STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675124	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Texan Nursing & Rehab of Gonzales	3428 Moulton Rd Gonzales, TX 78629

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview, and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 8 residents (Resident #2 and Resident #6) reviewed for reasonable accommodation of resident needs. 1. The facility failed to ensure Resident #2 had access to his call light which was draped over his nightstand outside of the resident's reach. 2. The facility failed to ensure Resident #6 had access to her call light which was wrapped around the call light plug on the wall, behind Resident #6 and outside of her reach. These deficient practices could place residents at risk of not maintaining and/or achieving independent functioning, dignity, and well-being. Findings include: 1) Record review of Resident #2's, undated, face sheet revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Hypertensive Heart Disease (heart problems caused by high blood pressure) and Dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #2's admission MDS assessment, dated 02/06/2025, revealed Resident #2 had a BIMS score of 7, which indicated severe cognitive impairment. Section GG - Functional Abilities revealed Resident #2 used a wheelchair for mobility and required moderate assistance with mobility in the wheelchair. Resident #2 required supervision with chair to bed transfers and bed mobility. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's comprehensive care plan revealed a care plan, dated 02/12/2025, which stated Resident #2 was at risk for falls related to Resident #2 requiring assistance, unsteady gait, confusion, medications, and behavioral symptoms. The care plan included an intervention which stated, call bell in reach, educate and encourage use, answer all requests for assistance. Resident #2 had a care plan, dated 02/21/2025, which stated Resident #2 was a fall risk related to self-transfers, unsteady gait and confusion and included an intervention, call bell in reach, explain/encourage use and answer promptly. Resident #2 had a care plan dated, 02/12/2025, which stated Resident #2 had a self-care deficit and required assistance with ADLs. The care plan intervention stated, keep call light within reach and encourage to use it for assistance. Respond to all requests for assistance. Record review of Resident #2 Fall Risk Assessment, dated 01/27/2025, completed by the DON revealed Resident #2 scored a 14. The risk assessment stated a score of 10 or higher represented a high risk for falls. During an observation on 03/25/2025 at 9:30 a.m., revealed Resident #2 was observed asleep in his recliner with leg rest halfway up. The resident was leaning to his far-right side and had a single serving size of chips in his lap that had spilled on his recliner and on his legs. Resident #2 had a push button call light and a soft touch call light that were both draped across a nightstand which was not within Resident #2's reach. During an observation on 03/25/2025 at 1:47 p.m., Resident #2 was observed sleeping upright in his recliner with his legs fully extended and the call light was draped across a nightstand which was not within Resident #2's reach. During an observation on 03/25/2025 at 2:00 p.m., Resident #2 was observed sitting in his recliner with his call light on the nightstand which was not within his reach. Resident #2 woke up when the state surveyor entered the room and immediately began trying to scoot out of the recliner and said, get me up. Resident #2 was not able to answer questions about his call light related to his cognition. During an interview with LVN A on 03/25/2025 at 1:48 p.m., LVN A stated all resident call lights should be within reach of the resident when the resident was in their room. LVN A stated she received education on keeping call lights in reach and the placement of call lights was the responsibility of the nurses and CNA's. LVN A observed Resident #2's call light placement and stated Resident #2's call light was out of reach of Resident #2. LVN A stated it was important call lights were in reach on residents in case the resident needs assistance and to prevent falls. 2) Record review of Resident #6's, undated, face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #6 had diagnoses which included Alzheimer's Disease (a progressive disease that affects memory and other important mental functions) and Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #6's quarterly MDS assessment, dated 01/30/2025, revealed Resident #6 had a BIMS score of 3, which indicated severe cognitive impairment. Section GG -Functional Abilities revealed Resident #6 required supervision with chair to bed transfers and was ambulatory with supervision. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's comprehensive care plan revealed a care plan, dated 07/21/204, which stated Resident #6 was at risk for falls due to requiring assistance, unsteady gait/balance, and cognitive impairment. An intervention for falls stated, call bell in reach, educate and encourage use and answer. A care plan, dated 07/31/2024, revealed Resident #6 required assistance for ADL's and the intervention stated, keep call light within reach and instruct resident on use as needed. During an observation on 03/25/2025 at 1:40 p.m. revealed Resident #6 was observed asleep in her bed with her call light cord wrapped around the call light plug on the wall behind Resident #6's bed, placing the call light outside of Resident #6's reach. During an interview with CNA B on 03/25/2025 at 2:08 p.m., CNA B stated resident call lights should be clipped to a resident sitting in a wheelchair in their room or laid across their chest when in bed so the resident could reach the call light. CNA B stated everyone was responsible for making sure call lights were within reach for residents in their rooms which included herself, housekeeping and the Administrator. CNA B stated Resident #6 used her call light faithfully to call for assistance when Resident #6 needed anything. CNA B observed Resident #6's call light placement wrapped around the call light plug on the wall behind Resident #6 and stated, maybe the resident placed it there and removed the call light cord from the wall and placed the call light next to Resident #6. During an interview with Resident #6 on 02/25/2025 at 3:30 p.m., Resident #6 stated she did not wrap her call cord after the call cord plug in on the wall and stated, why would I do that, I would have had to crawl up my bed and wrap it up, no I did not do that. Resident #6 stated staff usually kept her call light within reach and stated she used the call light to call for staff assistance with things she needed in her room. During an interview with the Administrator on 03/26/2025 at 12:56 p.m., the Administrator stated call lights should be located within reach of residents and she could not recall if an in-service had been conducted on call light placement within the last 12 months. The Administrator stated the CNA's and all staff were responsible for ensuring call lights were within reach of residents and a resident could get up on their own and hurt themselves if they did not have a way to reach anyone for help. During an interview with the DON on 03/26/2025 at 1:46 p.m., the DON stated call lights should be within reach of the residents in their rooms. The DON stated she trained staff to place the call lights across the laps or chest of residents but stated a lot of our clips are not working that are used to attached call light cords to clothing or sheets. The DON stated she would change out the call cords if a broken clip was identified. The DON stated she was not sure when the last training or call light placement education was conducted but she would be adding it to training in the near future for staff. The DON stated everyone was responsible for ensuring call lights were within reach for residents and a resident who did not have a call light in reach could fall and be injured. Record review of the facility policy titled Answering the Call Light, Nursing Services Policy and Procedure Manual, Copyrighted 2001 MED-PASS, Inc and revised October 2010, stated the purpose was to respond to the resident's requests and needs. Under the general guidelines .5. When a resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 8 residents (Residents #1 and #4) reviewed for care plans. 1. The facility failed to ensure a care plan was developed to address Resident #1's enhanced barrier precautions which required staff to utilize gowns and gloves when direct care was provided. 2. The facility failed to ensure a care plan was developed to address Resident #4's enhanced barrier precautions which required staff to utilize gowns and gloves when providing direct care. These deficient practices could place residents at risk of an infection. The findings include: 1) Record review of Resident #1's, undated, face sheet revealed Resident #1 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included Chronic Obstructive Pulmonary Disease (a group of lung diseases causing constriction of the airways and difficulty breathing) and Restlessness and Agitation. Record review of Resident #1's quarterly MDS assessment, dated 01/22/2025, revealed Resident #1 had a BIMS score of 3, which indicated a severe cognitive impairment. Section E -Behavioral Symptoms revealed Resident #1 had verbal behavioral symptoms directed toward others 1-3 days during the look back period. Resident also displayed other behavioral symptoms that were not directed toward others on 1-3 days during the look back period. Section GG- Functional Abilities revealed Resident #1 was ambulatory with a walker and was able to walk up to 150 feet with staff supervision. Resident #1 was independent with bed mobility and required supervision with sit to stand. Record review of Resident #1's comprehensive care plan revealed Resident #1 had a care plan, dated 03/21/2025, which revealed Resident #1 had a wound of a laceration to her eyebrow related to a fall. Resident #1 did not have a care plan for enhanced barrier precautions. Record review of Resident #1's emergency room physician note, dated 03/21/2025, revealed Resident #1 received 5 sutures to her left eyebrow and a dressing was placed over the wound. During an observation on 03/25/2025 at 9:45 a.m., revealed Resident #1 had an orange sign outside the resident's room door which had a stop sign on it and said, Enhanced Barrier Precautions and indicated providers and staff should wear gloves and a gown when providing high contact direct care activities like dressing, bathing, transferring, changing linens, providing hygiene or toileting/brief changes. The sign also included a gown and glove must be worn for device care or use for central lines, urinary catheters, feeding tubes, tracheostomy and any wound care with a skin opening that required a dressing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Record review of Resident #4's, undated, face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included Chronic Venous Hypertension (a condition characterized by high blood pressure in the veins of the legs), Colostomy (surgical procedure that creates an opening in the large intestine) and Dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #4's quarterly MDS assessment, dated 01/20/2025, revealed a BIMS score of 14, which indicated no cognitive impairment. Section GG - Functional Abilities revealed Resident #1 was dependent on staff for transfers, dressing, showers, and wheelchair mobility. Record review of Resident #4 care plan on 03/25/2025 at 1:26 p.m., revealed no care plan for enhanced barrier precautions. Record review of Resident #4's care plan on 03/26/2025 at 3:20 p.m., revealed a care plan, dated 03/26/2025, which stated Resident #4 was at risk for infection and listed the approach to prevent infection as utilize enhanced barrier precautions as ordered every shift. This care plan was added after survey intervention. Record review of Resident #4's March 2025 administration orders revealed an order, start date 03/03/2025 and end date 03/24/2025, which stated, top right foot: cleanse with wound cleaner, pat dry, apply calcium alginate to wound bed, cover with dry dressing. Resident #4 had an order, start date 03/24/2025 and no end date, which stated, right shin cleanse with wound cleaner, pat dry, apply Xeroform to wound bed, cover with dry dressing. Resident #4 had an order, dated 06/13/2023, which stated, change colostomy bag and wafer every three days. Monitor stoma for irritation, signs, and symptoms of infection. During an observation on 03/25/2025 at 10:55 a.m., revealed Resident #4 had an orange sign outside of the resident's room door had a stop sign on it and said, Enhanced Barrier Precautions and indicated providers and staff should wear gloves and a gown when providing high contact direct care activities like dressing, bathing, transferring, changing linens, providing hygiene or toileting/brief changes. The sign also included that a gown and gloves must be worn for device care or use for central lines, urinary catheters, feeding tubes, tracheostomy and any wound care with a skin opening which required a dressing. During an interview with LVN D on 03/26/2025 at 10:57 a.m., LVN D stated residents on enhanced barrier precautions should have a sign on their door and a care plan which stated the resident was on enhanced barrier precautions. LVN D stated she was aware of the level of care each resident needed when she arrived for her shift because she had access to the resident care plan and the staff completed a shift change report with the staff leaving their shift. During an interview with Agency CNA E on 03/26/2025 at 11:11 a.m., Agency CNA E stated she knew what level of care each resident needed when she arrived for her shift by looking at the resident profile and care plan in the electronic medical record. During an interview with the Administrator on 03/26/2025 at 12:56 p.m., the Administrator stated residents on enhanced barrier precautions should have a care plan so staff know what the plan of care is and staff can provide the proper protection. The Administrator stated the DON was responsible for updating the resident care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 03/26/2025 at 1:46 p.m., the DON stated she was responsible for updating resident care plans and residents on enhanced barrier precautions should have a care plan that addressed enhanced barrier precautions, so the staff had access to the information and interventions in place. The DON stated staff received training on enhanced barrier precautions and Resident #1 was on enhanced barrier precautions related to a wound from her fall and Resident #4 was on enhanced barrier precautions related to a wound on her foot and a colostomy. Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, Copyrighted 2001 MED-PASS, Inc., and revised March 2022, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .7. The comprehensive, person-centered care plan: B. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 3 of 8 residents (Residents # 2, #3 and #7) reviewed for respiratory therapy. 1. The facility failed to ensure Resident #2 had a physician order, was care planned or had an oxygen safety sign on the resident's room door. 2. The facility failed to ensure Resident #3 had a physician order, was care plan or had an oxygen safety sign on the resident's room door. 3. The facility failed to ensure Resident #7 had a care plan or oxygen safety sign on the door. These deficient practices could place residents at risk of receiving incorrect or inadequate oxygen support which could result in a decline in health. Findings include: 1) Record review of Resident #2's, undated, face sheet revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Hypertensive Heart Disease (heart problems caused by high blood pressure) and Dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #2's admission MDS assessment, dated 02/06/2025, revealed Resident #2 had a BIMS score of 7, which indicated severe cognitive impairment. Section GG - Functional Abilities revealed Resident #2 used a wheelchair for mobility and required moderate assistance with mobility in the wheelchair. Resident #2 required supervision with chair to bed transfers and bed mobility. Section O - Special Treatments, Procedures, and Programs revealed Resident #2 was not receiving oxygen therapy. Record review of Resident #2's March 2025 consolidated physician orders revealed Resident #2 did not have an order for oxygen administration. Record review of Resident #2's comprehensive care plan revealed a care plan, dated 02/12/2025, which stated Resident #2 was on hospice services related to a terminal condition. Resident #2 did not have a care plan for oxygen administration. During an observation on 03/25/2025 at 9:30 a.m., an oxygen concentrator and oxygen cylinder were observed in Resident #2's room and there was not a no smoking/oxygen in use sign on the door. The concentrator and cylinder were not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN A on 03/25/2025 at 1:48 p.m., LVN A stated Resident #2 was on hospice and had oxygen in his room as needed. LVN A said she thought Resident #2 had an order for oxygen and residents on oxygen were identified by having a sign on the resident's door which indicated oxygen was in use. 2) Record review of Resident #3's, undated, face sheet revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included Alzheimer's Disease (a progressive disease that affects memory and other important mental functions) and Congestive Heart Failure (a condition in which the heart doesn't pump blood as well as it should). Record review of Resident #3's quarterly MDS assessment, dated 01/08/2025, revealed Resident #3 had a BIMS score of 06, which indicated severe cognitive impairment. Section GG- Functional Abilities revealed Resident #3 used a wheelchair for mobility and was dependent on staff for transfers and bed mobility. Section O - Special Treatments, Procedures, and Programs revealed Resident #3 was not receiving oxygen therapy. Record review of Resident #2's March 2025 consolidated physician orders revealed Resident #2 did not have an order for oxygen administration. Record review of Resident #3's comprehensive care plan revealed a care plan, dated 10/11/2024, which stated Resident #3 was on hospice services related to a terminal condition. Resident #3 did not have a care plan for oxygen administration. During an observation on 03/25/2025 at 9:40 a.m., an oxygen cylinder was observed in Resident #3's room and there was not a no smoking/oxygen in use sign on the door. The oxygen cylinder was not in use. 3) Record review of Resident #7's, undated, face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included End Stage Renal Disease (progressive loss of kidney function), Hemiplegia (paralysis of one side of the body), Type II Diabetes (a condition that results in too much sugar circulating in the body) and Depression (a mood disorder that causes persistent feelings of sadness and loss of interest). Record review of Resident #7's admission MDS assessment, dated 03/19/2025, revealed Resident #7 had a BIMS score of 1, which indicated severe cognitive impairment. Section GG- Functional Abilities required partial to moderate assistance with ADL's, transfers, and bed mobility. Section O - Special Treatments, Procedures, and Programs revealed Resident #7 was not coded as receiving oxygen therapy. Record review of Resident #7's March 2025 consolidated physician orders revealed Resident #7 had an order, dated 03/07/2025, for oxygen at 2-5 liters per minute for shortness of breath as needed. The MAR revealed oxygen had not been administered since admission. Record review of Resident #7's comprehensive care plan, dated 03/20/2025, revealed a care plan, which stated Resident #7 was on hospice services related to a terminal condition. Resident #7 had a care plan that revealed Resident #7 was at risk for edema (swelling), shortness of breath and fluid volume overload related to renal failure. Resident #7 had a care plan that revealed Resident #7 was had the potential for a safety hazard or injury related to Resident #7 being a smoker. Resident #7 did not have a care plan for oxygen administration. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/25/2025 at 2:03 p.m., an oxygen cylinder was observed in Resident #7's room and there was not a no smoking/oxygen in use sign on the door. The oxygen cylinder was not in use. During an interview with CNA B on 03/25/2025 at 2:08 p.m., CNA B stated Resident #7 did not use the oxygen in her room and hospice brought the tank just in case it was needed. CNA B stated there should have been an oxygen in use sign on Resident #7's door and the Charge Nurse or DON were responsible for placing the signs on the door. During an interview with LVN D on 03/26/2024 at 10:57 a.m., LVN D stated residents on oxygen were identified by having a sign on their door and most of the hospice patients had oxygen in their rooms and should have oxygen orders. LVN D stated the nursing staff was responsible for managing the oxygen and getting oxygen orders. During an interview with the Administrator on 03/26/2025 at 12:56 p.m., the Administrator stated residents on oxygen or residents with oxygen equipment in their room were supposed to have signs for oxygen on their room door. The Administrator stated it was important to have the oxygen in use signs so we can make sure we are changing out the tubing and have the oxygen on the resident but also to remind people to not smoke, or if there is an issue with fire, to get them to safety. The Administrator stated it was important to have oxygen orders so we know if and what amount of oxygen we should be giving to the resident. The Administrator stated oxygen administration should be part of a resident's comprehensive care plan so we know what level of care we are supposed to be providing to the resident and stated it was the responsibility of nursing to place the place the oxygen signs, obtain the orders and update the resident care plan. The Administrator stated staff received education on the oxygen administration system on 3/25/2025 but was unsure when educated was offered prior to that date. During an interview with the DON on 02/26/2025 at 1:46 p.m., the DON stated residents on oxygen should have a sign on their door and an order for oxygen administration. The DON stated she was unsure if these measures should be in place for a resident not actively using the oxygen but had oxygen equipment in their room. The DON stated it was important for a resident with oxygen equipment to have an order so the nurses know what to administer with the order if the resident needs it. The DON stated residents on oxygen should have a care plan so the nurses know how much oxygen to give them and what interventions to use. The DON stated Residents #2, #3 and #7 had not used their oxygen equipment and hospice placed oxygen equipment in rooms of hospice patients so it was available if needed. The DON stated oxygen should not have been placed in resident rooms without an order. Record review of the facility's policy titled Oxygen Administration, Copyrighted 2001 MED-PASS, Inc. (Revised October 2010), revealed the purpose of the policy was to provide guidelines for safe oxygen administration. Under Preparation it stated, 1. Verify that there is a physician's order for this procedure . 2. Review the resident's care plan to assess any special needs of this resident. 3. Assemble the equipment and supplies needed .The following equipment will be necessary when performing this procedure .4. 'No Smoking/Oxygen in Use' signs.