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| 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 10/18/2024 |
| 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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031</p> <p>Based on interview and record review, the facility failed to refer a resident with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review for 1 of 5 residents (Resident #4) reviewed for resident assessment.</p> <p>Resident #4 was not referred to the pre-admission screening and resident review (PASARR) program for a level II resident review despite having a serious mental disorder diagnosis.</p> <p>This failure could place residents at risk of not receiving specialized services to meet their needs.</p> <p>The findings were:</p> <p>Record review of Resident #4's face sheet dated 10/18/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), delusional disorders (classified as a psychotic disorder, a disorder where a person has trouble recognizing reality), alcohol dependence with alcohol-induced persisting dementia (form of dementia caused by long-term, excessive consumption of alcohol, resulting in neurological damage and impaired cognitive function), and generalized anxiety disorder (excessive, ongoing anxiety and worry that interferes with daily activities). Further review revealed major depressive disorder was the primary admitting diagnosis.</p> <p>Record review of Resident #4's annual MDS assessment dated [DATE] revealed the resident was not considered to have a serious mental disorder or illness by the state level II PASRR process, serious mental illness was left blank, and the resident had a BIMS score of 4 indicating the resident was severely cognitively impaired. The MDS reflected the resident had depression and a psychotic disorder.</p> <p>Record review of Resident #4's care plan undated revealed a focus initiated on 5/30/23 and revised on 8/28/24 for the resident being at risk of having behaviors related to her diagnoses Dementia w/agitation, irritability & psychosis; Major Depressive Disorder; Delusional Disorder; & Anxiety. She has voiced being tired and having trouble concentrating. HX of hiding medications & confusing them. HX of insomnia. Voices having little interest, feeling down and moving slower than normal. Interventions included giving the resident antidepressant and antipsychotic medications as ordered.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #4's PASRR (Preadmission Screening and Resident Review) level 1 screening form dated 5/23/22 revealed under the question if the resident had a mental illness was marked no.</p> <p>Record review of Resident #4's EHR revealed there was no evidence that a PASRR level 2 screening was completed for Resident #4.</p> <p>In an interview on 10/17/24 at 1:25 p.m. LVN A was unable to state why Resident #4's PASRR level 1 was marked no under mental illness and stated there was nothing she could see from the physician certifying dementia as the resident's primary diagnosis and would look for more information.</p> <p>In an interview on 10/18/24 at 11:18 a.m. LVN B stated Resident #4's PASRR level 1 should have been marked yes under mental illness and the resident should have been referred to the pre-admission screening and resident review (PASARR) program for a level 2 but they were contacting the physician because dementia was the primary diagnosis and they would likely have form 1012 completed. LVN B stated it was important for residents PASRR level 1 screenings to be correct so residents got a level 2 evaluation and PASARR specialized services if needed. LVN B stated LVN A was fairly new and was how it got missed but was being corrected . LVN B stated the facility was not aware of the error on Resident #4's PASRR level 1 screening form until brought to their attention by the surveyor.</p> <p>In an interview on 10/18/24 at 12:13 p.m. the facility PASARR policy was requested from the DON and she stated she would ask the regional consultant.</p> <p>In an interview on 10/18/24 at 12:17 p.m. the DON stated the facility did not have a PASARR policy.</p> |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520</p> <p>Based on interview and record review the facility failed to ensure the attending physician documented in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it in response to the pharmacist report for 1 of 2 Residents (Resident #15) reviewed for antipsychotic use.</p> <p>Nursing staff failed to ensure the attending physician responded to the pharmacists' recommendations for Resident #15.</p> <p>This deficient practice could affect residents who receive recommendations for psychotropic medications and result in the unnecessary adverse side affects.</p> <p>The findings were:</p> <p>Review of Resident #15's face sheet, dated, 10/18/24, revealed she was admitted to the facility on [DATE] with diagnoses including unspecified Dementia, unspecified severity, with psychotic disturbance, Bipolar disorder, unspecified, Major Depressive disorder, recurrent, mild, Anxiety disorder, unspecified.</p> <p>Review of Resident #15's quarterly MDS, dated [DATE], revealed her BIMS was 7 reflective of severe cognitive impairment, was diagnosed with anxiety, Bipolar disorder and Dementia, unspecified severity, with psychotic disturbance and was receiving antipsychotic and antianxiety medications.</p> <p>Review of Resident #15's Care Plan revised on 9/10/24 revealed she had behaviors related to DX: Bipolar, Schizoaffective Disorder, Dementia w/ Psychotic Disturbance, Anxiety & Depression. Interventions included Administer antianxiety, mood stabilizers & antipsychotic medications as ordered. Observe/document for side effects and effectiveness. F/U with [Psychiatrist name] (Psychiatry) as ordered or needed.</p> <p>Review of Resident #15's physician's consolidated orders, dated October 2024, revealed the following orders: LORazepam Oral Concentrate 2 MG/ML (Lorazepam), Give 0.25 ml by mouth every 6 hours as needed for AGITATION, start date 10/17/24 for ANXIETY, OR RESTLESSNESS for 14 Days; LORazepam Oral Tablet 0.5 MG (Lorazepam) Give 1</p> <p>tablet by mouth two times a day for AGITATION; risperiDONE Oral Tablet 2 MG (Risperidone) Give 1 tablet by mouth in the morning for BIPOLAR; risperiDONE Oral Tablet 3 MG (Risperidone) Give 1 tablet by mouth at bedtime for BIPOLAR; and Valproic Acid Oral Solution 250 MG/5ML (Valproate Sodium) Give 5 ml by mouth every 12 hours for</p> <p>seizures.</p> <p>Review of Resident #15's MAR for October 2024 revealed Resident #15 was receiving Lorazepam, RisperiDONE and Valproic Acid according to physician's orders.</p> <p>(continued on next page)</p> | | |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident #15's Consultant Pharmacist/Physician Communication reviews revealed on 9/25/23 the review read: Per CMS regulations please evaluate resident for trial dose reduction.</p> <p>Clonazepam 0.25mg po on time a day for anxiety since 3/21/23 Clonazepam 0.5mg po hs for anxiety since 12/4/22</p> <p>Risperidone 3mg po hs for Bipolar Disorder since 3/30/23</p> <p>Resident is also receiving:</p> <p>Depakene 250mg/5ml give 10ml=500mg po bid for Bipolar Disorder</p> <p>If dose reduction is contraindicated or resident failed previous dose reduction attempt, please document below. Further review revealed response, Psych managing with an illegible signature and dated, 10/4/23. There was no response to the recommendation.</p> <p>Review of Resident #15's Consultant Pharmacist/Physician Communication reviews revealed on 1/11/24 read Per CMS regulations please evaluate resident for trial dose.</p> <p>Depakene 250mg/5ml give 10ml=500mg po bid for Bipolar Disorder since 1/30/23</p> <p>Resident is also receiving:</p> <p>Clonazepam 0.25mg po one time a day for anxiety Clonazepam 0.5mg po hs for anxiety</p> <p>Risperidone 3mg po hs for Bipolar Disorder</p> <p>If dose reduction is contraindicated or resident failed previous dose reduction attempt, please document below. Further review revealed response, under psychiatric care with an illegible signature and dated, 2/6/24. There was no response to the recommendation.</p> <p>Review of Resident #15's EHR revealed there was no documentation from the PCP regarding the pharmacist's recommendations dated 9/25/23 and 1/11/24.</p> <p>Interview on 10/18/24 at 12:48 PM with the DON revealed Resident #15 was receiving LORazepam Oral Concentrate 2 MG/ML PRN and scheduled LORazepam for anxiety, risperiDONE for BIPOLAR and Valproic Acid Oral Solution 250 MG/5ML as a mood stabilizer. The DON stated she received the pharmacist's recommendations for review. She stated the signature on the Consultant Pharmacist reviews revealed Resident #15's PCP signed them but did not respond to the actual recommendations which was required in order to make necessary changes to Resident #15's medication regimen.</p> <p>(continued on next page)</p> | | |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of facility policy, Consultant Pharmacist Services and Reports, revised 10/1/19, read in relevant part: The consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and or responsibility to implement the recommendations, and responded to in an appropriate and timely fashion. Procedure: 3. Recommendations are acted upon and documented by the facility staff and or the prescriber. If the prescriber does not respond to recommendation directed to him/her within 30 days, the Director of Nursing and or the consultant pharmacist may contact the Medical Director.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>27520</p> <p>Based on observation, interview and record review the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen.</p> <p>Cook C failed to cover a pan of wheat rolls to prevent the rolls from being contaminated.</p> <p>Cook D failed to ensure all foods were covered during meal preparation and failed to allow two pans to air dry before using them also to prevent debris from contaminating the foods. [NAME] D also dried two pans with paper towels then used them during meal prep which could also contaminate the food.</p> <p>These deficient practices could affect the majority of residents who ate from the kitchen and could result in resident getting sick due to the spread of food borne illnesses.</p> <p>Observation on 10/15/24 at 9:05 AM revealed a pan of wheat rolls sitting on the side tabletop of the steam table. The pan of wheat rolls was not covered.</p> <p>Observation and interview on 10/15/24 at 9:16 AM revealed a pan of wheat rolls sitting on the side tabletop of the steam table. The pan of wheat rolls was not covered. Interview with [NAME] C revealed she did not cover the rolls with wax paper because the wax paper would get stuck to the rolls. She stated she understood all food should be covered to prevent from debris landing on it and risk contaminating the food. [NAME] C stated it could make the residents sick.</p> <p>Observation and interview on 10/17/24 at 10:58 AM revealed covered pans of food on the steam table. There was a large pan full of chicken fried steak on the steam table as well. It was not covered. Interview with [NAME] D revealed she was getting ready to take temperatures of the food. She called out the following temperature for the macaroni and cheese was 100 degrees. [NAME] D stated she would put it back in the oven until it reached temperature of at least 135 degrees. She stated the steam table was set at 10 which was the highest setting.</p> <p>Observation on 10/17/25 at 11:05 AM revealed the pan of chicken fried steak was still uncovered. Further observation revealed a large pan of corn bread, sprinkled with honey, was on the prep table. It was not covered.</p> <p>Observation and interview on 10/17/24 at 11:07 AM revealed [NAME] D removed the puree macaroni and cheese from the oven. She stated the temperature was 120 degrees and placed it on the steam table.</p> <p>Observation interview on 10/17/24 at 11:12 AM revealed [NAME] D stated the pureed spinach was 131 degrees and the puree macaroni and cheese was 100 degrees. [NAME] D left the items on the steam table.</p> <p>Observation on 10/17/24 at 11:13 AM revealed the DM covered the pan of cornbread with foil paper.</p> <p>Observation on 10/17/24 at 11:15 AM revealed a deep pan of ground beef patties in water next to the robocoupe blender on a prep table alongside the stove. The pan was not covered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Observation on 10/17/24 at 11:16 AM revealed [NAME] D took the temperature for the puree spinach again and stated it was 131 degrees and she also took the temp of the puree macaroni and cheese and stated it was 113 degrees. [NAME] D grabbed a ladle and stirred the puree macaroni and cheese.</p> <p>Observation and interview on 10/17/24 at 11:17 PM revealed [NAME] D removing a small pan and a long pan from the dish rack. Water was dripping from the pans onto the floor. [NAME] D placed the pans by the Robocoupe blender. The pan of boiled meat patties was still uncovered. [NAME] D then started looking for alternate thermometer reaching into the bottom shelf hanging right over the pan of meat patties. There were crumbs on the bottom shelf where [NAME] D reached into. Interview with [NAME] D revealed she changed from manual thermometer to digital thermometer and stated the DM had a digital thermometer in her office. Further observation revealed [NAME] D adding water to the pans on the steam table. She stated she noticed there was not enough water in the pans and that was why the steam table was not heating the food properly.</p> <p>Observation on 10/17/24 at 11:45 AM revealed [NAME] D initiated plating the lunch meal of the day which included Country Fried Steak, Country gravy, macaroni and cheese, spinach, cornbread, margarine, red velvet cake, coffee or tea and garnish parsley sprig.</p> <p>Interview on 10/17/24 at 1:57 PM with [NAME] D revealed she had been a cook for 6 months. She stated she felt nervous and was having trouble with the temperatures and had to make adjustment. She stated she felt distracted. [NAME] D stated all food should reach at least 135 degrees for safe service. She stated the puree macaroni and cheese, and the puree spinach did not reach 135 degrees. [NAME] D stated she did not write the temperatures down as she took them and was unsure what the exact temperature was for all food items. She stated she served all items on the steam table even the ones that did not reach temperature. Further interview revealed [NAME] D stated she used the pans she took from the dish rack for the puree and mechanical soft meat patties. Initially, she stated the pans were dry and then stated she remembered they were wet because she wiped the inside of the pans dry with a paper towel. She stated the pans should be air dried to prevent bacteria from forming. [NAME] D stated all the pans of food on the steam table were covered with foil paper to keep at safe temperature. She stated she uncovered the pan of chicken fried steam to take the temperature of the meat but then she did not cover it back up. [NAME] D stated food on the steam table should also be covered to prevent from debris landing on the food. It could make the residents sick. [NAME] D stated the beef patties were also not covered. She stated again she felt nervous and distracted. [NAME] D stated she saw a fly in the kitchen but stated flies did not get into the kitchen very often. [NAME] D also stated she did not cover the pan of cornbread because she was going to cut it.</p> <p>(continued on next page)</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Interview on 10/18/24 at 10:35 AM with the DM revealed food temperatures should reach 135 to 165 degrees for safe service. She stated she understood [NAME] D missed some things She stated she talked with [NAME] D who said she was nervous and was distracted because the food temperatures were not all reaching 135 degrees. The DM stated it was important food items reached at least 135 degrees and hold for serving to prevent the development of food borne illnesses to prevent residents from getting sick. She stated she did not know the food had to reach 165 degrees for at least 15 seconds after rewarming before serving. The DM revealed food Items should be covered related to cross contamination, debris falling in it and contaminating the foods, infection control and to prevent the spread of diseases. The DM also stated flies usually did not get into kitchen but the door was opened more than usual as a result of the food delivery. The DM stated pans should be air dried and staff should not use paper towels to dry because it could get resin (According to Wikipedia, Polyamide epichlorohydrin (PAAE) is a permanent wet strength additive used in papermaking) on the pan and contaminate the pan that had been sanitized.</p> <p>Review of facility policy, Food Preparation and Handling revised on June 1, 2019 read in relevant part: Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be prepared and handled according to the state and Us Food Codes and HACCP (according to Wikipedia it is Systems and methods for monitoring food processing and food storage) guidelines.</p> <p>Procedure: 1. General Guidelines a. Use clean, sanitized surfaces, equipment and utensils.</p> <p>4. Hot Food Temperatures: f. fresh, frozen, or canned fruits and vegetables that are cooked for hot holding shall be cooked to a minimum temperature of 140-degree F.</p> <p>Review of FDA Food Code 2022 read in relevant part: 3-403.11 Reheating for Hot Holding. (A) Except as specified under (B) and (C) and in (E) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74oC (165oF) for 15 seconds.</p> <p>4-9 Protection of Clean Items</p> <p>4-901 Drying</p> <p>4-901.11 Equipment and Utensils, Air-Drying Required.</p> <p>After cleaning and SANITIZING, EQUIPMENT and UTENSILS:</p> <p>(A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD; and</p> <p>(B) May not be cloth dried except that UTENSILS that have been air-dried</p> <p>(continued on next page)</p> | | |

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| <p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Dispose of garbage and refuse properly.</p> <p>27520</p> <p>Based on observation, interview and record review revealed the facility failed to dispose of garbage and refuse properly for 1 of 4 survey dates (10/18/24).</p> <p>The facility failed to ensure all dumpster's had a plug at the bottom to keep spillage and the attraction of insects, bugs and rodents which could carry diseases and infections.</p> <p>This deficient practice could affect all residents and result in the spillage of trash seepage, attraction of bugs, rodents and insects that could enter the facility.</p> <p>The findings were:</p> <p>Observation on 10/18/24 at 11:20 AM revealed one of three dumpster's did not have a plug on the opening located one of the sides and bottom of the dumpster. The dumpster's were located within 10 to 15 feet away from the nursing facility. Interview with the DM stated the first dumpster did not have a plug on the opening. She stated all dumpster's should have a plug to prevent spillage from inside the dumpster which could be an infection control problem. She stated staff could step on the spillage and carry the germs inside the facility or flies could land on the spillage and carry the germs inside the facility. She stated the smell of trash could also attract insects, bugs and rodents and they could access the facility and resident rooms. The DM stated germs, diseases and infections could make the residents sick.</p> <p>Review of facility policy, Garbage Receptacles, revised June 1, 2019 read in relevant part: The facility will maintain garbage receptacles in a clean and sanitary manner to minimize the risk of food hazards. It should be constructed to have tight fitting lids, doors or covers and stored in a manner that is inaccessible to insect and rodents with doors/lids kept closed and no waste outside of the receptacle.</p> |