a pimento cheese sandwich from Dietary Services with one slice of bread on [DATE] at 11:30AM. The pimento cheese had shredded cheese pieces as well as pimento peppers, all of regular consistency. This was the same cheese used by Dietary Services on the day the sandwich was given to Resident #2.</p> <p>During an interview on [DATE] at 1:13PM the ST stated Resident #2 had issues with swallowing and he would eat very fast. The ST stated for a while Resident #2 had a mechanical soft diet but because of his swallowing difficulties, he was put on a pureed diet. The ST stated sometimes he would allow help to eat which could facilitate a slower speed eating and sometimes he would refuse. He would be given verbal cues, but he would not listen to them which was another catalyst for his diet change to pureed. She stated pimento sandwich was not safe for a resident on pureed diet unless it was pureed.</p> <p>During an interview on [DATE] at 4:36PM DA N (Dietary Aide) stated she had in-service for dietary consistency. DA N stated a pimento cheese sandwich would not be appropriate for someone on a pureed diet because they would not be able to chew the bread and the pimento cheese had pieces of food that would make it hard to swallow, especially the bread.</p> <p>During an interview on [DATE] at 4:43PM LVN L stated she was in-serviced on the different dietary textures and to follow the dietary orders and not what family does. LVN L stated a pimento cheese sandwich would not be safe because a resident on a pureed diet would not be able to swallow the bread and the cheese. LVN L stated pureed had the consistency of baby food and a sandwich was not that consistency.</p> <p>During an interview on [DATE] at 9:32AM RN O stated she was in-serviced about dietary textures and to follow physician's orders and not what family does. RN O stated nurses must check all the trays and snacks to ensure resident received the appropriate dietary per doctor's orders.</p> <p>Record review of in-services done on [DATE] for Abuse &amp; Neglect and Dietary Textures were done for , d+[DATE] employees received the in-service for dietary texture and following dietary orders, and not follow what residents' family does.</p> <p>Record review of Dietary Policy, undated revealed the facility will ensure food texture is appropriate to individual needs of the residents.</p> <p>The Administrator was notified on [DATE] at 11:45AM, a past non-compliance IJ situation starting on [DATE] and ending on [DATE] had been identified.</p>		