

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 07/10/2025
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice for 2 of 5 (Resident #1 and Resident #2) residents reviewed for quality of care. 1. The facility failed to follow policy and Resident #1's care plan intervention to conduct weekly skin assessments for 1 of 14 (week of 05/09/2025) weeks reviewed. 2. The facility failed to follow policy and conduct a quarterly fall risk assessment for Resident #2 scheduled on 06/26/2025. This failure could affect residents currently residing in the facility resulting in not receiving needed care to maintain optimum health and placing them at risk for injury and/or deterioration in their condition. The findings included: 1. Record review of Resident #1's admission Record, dated 07/08/2025, reflected a [AGE] year-old male, admitted to the facility on [DATE]. Record review of Resident #1's Medical Diagnosis EMR tab, undated and accessed on 07/08/2025, reflected Resident #1 had diagnoses which included alcohol dependence with alcohol-induced persisting dementia (a general term for impaired ability to remember, think, or make decisions), hypertension (condition of high pressure in the vessels that carry blood from the heart to the rest of the body), and muscle wasting and atrophy (shrinking of muscle or nerve tissue). Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 12, which indicated he was mildly cognitively impaired. He was documented as received a pressure reducing device for his bed under skin and ulcer/injury treatments. Record review of Resident #1's Care Plan, undated and accessed 07/08/2025, reflected Resident #1 had a focus for skin integrity, noted as at risk for impaired skin integrity related to decreased mobility, smoker, hx of alcohol dependence., date initiated and revised 10/01/2024. His interventions included, Conduct skin inspections / examinations weekly and as needed. Document findings., date initiated 10/01/2024. Record review of Resident #1's [EMR] Skin & Wound- Total Body Skin Assessments, located under the EMR Forms tab, reflected an assessment was not recorded in the medical record for the week of 05/09/2025. His prior [EMR] Skin & Wound- Total Body Skin Assessment was dated 05/02/2025 and his following assessment was dated 05/12/2025. Record review of Resident #1's Progress Notes, dated 05/02/2025 to 05/14/2025, did not reveal a progress note mentioning skin conditions, appointments, passes, or transfers/discharges. Record review of facility document, Daily Nursing Schedule, dated 05/09/2025 and 05/10/2025, revealed LPN E was scheduled as the nurse for Resident #1's hall from 06:00 a.m. to 06:00 p.m. LPN E had initialed next to her name on both dates. During an interview on 07/10/2025 at 11:09 a.m., Resident #1 revealed he had not experienced any skin issues or wounds since his admission to the facility. Resident #1 revealed he could not recall a skin assessment having been missed. During an interview on 07/10/2025 at 02:53 p.m., the DON revealed the [EMR] Skin & Wound- Total Body Skin Assessment was to be completed every 7 days. She stated the assessment was assigned by hall and the treatment nurse was responsible for completing those assessments. She revealed the impact of a missed skin assessment might be that a skin issue was not identified timely and could develop into something worse. During an interview on 07/10/2025 at 03:13 p.m., LPN F revealed she had worked for the facility since around November or December of 2024, but transitioned to the treatment nurse position in late May 2025. She revealed she was not the treatment nurse during the week of 05/09/2025. She stated it was possible Resident #1 was out for an appointment or something, which caused him to miss his skin assessment. She stated the charge nurses were completing the weekly skin assessments between the time the prior full-time treatment nurse left and she transitioned into the position, no more than a week. She revealed since starting the treatment nurse position, she was responsible for completing the weekly skin assessments. She revealed Resident #1 had not experienced any skin issues other than dry skin since she had started completing the weekly skin assessments. During an interview on 07/10/2025 at 03:24 p.m., LPN E revealed she did not recall Resident #1's skin assessment for the week on 05/09/2025. She stated she did not know if the assessment was not done or just not marked as done. She stated that at the time, the system for completing the skin assessments was being changed. She stated the nurses could go to the forms tab in the EMR and see if there were any resident assessments due that day or past due. She stated she was unsure what would have been due on 05/09/2025 or 05/10/2025 for Resident #1. She revealed she was not aware of Resident #1 having had any skin issues. She stated Resident #1 was very independent and would tell the staff if he had any concerns. She stated that if an assessment was missed, the staff would have to go back and assess him to ensure they didn't miss any changes. Record review of facility policy Skin</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing, administering, and timely documentation of medications given, to meet the needs of each resident for 2 of 17 residents (Resident #3 and Resident #4) reviewed for pharmacy services. 1. CMA A failed to ensure medications were signed out as given to Resident #3 after administration, and not before they were given. 2. LPN H failed to reconcile Resident #4's documented penicillin (antibiotic) allergy with the physician's order for amoxicillin (antibiotic) before it was scheduled for administration on 06/29/2025. These failures could place residents at risk for loss of prescribed medications, drug diversion, and not receiving the intended therapeutic effects of prescribed medications or receiving potentially harmful side effects from prescribed medications. Findings included: 1. Record review of Resident #3's admission Record reflected a [AGE] year-old male, with an original admission date of 05/29/2025 and a re-admission date of 06/09/2025. Record review of Resident #3's Medical Diagnosis EMR tab, undated and reviewed on 07/10/2025, reflected Resident #3 had diagnoses including high blood pressure, pain in the right knee, constipation, stiffness in the right knee, and low back pain. Record review of Resident #3's MDS dated [DATE] documented a BIMS score of 12 out of 15, which suggested a moderate cognitive impairment (some trouble with memory, thinking issues, and making decisions that affected daily life). Record review of Resident #3's Care, undated and assessed on 07/10/2025, reflected the following focus, The resident has an AOL self-care, initiated on 05/30/2025 and revised on 06/25/2025. The interventions included staff assistance with showering, dressing, transferring, and monitoring for any changes. Record review of Resident #3's Order Summary Report dated 07/09/2025 reflected the following orders: Baclofen Oral Tablet (Baclofen) Give 20 mg by mouth three times a day for muscle spasm, dated 06/09/2025. Docusate Sodium Oral Capsule 100 MG (Docusate Sodium) Give 1 capsule by mouth two times a day for Constipation dated 06/09/2025. Gabapentin Oral Tablet 600 MG (Gabapentin) Give 1 tablet by mouth three times a day for NERVE PAIN, dated 06/09/2025. hydrALAZINE HCl Oral Tablet 100 MG (Hydralazine HCl) Give 1 tablet by mouth three times a day related to ESSENTIAL (PRIMARY) HYPERTENSION (110) **Give 2-50mg tablets to equal 100mg until supplyexhaust**, dated 06/12/2025. oxyCODONE HCl Oral Tablet 20 MG (Oxycodone HCl) Give 1 tablet by mouth every 6 hours for PAIN, dated 06/09/2025. During an observation on 07/08/2025 at 05:00 p.m., CMA A pulled and poured Resident #3's medications, . CMA A then proceeded to sign out all medications as given, which turned each medication color on the electronic medication administration record from yellow to green, CMA A then went into Resident #3's room where he took all of the medications. During an interview on 07/08/2025 at 05:10 p.m., CMA A stated that she administered Resident #3's and indicated she signed the medications out as given before Resident #3 took them and that she was trained that way two years ago by a CMA who no longer worked in the facility and had not had any training since that time. CMA A revealed that when it was time for medications to be given, the color on the screen appeared yellow, and that when they were signed as given the medications turned green. Record review of the facility's policy titled Medication Administration dated 10/01/2019, reflected that for Documentation (including electronic) A. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. 2. Record review of Resident #4's admission Record, dated 07/09/2025, reflected an [AGE] year-old female. She was originally admitted to the facility on [DATE] and re-admitted on [DATE]. Record review of Resident #4's Medical Diagnosis EMR tab, undated and accessed on 07/09/2025, reflected Resident #4 had diagnoses which included vascular dementia (brain damage typically caused by multiple strokes), cerebral infarction (a disruption in the brain's blood flow), and type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel) with hyperglycemia (high sugar levels in the blood). Record review of Resident #4's Quarterly MDS, dated [DATE] with observation end date of 07/02/2025, reflected Resident #4 had a BIMS score of 8, which indicated she was mildly cognitively impaired. She was documented as having taken an antibiotic during the last 7 days or since admission/entry or reentry if less than 7 days. Record review of Resident #4's EMR Allergy tab, accessed on 07/09/2025, reflected Resident #2 had an allergy to Penicillin, dated 11/18/2019, with unknown severity. Record review of Resident #4's Care Plan, undated and accessed 07/09/2025, reflected the following focus, [Resident #4] is at risk for allergic reaction as she is allergic to: PENICILLIN & SULFA ANTIBIOTICS, date initiated 12/07/2024 and revised 02/05/2025. The interventions included [NAME] chart with allergies. Notif</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 2 of 4 residents (Resident #1 and Resident #4) reviewed for clinical records.</p> <p>1. CMA A failed to document a progress note following the entry of chart code 5= Hold/See Progress Notes on 06/16/2025 for Resident #1's Metoprolol Tartrate (a blood pressure medication) order. 2. CMA A failed to document progress notes following the entry of chart code 9= Other/See Progress Notes on 07/02/2025 and 07/03/2025 for Resident #5's Olmesartan Medoxomil-HCTZ (a blood pressure medication) order. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. Findings included: 1. Record review of Resident #1's admission Record, dated 07/08/2025, reflected a [AGE] year-old male. He was admitted to the facility on [DATE]. Record review of Resident #1's Medical Diagnosis EMR tab, undated and accessed on 07/08/2025, reflected Resident #1 had diagnoses which included alcohol dependence with alcohol-induced persisting dementia (a general term for impaired ability to remember, think, or make decisions), hypertension (condition of high pressure in the vessels that carry blood from the heart to the rest of the body), and muscle wasting and atrophy (shrinking of muscle or nerve tissue). Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 12, which indicated he was mildly cognitively impaired. Record review of Resident #1's Order Recap Report, order date: 06/01/2025- 07/31/2025 and printed on 07/08/2025, reflected Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) hold for sbp&lt;100 dbp&lt; 60 hr &lt;60, order date 11/13/2024, start date 11/14/2024, and end date 07/02/2025. Record review of Resident #1's MAR, dated 06/01/2025 - 06/30/2025 and printed on 07/08/2025, reflected: Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) hold for sbp&lt;100 dbp&lt; 60 HR &lt;60, start date 11/14/2024 at 06:00 p.m. and d/c date 07/02/2025 at 01:12 p.m., was coded as 5 on 06/16/2025 by CMA A. Vitals entered on 06/16/2025 reflect a blood pressure of 94/62 and pulse of 67. Chart Codes reflect 4=BS/VS Outside of Parameters for Admin and 5=Hold/See Progress Notes. Record review of Resident #1's Progress Notes, dated 06/11/2025 to 06/25/2025, did not reveal a progress note mentioning medication administration or blood pressure values. During an interview on 07/10/2025 at 11:09 a.m., Resident #1 revealed he had received his medications on time and had not observed any issues with his medication administration. He revealed the staff check his blood pressure twice a day and he knew his blood pressure values go up and down due to his heart issues. He stated he had not had any issues with his blood pressures or blood pressure medication. 2. Record review of Resident #5's admission Record, dated 07/08/2025, reflected an [AGE] year-old female. She was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #5's Medical Diagnosis EMR tab, undated and accessed on 07/08/2025, reflected Resident #5 had diagnoses which included unspecified dementia, polyneuropathy, and hypertension. Record review of Resident #5's Annual MDS, dated [DATE], reflected Resident #5 had a BIMS score of 9, which indicated she was mildly cognitively impaired. Record review of Resident #5's Order Summary Report, dated on 07/08/2025, reflected Olmesartan Medoxomil-HCTZ Oral Tablet 40-12.5 MG (Olmesartan Medoxomil-Hydrochlorothiazide) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10), order date 07/01/2025 and start date 07/02/2025. Record review of Resident #5's MAR, dated 07/01/2025 - 07/31/2025 and printed on 07/08/2025, reflected: Olmesartan Medoxomil-HCTZ Oral Tablet 40-12.5 MG (Olmesartan Medoxomil-Hydrochlorothiazide) Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10), start date 07/02/2025 at 08:00 a.m., was coded as 9 on 07/02/2025 and 07/03/2025 by CMA A. Chart Codes reflect 9=Other / See Progress Notes. Chart Codes did not reflect a code description for On order. Record review of Resident #5's Progress Notes, printed on 07/08/2025 and dated effective date range: 06/08/2025 to 09/09/2025 and created date range: all created; did not reveal a progress note entered after 07/01/2025. During an interview on 07/10/2025 at 02:13 p.m., Resident #5 revealed she was administered her medications generally at the same time each day. She stated she took medication for blood pressure and the staff checked her blood pressure twice a day. She stated her blood pressure was different at different times a day. During an interview on 07/10/2025 at 12:51 p</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>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 to help prevent the development and transmission of infections involving 1 of 3 staff (CMA B) reviewed for infection control, in that: The facility failed to ensure CMA B cleaned the blood pressure cuff between Resident #6 and Resident #7. These deficient practices could place residents at-risk for infections. The findings included: During an observation on 07/09/2025 at 02:36 p.m., CMA B was observed taking Resident #6's blood pressure prior to administering medications to the resident. CMA B returned to her medication cart and placed the blood pressure cuff on the cart. CMA B did not sanitize the blood pressure cuff. CMA B then went and took Resident #7's blood pressure with the same cuff. CMA B again returned to her medication cart and placed the blood pressure on top of her cart. CMA B again did not sanitize the blood pressure cuff. During an interview on 07/09/2025 at 02:49 p.m., CMA B stated she knew she was forgetting something during her medication administration observation. She revealed she was supposed to wipe the blood pressure cuff after and between each resident. She stated the nursing facility had provided training that reviewed these procedures. She stated wiping the cuff between residents was for sanitation reasons, to stop the spread of germs. During an interview on 07/10/2025 at 02:53 p.m., the DON revealed staff were to take blood pressure readings prior to administering blood pressure medications and the staff were to disinfect the blood pressure cuff between each resident. She stated disinfecting the cuff was for infection control purposes. Record review of facility policy, Infection Prevention and Control Program, date implemented 05/13/2023, reflected under Policy Explanation and Compliance Guidelines, 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. and 10. Equipment Protocol: a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.</p>