STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675110	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuero Nursing and Rehabilitation Center	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 19 residents (Resident #3) reviewed for assessments: Resident #3's admission MDS, dated [DATE], identified the resident had urinary indwelling catheter. This failure could place residents at risk for inadequate care due to inaccurate assessments.The findings included: Record review of Resident #3's face sheet, dated 01/23/2026, revealed the resident was a [AGE] year-old male and admitted to the facility on [DATE] with diagnoses of hypertensive chronic kidney disease (high blood pressure can constrict and narrow the blood vessels in your kidneys, which reduces blood flow and stops the kidneys from working well regarding removing all wastes and extra fluid from the body) and retention of urine (blockage that partially of fully prevents urine from leaving the bladder or urethra or bladder not being able to maintain a strong enough force to expel all the urine). Record review of Resident #3's admission MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive was intact. Section H (Bladder and Bowel), the resident had indwelling urinary catheter. Question H0300 of Urinary Continence? was coded to 1- occasionally incontinent, Record review of Resident #3's comprehensive care plan, dated 12/22/2025, revealed that Resident #3 has an indwelling catheter related to urinary retention. For intervention, the resident has indwelling urinary catheter - Position catheter bag and tubing below the level of the bladder and away from entrance room door and check tubing for kinks each shift. Observation on 01/20/2026 at 2:57 p.m. revealed Resident #3 had an indwelling urinary catheter, and the catheter bag was secured at the bed frame. During an interview on 01/23/2026 at 9:04 a.m. MDS nurse LVN-A stated Resident #3's admission MDS, dated [DATE], indicated the resident had an indwelling urinary catheter. MDS Nurse LVN-A stated question H0300 of Urinary Continence? should have been coded 9 - not rated because Resident #3 had an indwelling urinary catheter. The MDS nurse LVN-A said coding accurately was a MDS nurse's responsibility, and inaccurate MDS assessments might result in improper care to the resident, and the facility did not have policy for MDS accuracy, but following CMS's RAI Manual guidelines. Record review of CMS's RAI version 3.0 Manual, titled H0300: Urinary Continence: Prognosis, paged H-10, dated 10/2025, revealed Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days.

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
	675110	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuero Nursing and Rehabilitation Center	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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #39) reviewed for incontinence care. CNA-B used multiple passes with the same wipe while cleaning the Resident #39'sgenital area on 01/21/2026. This failure could place residents at risk for cross contamination and the development of new or worsening urinary tract infections.The findings included: Record review of Resident #39's face sheet, dated 01/23/2026, revealed Resident #39 was a [AGE] year-old male, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with the diagnosis of end stage renal disease (when kidneys no longer function well enough to meet a body's needs). Record review of Resident #39's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 8 out of 15, which indicated the resident had moderate cognitive impairment, and the resident was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to chair to bed transfer and Not attempted due to medical condition or safety concerns to toilet transfer. Further record review of the MDS indicated Resident #39 was always bladder and bowel incontinent. Record review of Resident #39's comprehensive care plan, dated 10/30/2025, The resident has functional incontinence of bladder and bowels related to impaired cognition and decreased mobility. For intervention - Clean peri-area with each incontinence episode. Observation on 01/21/2026 at 4:37 p.m. revealed CNA-B washed her hands with water, put on gloves and gown, opened the old and dirty brief of Resident #39, then cleaned the resident's genital area. When CNA-B cleaned Resident #39's genital area (the penis), the CNA had multiple pass with the same wipe, and then CNA-B turned Resident #39 on his side and cleaned the resident's anal area. Further observation revealed that CNA-B changed her gloves after sanitizing her hands and put a new and clean brief under the resident, then closed the brief. During an interview on 01/21/2026 at 4:43 p.m. CNA-B stated she had multiple pass with the same wipe when cleaning Resident #39's penis area. CNA-B said she was nervous, so she forgot to use new disposable wipe with each stroke when cleaning Resident #39's genital areas. CNA-B stated she should have used new wipe with each stroke, instead of multiple pass, to prevent possible infection. During an interview on 01/22/2026 at 11:40 a.m. DON stated CNA-B should have used new wipe with each stroke when cleaning Resident #39's genital area to prevent possible urinary tract infection. Record review of the facility policy, titled Perineal Care, dated 10/24/2022, revealed . 12. Males. G. Cleans the shaft of the penis, using downward strokes toward the scrotum. Use separate section of washcloth or new disposable wipe with each stroke.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675110	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuero Nursing and Rehabilitation Center	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments for 2 medication carts (200 & 400 hall nursing cart and 500 hall nursing cart) of 5 medication carts reviewed for medication storage. 1. In the nurse cart in hall 200 & 400, one insulin bottle (Novolin) of Resident #8 was opened, but there was no open date on the label of the insulin bottle. 2. The nurse cart in hall 500 was unlocked unattended while LVN-D was providing intravascular care to Resident #102. This failure could place residents at risk of missing or misuse of drugs by unauthorized personnel and not reach to therapeutic effects.The findings included: 1. Observation nursing cart foe the hall 200 & 400 on [DATE] at 3:29 p.m. revealed there was one bottle of Resident #8's NovoLIN R Injection Solution 100 UNIT/ML inside the. The insulin bottle was opened, but there was no open date on the bottle. During an interview on [DATE] at 3:40 p.m. with LVN-D stated there was one bottle of Resident #8's NovoLIN R Injection Solution 100 UNIT/ML inside the nursing cart in hall 200 & 400, and the insulin bottle was opened, but there was no open date on the bottle. LVN-D said she opened it morning time on [DATE] and forgot to write open date on it. Further interview with the LVN-D said writing open date on the insulin was very important because per the facility policy, they should discard NovoLIN R Injection Solution 100 UNIT/ML after 42 days once it was opened. The nurse said if the insulin bottle did not have open date, facility nurses did not know when they have to discard it, might use it, and it might not have therapeutic effects. During an interview on [DATE] at 11:40 a.m. with DON stated facility nurses should have written open date on the insulin bottle of Resident #8's NovoLIN R Injection Solution 100 UNIT/ML because per the facility policy, they should discard NovoLIN R Injection Solution 100 UNIT/ML after 42 days once it was opened, and if facility nurses used the expired insulins, the resident might not have therapeutic effects. 2. Observation on [DATE] at 2:55 p.m. revealed LVN-D opened the nurse cart in hall 500, took out Resident #102's intravenous medication and equipment, entered Resident #102's room, and closed the room door without locking the nurse cart. The nurse cart in hall 500 was unlocked unattended in the 500-hall way while LVN-D was administrating IV medication to Resident #102. During an interview on [DATE] at 3:00 p.m. with LVN-D stated she forgot to lock the nurse cart and left the cart to be unlocked while she was administering IV medication to Resident #102. LVN-D said it was her mistake, and she should have locked the cart all the time to prevent missing or misuse of drugs by unauthorized personnel. During an interview on [DATE] at 11:40 a.m. with DON stated facility nurses should have locked their carts all the time for safety and to prevent missing or misuse of drugs by unauthorized personnel. Record review of the facility policy, titled Storage and expiration - Diabetes injections, undated, revealed discard the insulin Novolin R Vial after 42 days once it was opened. Record review of the facility policy, titled Medication Administration, revised [DATE], revealed . p. during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675110	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuero Nursing and Rehabilitation Center	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 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** Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Resident #41) of 8 residents reviewed, in that: Resident #'41s personal refrigerator located in her room was observed on 01/20/2026. There were three small plastic containers inside the refrigerator, with no dates and no labels on the plastic containers. This failure could place residents at risk of foodborne illness due to consuming foods which might be spoiled. The findings included: Record review of Resident #41's face sheet, dated 01/23/2026, reflected the resident was an 88-years-old female and was initially admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (progressive disease that destroy memories and other important mental functions), dementia (loss of memory and thinking ability), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and hypertension (high blood pressures). Record review of Resident #41's Quarterly MDS assessment, dated 12/22/2025, reflected the resident's BIMS score was 7 out of 15 which indicated the resident had severe cognitive impairment, and the resident was Setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating and Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for sit to stand and chair to bed transfer. Record review of Resident #41's comprehensive care plan, dated 11/12/2025, revealed the resident had The resident is at risk for nutritional problems related to impaired cognition and poor dentition. She is at risk for malnutrition and for interventions - Provide, serve diet as ordered. Observe intake and record every meal. Observation on 01/20/2026 at 11:23 a.m. revealed Resident #41 was on the bed and sleeping in her room. There was a personal refrigerator in the room, and inside the refrigerator there were three small plastic containers with food, but no dates and no labels on the containers. During an observation and interview on 01/20/2026 at 12:00 p.m. with RN-C stated Resident #41's refrigerator in her room had three small plastic containers with food, but the containers were not dated and labeled. RN-C said that the food in three small plastic containers looked like salad dressings. The facility night nurses were supposed to check it every day and write dates and labels to prevent possible food-born illness. During an interview on 01/22/2026 at 11:40 a.m. the DON stated facility night nurses were responsible for overseeing Resident #41's personal refrigerator and also responsible for monitoring it daily. The DON stated the resident might have illness due to food. Record review of the facility policy, titled Resident Refrigerators, dated 07/03/2023, revealed . 4. Residents and staff shall comply with safe food handling and storage principles: b. leftovers shall be dated upon receipt and discard within three days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675110	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuero Nursing and Rehabilitation Center	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 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** Based on observation, interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 2 (Resident #6 and #102) out of 6 residents reviewed for medical records. 1. ADON LVN-E did not document on Resident #6's treatment administration record on 01/09/2026 after providing wound care to the resident. 2. The facility nurse did not document on Resident 102's medication administration record on 01/17/2026 regarding the resident was out on pass. This failure placed residents at risk for missed treatment and medications which could result in decline in health and well-being.Findings included: 1. Record review of Resident #6's face sheet, dated 01/23/2026, revealed the resident was a [AGE] year-old female and admitted to the facility on [DATE] with diagnoses of cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), pressure ulcer of left ankle-stage 4 (injuries to the skin and the tissue below skin that are due to pressure on the skin for a long time), hemiplegia and hemiparesis (partial weakness that occurs on one side of the body), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #6's Quarterly MDS assessment, dated 01/20/2026, revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment and was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to most activities of daily life such as sit to stand, chair-to-bed, and toilet transfer and had unhealed pressure ulcer and moisture associated skin damage in Section M (Skin Condition). Record review Resident #6's comprehensive care plan, dated 01/16/2026, revealed that the resident had the care plan of PRESSURE ULCER/INJURY: the resident has impaired skin integrity related to Unstageable ulcer to left lateral Ankle and Moisture Associated Skin Damage to right gluteus (bittock). For intervention - Apply treatment as ordered. Record review of Resident #6's physician order, dated 12/26/2025, revealed the resident had the order of Right buttocks Moisture Associated Skin Damage - Cleanse with wound cleanser, pat dry, apply Zinc Oxide & cover with border foam dressing QOD (every other day) & as needed if soiled or dislodged. Record review of Resident #6's treatment administration record from 01/01/2026 to 01/31/2026 revealed Right buttocks Moisture Associated Skin Damage - Cleanse with wound cleanser, pat dry, apply Zinc Oxide & cover with border foam dressing QOD (every other day) & as needed if soiled or dislodged was scheduled every other day. Further record review of the treatment administration record revealed there was blank on 01/09/2026, which was scheduled for the wound care. During an interview on 01/23/2026 at 8:43 a.m. with ADON LVN-E said the facility wound care nurse usually provided wound care to Resident #6, but ADON LVN-E provided the wound care on 01/09/2026 because the facility wound care nurse left early from the facility on 01/09/2026 due to private reasons. ADON LVN-E said she forgot to document it on the treatment administration record, it was her mistake, and the resident's treatment administration record should have been accurate to prevent providing incorrect wound care to the resident. 2. Record review of Resident #102's face sheet, dated 01/23/2026, revealed Resident #102 was a [AGE] year-old male, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with the diagnoses of urinary tract infection (bacteria enter the urinary tract through the urethra and begin to spread in the bladder), anemia (A condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), hepatitis C (viral infection that causes liver swelling, called inflammation). Record review of Resident #102's admission MDS, dated [DATE], revealed the resident's BIMS score was 10 out of 15, which indicated the resident had moderate cognitive (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675110	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuero Nursing and Rehabilitation Center	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment, and the resident had intravenous medications as ordered in Section O (Special Treatments, Procedures, and Programs). Record review of Resident #102's comprehensive care plan, dated 01/19/2026, revealed the resident had the care plan of The resident potential fluid deficit related to use of IV fluids in hospital and current use of IV antibiotics. For intervention - Administer medications as ordered. Monitor/document for side effects and effectiveness. Record review of Resident #102's physician order, dated 01/15/2026, revealed Meropenem Intravenous Solution Reconstituted 1 Gram (Meropenem) Use 1 gram intravenously every 8 hours related to URINARY TRACT INFECTION until 02/03/2026. Record review of Resident #102's medication administration record from 01/01/2026 to 01/31/2026 revealed Meropenem Intravenous Solution Reconstituted 1 Gram (Meropenem) Use 1 gram intravenously every 8 hours related to URINARY TRACT INFECTION until 02/03/2026 was scheduled 7:00 am, 3:00 pm, and 11:00 pm. Further record review of the medication administration record revealed there was a blank on 01/17/2026 at 3:00 pm. Observation on 01/21/2026 at 2:55 p.m. revealed the facility nurse administrated Meropenem Intravenous Solution Reconstituted 1 Gram (Meropenem) to Resident #102 via IV. During an interview on 01/23/2026 at 9:31 a.m. with DON said Resident #102 was out on pass on 01/17/2026 at 3:00 pm for the resident's appointment as evidence by the facility in and out log. Further interview with DON said the facility nurse should have documented on the medication administration record as 1 which mean 1=out on pass without meds per the direction. The facility nurse should not leave blank on the medication administration record because the resident's medication administration record should have been accurate to prevent providing incorrect dosage to the resident, and it was the facility nurses' mistake. The DON had responsibility to oversee residents had accurate medication administration records. Record review of the facility policy, titled Documentation in Medical Record, dated 10/24/2022, revealed . 3. Principles of documentation include, but are not limited to. b. documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and /or responses to care. C. documentation shall be timely and in chronological order.