

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/14/2024
NAME OF PROVIDER OR SUPPLIER  Whispering Oaks Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  105 Hospital Dr Cuero, TX 77954	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>44020</p> <p>Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 3 of 17 Residents (Resident #5, Resident #11 and Resident #42) whose MDS records were reviewed for accuracy.</p> <ol style="list-style-type: none"> <li>1. Facility failed to ensure Resident #5's comprehensive MDS, dated [DATE] assessment accurately reflected that he had a suprapubic catheter.</li> <li>2. The facility failed to ensure Resident #11's quarterly MDS assessment dated [DATE] accurately reflected she had a significant weight loss.</li> <li>3. The facility failed to ensure Resident #42's Quarterly MDS assessment dated [DATE] accurately reflected she had received a therapeutic diet while a resident at the facility.</li> </ol> <p>This failure could place residents at risk for inadequate care due to inaccurate assessments.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #5's quarterly MDS assessment with an ARD of 02/27/2024 reflected he had an indwelling catheter. He scored a 02 out of 15 on his BIMS which signified he was severely cognitively impaired.</li> </ol> <p>Record review of Resident #5's electronic face sheet dated 06/13/2024 reflected he was admitted to the facility on [DATE] with diagnoses that included: cerebrovascular disease, cognitive communication deficit, obstructive and reflux uropathy and dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).</p> <p>During an interview on 6/14/2024 at 9:30AM the CMM confirmed the suprapubic catheter was not coded on the MDS. She stated it was important to code the MDS correctly because it drives the care for the resident. She clarified the statement by saying it was a way to know how take care of the residents.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/14/2024 at 10:05AM the DON stated the MDS assessment needed to be accurate for proper care for the resident. The DON confirmed the suprapubic catheter was not coded on the MDS.</p> <p>2. Record review of Resident #11's electronic face sheet, dated 01/13/2024, reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: end stage renal disease (kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), pressure ulcer of left heel-stage 3 (full thickness tissue loss and subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic obstructive pulmonary disease ( a common lung disease causing restricted airflow and breathing problems).</p> <p>Record review of Resident #11's quarterly MDS assessment with an ARD of 03/01/2024 reflected she scored an 15/15 on her BIMS which signified she was cognitively intact, and weight loss (loss of 5% or more in the last month or loss of 10% or more in last 6 months) in the section K (Swallowing/Nutritional status) was marked as No or unknown.</p> <p>Record review of Resident #11's comprehensive care plan revised on 02/01/2024 reflected A significant weight loss is more than 5% in 30 days, more than 7.5% in 90 days, or more than 10% in 180 days. Invite the resident to activities that promote additional intake and weight and record at least monthly. Report signs and symptoms of malnutrition such as emaciation, cachexia (great weight loss and muscle loss), temporal wasting or any significant weight loss to the physician as detected.</p> <p>Record review of Resident #11's weight log revealed the resident weighed 165 pounds on 01/29/2024 (admission MDS) and 126 pounds on 03/01/2024 (quarterly MDS) which the resident had a -23.64% significant weight loss due to starting hemodialysis on 02/28/2024.</p> <p>Record review of Resident #11's nutrition assessment, dated on 03/19/2024, revealed Weight history reflects significant/severe weight loss (54.2 pounds) x 30 days from 02/13/24 to 03/18/24. hospitalized [DATE] - 02/28/24 &amp; now on dialysis. Some/most of weight loss related to diuresis (increase in the amount of urine) &amp; new dialysis. However, some recent weight loss may be related to inconsistent/poor intake. Weight appears to have stabilized 111-114 pounds per post hemodialysis weight 03/13/24 - 03/18/24. BMI (body mass index) within desirable weight range. Further record review of the nutrition assessment indicated Recommendations were Renal, Regular Texture, thin Liquid diet, Nepro (8oz) by mouth every day for supplement, and follow-up as needed for updates to preferences &amp; meal choices; acceptance of supplement.</p> <p>Observation on 06/12/2024 at 10:00 am revealed Resident #11 was sitting on the bed in her room for waiting for the transportation for dialysis revealed there were three energy bars and snack box on the bedside table.</p> <p>Interview with Resident #11 on 06/12/2024 at 10:03 am revealed she refused taking Nepro, and it was her choice because she did not like Nepro, but the facility gave her energy bar and snack every day. The resident said she did not have any issue related to nutrition or weight loss.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with LVN A on 06/13/2024 at 4:20 pm confirmed since Resident #11 had dialysis, the resident's weight was lost. The facility gave the resident Nepro as the dietitian's recommendation, but the resident refused. The facility communicated to the nurses at the dialysis center and started giving her an energy bar.</p> <p>Interview with the CMM on 06/14/2024 at 12:08 pm confirmed Resident #11 had a -23.64% significant weight loss from 01/29/2024 to 03/01/2024, and the quarterly MDS assessment with an ARD of 03/01/2024's weight loss in the section K (Swallowing/Nutritional status) should have been marked as Yes. The CMM stated she did not know the reason it was marked No.; it was mistake, and the CMM would modify it.</p> <p>3. Record review of Resident #42's face sheet dated 06/12/2024 revealed Resident #42 was admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus without complications, and dysphagia, unspecified.</p> <p>Record review of Resident #42's physician order summary dated 06/12/2024, revealed order dated 01/19/2024, No added Salt diet, Regular texture, THIN LIQUIDS consistency.</p> <p>Record review of Resident #42's Quarterly MDS, dated [DATE], revealed while a resident, Resident #42 had not received a therapeutic diet within the last 7 days.</p> <p>Record review of Resident #42's Modified Quarterly MDS, dated [DATE], revealed while a resident, Resident #42 had not received a therapeutic diet within the last 7 days.</p> <p>During an interview on 06/13/24 at 4:55 p.m. the CMM confirmed Resident #42' MDS assessment was miscoded, and it had been completed by the prior dietary supervisor. The CMM further stated the importance of the MDS assessment was to ensure proper care of the resident and proper reimbursement for the facility. The CMM stated the MDS assessment miscoded, affected proper care and affected the accuracy of care plan which affected the tasks for staff. The CMM stated when the dietary supervisor at the facility it was the dietary supervisor's responsibility for the accurate coding of the MDS assessment and in absence of a dietary supervisor the CMM was responsible.</p> <p>Record review of the facility's MDS Completion: Clinical Practice Guidelines MDS Completion policy, review date 02/10/2021, revealed Anticipated Outcome: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Process: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State.</p> <p>Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>44020</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 9 residents (Resident #9 and Resident #46) reviewed for care plans.</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure Residents #9's care plan reflected her dental issues of missing teeth.</li> <li>2. The facility failed to ensure Resident #46's comprehensive care plan, dated 05/28/2024, reflected nurses might replace plunger back into syringe and push in gently when flushing because the resident had Jejunostomy feeding tube.</li> </ol> <p>This deficient practice places residents at risk for not receiving proper care and services due to inaccurate care plans.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #'s face sheet, dated 06/13/2024, revealed Resident #9 was admitted on [DATE] with diagnoses which included: muscle wasting and atrophy, not elsewhere classified, multiple sites, dysphagia, oropharyngeal phase, type 2 diabetes, and peripheral vascular disease.</li> </ol> <p>Record review of Resident #9's Admission assessment, dated 04/24/2024, revealed Resident #9's BIMS score was 15 for intact cognition with no dental issues coded.</p> <p>Observation and interview on 06/11/2024 at 11:29 a.m. revealed Resident #9 was missing a majority of her teeth and some teeth were worn/broken to the gum. Resident #9 stated it had been a long time since she had seen a dentist. Resident #9 further stated she was honestly scared to see one and couldn't remember if the facility had offered for her to be seen by a dentist.</p> <p>Record review of Resident #9's care plan with a revision date of 05/08/2024 and a targeted date 08/06/2024, revealed no care plan addressing Resident #9's missing teeth with teeth to the gums.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/13/2024 at 4:49 p.m. the CMM stated if the teeth were not bothering Resident #9 or causing her issues, she would not code them on the MDS assessment which triggered the care plan. The CMM further stated the care plans were in the middle of a major overhaul. The CMM stated she started her employment at the facility on 03/08/2024 and in April 2024 it was noted there was a care plan issue of which the facility had a PIP (performance improvement plan) for care plans. The CMM stated dental issues should be care planned due to the risk of the resident suffering weight loss. She further stated the IDT (interdisciplinary team) all had a hand in care plans. The CMM again stated there was a PIP in place for care plans and were reviewed every 3 months with the MDS.</p> <p>During an interview on 06/14/2024 at 9:34a.m. the DON stated the care plans were reviewed by each section by the IDT and they were brought to the QAPI meetings to review. The DON further stated each department would have their sections and stated the dietary supervisor was responsible for the sections regarding nutrition. The DON stated the responsibility of the care plans was the IDT. She stated the care plan was to ensure proper care was provided to the residents.</p> <p>2. Record review of Resident #46's electronic face sheet, dated 01/13/2024, reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (characterized by one side weakness, but without complete paralysis by a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), dysphagia (difficulty swallowing), cerebral edema (brain swelling, or swelling that happens in part or all of brain because of excessive fluid buildup in the tissue), and diaphragmatic hernia without obstruction or gangrene (a hole that abdominal organs move upward into chest through in the diaphragm).</p> <p>Record review of Resident #46's significant change MDS assessment with an ARD of 04/10/2024 reflected she scored an 15/15 on her BIMS which signified she was cognitively intact, and feeding tube was marked as Yes.</p> <p>Record review of Resident #46's comprehensive care plan, revised on 05/28/2024, reflected Administer tube feeding and water flushes as ordered, and Glucerna 1.2 calory at 75 milliliter per hour &amp; pump to start at 1600 or 4 pm and run x 19 hours (down 11 am or 1320 milliliter volume delivered) via Jejunostomy feeding tube.</p> <p>Record review of Resident #46's physician's order, dated 04/08/2024, revealed every shift flush enteral tube with 30 milliliter water pre and post medication administration and 5 to 10 milliliters water between each medication and every shift administer tube feeding and water flushes as ordered, and Glucerna 1.2 calory at 75 milliliter per hour &amp; pump to start at 1600 or 4 pm and run x 19 hours (down 11 am or 1320 milliliter volume delivered) via Jejunostomy feeding tube.</p> <p>Record review of competency evaluation tool of LVN C for Gastrostomy feeding tube or Jejunostomy feeding tube continuous feeding and discontinuation of feeding, dated 04/05/2024, revealed . 9. Pours 20 milliliters or other prescribed amount of water into syringe, unclamps tube and allows water to flow into stomach/intestine by gravity. For Jejunostomy feeding tube, may have to replace plunger back into barrel and push in gently.</p> <p>Observation on 06/13/2024 at 11:00 am revealed LVN C discontinued Resident #46's Jejunostomy feeding tube and flushed it with 30 milliliters of water by pushing a plunger gently, instead of using gravity.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 06/13/2024 at 3:40 pm revealed LVN C tried to flush 30 milliliters of water by gravity after administering a medication via Resident #46's Jejunostomy feeding tube. However, the water inside the syringe could not flow into Resident #46's Jejunostomy feeding tube. LVN C stopped using gravity and flushed the tube by pushing a plunger gently.</p> <p>Interview with LVN C on 06/13/2024 at 12:00 pm and 3:45 pm confirmed LVN C flushed Resident #46's Jejunostomy feeding tube with 30 milliliters of water by pushing a plunger gently, instead of using gravity when discontinuing the feeding tube and administering a medication because Resident #46 had history of her Jejunostomy feeding tube clogged.</p> <p>Interview with the DON on 06/13/2024 at 12:05 pm confirmed nurses usually pushed a plunger gently, instead of using gravity when nurses flushed Resident #46's Jejunostomy feeding tube because Resident #46 had a history of her Jejunostomy feeding tube getting clogged. Further interview with the DON confirmed Resident #46's comprehensive care plan should address that nurses should use pushing a plunger gently, instead of using gravity when discontinuing the feeding tube and administering a medication because Resident #46 had history of her Jejunostomy feeding tube clogged because all nurses could provide the same care to Resident #46 based on the care plan.</p> <p>Interview with RN D (care plan nurse) on 06/13/2024 at 2:21 pm confirmed Resident #46's comprehensive care plan should address nurses should use pushing a plunger gently, instead of using gravity when discontinuing the feeding tube and administering a medication because Resident #46 had history of her Jejunostomy feeding tube clogged because a care plan should be individualized. However, Resident #46's current comprehensive care plan did not reflect Resident #46's status regarding her Jejunostomy feeding tube.</p> <p>Record review of facility's Care Plan Guidelines policy, revision date 05/06/2016, revealed Purpose: The purpose of this guide is to ensure that interdisciplinary (IDT) approach is utilized in addressing the Care Area Triggers (CATs) that were generated by the completion of the Minimum Data Set (MDS) in order to effectively address the Care Area Assessments (CAAs) and ultimately achieve the completion of an effective comprehensive plan of care for each resident. Acute Care Plans: As acute problems or changes to intervention or goals are identified, an appropriate care plan will be developed or modified by a Nursing staff member.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28619</p> <p>Based on interviews and record reviews, the facility failed to review and revise the comprehensive person-centered care plan for one resident (Resident #28) out of 24 residents reviewed for comprehensive care plans timing and revision.</p> <p>Resident #28's annual MDS assessment dated [DATE] reflected she was incontinent of bowel and her comprehensive care was not revised by the MDS Nurse to reflect she was incontinent of bowel.</p> <p>This deficient practice could affect residents who are assessed and have care plans and places them at risk for not receiving necessary care.</p> <p>The findings included:</p> <p>Record review of Resident #28's electronic face sheet dated 06/12/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (an irreversible brain disease that destroys memory, thinking and the ability to carry out daily activities), polyarthritis (refers to a joint disease that involves at least 5 joints, inflammation, pain, movement restriction, warmth, swelling and redness can occur) and dementia (a group of conditions characterized by impairment of at least two brain functions such as memory loss and judgment).</p> <p>Record review of Resident #28's annual MDS assessment dated [DATE] reflected she was not a candidate for a BIMS which signified she was severely cognitively impaired. She was dependent on staff for her ADL's and was always incontinent of bowel and bladder.</p> <p>Record review of Resident #28's comprehensive person-centered care plan revised 05/08/2024 reflected Focus, incontinent of bladder r/t dementia. No incontinence of bowel was noted.</p> <p>During an interview on 06/13/2024 at 4:12 PM with LVN A, she stated Resident #28 was incontinent of bowel and bladder. She stated it was important for the care plan to be accurate and updated because it communicated the care the resident required, and care could be missed.</p> <p>During an interview on 06/14/2024 at 07:38 AM with the CMM, she stated she had not reviewed Resident #28's care plan since she took over the position in March 2024. She stated it was important for the care plan to be revised after an MDS assessment and reviewed in case there were changes and to confirm the residents care was accurate, or they could get care that was needed and identified in the MDS assessment missed.</p> <p>During an interview on 06/14/2024 at 09:30 a.m. with the DON, she stated it was important for the MDS assessments to be accurate because they communicated the type of care required for a resident and the care could be missed if inaccurate.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, October 2023 revealed Care Plan Completion .the resident's care plan must be reviewed after each assessment, as required by S483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28619</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident #5) reviewed for supra-pubic catheter care.</p> <p>When CNA B moved Resident #5 to his bed from his wheelchair on 06/13/2024 at 2:00 PM he took Resident #5's urinary drainage bag out of the privacy bag tied to the wheelchair and hooked it onto the low rail of his bed. The uncovered urinary catheter bag and drainage spout touched the floor. Resident #5 did not have a strap to secure his catheter tubing to his leg.</p> <p>This deficient practice could place residents with in dwelling urinary catheters at-risk for urinary tract infections and/or pain related to injury from the unsecured catheter tube pulling on the bladder. He could make himself understood and usually understands. He required substantial assistance with his ADL's.</p> <p>The findings were:</p> <p>Record review of Resident #5's electronic face sheet dated 06/13/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), cognitive communication deficit, obstructive and reflux uropathy and dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).</p> <p>Record review of Resident #5's quarterly MDS assessment with an ARD of 02/27/2024 reflected he had an indwelling catheter. He scored a 02 out of 15 on his BIMS which signified he was severely cognitively impaired.</p> <p>Record review of Resident #5's comprehensive person-centered care plan revised 05/21/2024 reflected Focus, has a suprapubic catheter and is at risk for urinary tract infections, Interventions, monitor for pain and discomfort due to catheter, position catheter bag and tubing below the level of the bladder and away from the entrance door.</p> <p>Observation on 06/13/2024 at 2:00 PM of CNA B assist Resident #5 out of his wheelchair and onto his bed so that LVN A could perform catheter care, he pulled the urinary drainage bag out of the privacy bag and hooked it onto the lower rail of the bed. The bottom of the urinary drainage bag and spout which was loose, were touching the floor. Resident #5 did not have a leg strap to secure the catheter tubing.</p> <p>Interview on 06/13/24 at 2:05 PM with CNA B, he stated Resident #5 had a leg strap on the day prior and maybe someone took it off when they showered him and forgot to put one back on. He stated the strap holds the tubing in place so the catheter will not pull out. He stated the bag and tubing should not touch the floor because of cross contamination and potential for infection.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/13/2024 with LVN A, she stated Resident ##5's indwelling urinary catheter bag and open drainage spout should not have touched the floor because of the risk of cross contamination and infection. She stated without a leg strap to anchor the catheter tubing, it could pull and cause pain or come out.</p> <p>During an interview on 06/14/2024 at 09:30 a.m. with the DON, she stated it was important for Resident #5 to have a leg strap in place to prevent the catheter tubing from being pulled out, and to prevent cross contamination and infection, the drainage bag should be off the floor.</p> <p>Record review of the facility policy and procedure titled Indwelling Foley Catheter Guidelines reviewed dated 02/10/2021 reflected Properly secure indwelling catheters after insertion to prevent movement, do not rest the bag on the floor.</p>		

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NAME OF PROVIDER OR SUPPLIER  Whispering Oaks Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  105 Hospital Dr Cuero, TX 77954	
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers for 1 resident (Resident #46) of 1 resident reviewed for J tube feeding.</p> <p>The facility failed to follow the facility policy regarding checking the placement of Resident #46's Jejunostomy feeding tube by auscultation (the action of listening to sounds) of growl sounds with injecting the air into the feeding port, but the facility policy indicated checking Jejunostomy feeding tube placement by the visualization and comparison of tube markings to prior check.</p> <p>This failure could place resident at risk of discomfort, aspiration, bleeding, perforation, and even pneumonia.</p> <p>Findings Included:</p> <p>Record review of Resident #46's electronic face sheet, dated 01/13/2024, reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (characterized by one side weakness, but without complete paralysis by a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), dysphagia (difficulty swallowing), cerebral edema (brain swelling, or swelling that happens in part or all of brain because of excessive fluid buildup in the tissue), and diaphragmatic hernia without obstruction or gangrene (a hole that abdominal organs move upward into chest through in the diaphragm).</p> <p>Record review of Resident #46's significant change MDS assessment with an ARD of 04/10/2024 reflected she scored an 15/15 on her BIMS which signified she was cognitively intact, and feeding tube was marked as Yes.</p> <p>Record review of Resident #46's comprehensive care plan, dated on 12/26/2023, reflected Check for tube placement and monitor contents residual volume per facility protocol. Hold tube feedings and notify physician if residual volume is greater than threshold as dictated by the physician.</p> <p>Record review of Resident #46's physician's order, dated 04/08/2024, revealed every shift check tube placement prior to administration of meds and hanging enteral feedings.</p> <p>Record review of LVN C's competency evaluation tool for Gastrostomy feeding tube or Jejunostomy feeding tube continuous feeding and discontinuation of feeding, dated 04/05/2024, revealed LVN C was assessed and passed to . 6. Check Jejunostomy feeding tube placement by the visualization and compare tube markings to prior marking or check measurement of tube length outside the skin the length of the tube if there are no markings on the tube, compare with previous measurement.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 06/13/2024 at 11:00 am revealed LVN C turned off Resident #46's pump machine. LVN C checked the resident's Jejunostomy feeding tube placement by listening to growl sounds by injecting 20 milliliters of air into the feeding port with LVN C's stethoscope and flushed the Jejunostomy feeding tube with 30 milliliters of water by pushing the syringe gently, and then discontinued the Resident #46's Jejunostomy feeding tube.</p> <p>Interview on 06/13/2024 at 11:30 am with Resident #46 revealed the resident did not have any discomfort to her abdomen.</p> <p>Interview on 06/13/2024 at 12:00 pm with LVN C confirmed LVN C checked Resident #46's Jejunostomy feeding tube placement by listening to growl sounds by injecting 20 milliliters of air into the feeding port with LVN C's stethoscope. Further interview with LVN C on 06/13/2024 at 4:00 pm, LVN C stated the nurse did not know the facility policy regarding checking placement by visualization and comparison of tube markings to the prior check, but LVN C said she checked Resident #46's Jejunostomy feeding tube placement with her eyes when checking the tube placement by listening to injecting the air. LVN C stated she should have followed the facility policy regarding checking placement by visualization and comparison of tube markings to the prior check. Checking tube placement by auscultation of growl sounds by injecting the air into the feeding port was not part of the facility policy and it might cause discomfort to the resident. The LVN C stated, I forgot the policy regarding checking Jejunostomy feeding tube placement by visualization and comparison of tube markings to prior check. I might need to have more training related to Jejunostomy feeding tube because most of residents had gastrostomy feeding tube.</p> <p>Interview on 06/13/2024 at 12:05 pm the DON stated LVN C checked Resident #46's Jejunostomy feeding tube placement with visualization by seeing the tube and auscultation by listening to growl sounds by injecting the air into the feeding port. However, the facility policy did not say checking tube placement with auscultation by listening to growl sounds by injecting the air into the feeding port, and the DON checked LVN C's competency for Gastrostomy feeding tube or Jejunostomy feeding tube continuous feeding and discontinuation of feeding on 04/05/2024.</p> <p>Record review of the facility policy and procedure, titled G-Jejunostomy Tube, reviewed 02/14/2020, revealed Safety consideration - Check J-tube [Jejunostomy feeding tube] placement by the visualization and comparison of tube markings to prior check.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care consistent with professional standards of practice for 1 of 2 residents (Resident #11) reviewed for oxygen in that:</p> <p>Resident #11's oxygen was administered at 3 Lpm, instead of 2.0 Lpm, via nasal cannula as ordered by physician.</p> <p>This failure could place residents who received oxygen at risk of developing respiratory complications and a decreased quality of care.</p> <p>The findings included:</p> <p>Record review of Resident #11's electronic face sheet, dated 01/13/2024, reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: end stage renal disease (kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), pressure ulcer of left heel-stage 3 (full thickness tissue loss and subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic obstructive pulmonary disease ( a common lung disease causing restricted airflow and breathing problems).</p> <p>Record review of Resident #11's quarterly MDS assessment with an ARD of 03/01/2024 reflected she scored an 15/15 on her BIMS which signified she was cognitively intact, and oxygen therapy was marked as Yes.</p> <p>Record review of Resident #11's comprehensive care plan, dated on 04/10/2024, revealed Resident on oxygen 2.0 Lpm via nasal cannula.</p> <p>Record review of Resident #11's physician's order, dated on 02/28/2024, revealed oxygen 2.0 Lpm via nasal cannula every shift related to chronic obstructive pulmonary disease.</p> <p>Observation on 06/12/2024 at 10:10 am revealed Resident #11 was receiving oxygen at 3.0 Lpm via nasal cannula.</p> <p>Observation on 06/14/2024 at 9:10 am revealed Resident #11 was sitting on the bed in her room and was receiving oxygen 3.0 Lpm via nasal cannula.</p> <p>Interview on 06/14/2024 at 9:10 am with Resident #11 stated nurses set up the resident's oxygen, and she though it was supposed to 3.0 Lpm because she saw the oxygen was set up to 3.0 Lpm.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/14/2024 at 9:13 am with LVN A confirmed Resident #11 had oxygen 3.0 Lpm via nasal cannula. However, the physician order indicated the resident should have oxygen 2.0 Lpm via nasal cannula, instead of 3.0 Lpm. LVN A stated the resident might increase oxygen 2.0 Lpm to 3.0 Lpm, but checking oxygen every shift was a nurse's responsibility. LVN A confirmed she usually checked Resident #11's oxygen every day, but she did not check Resident #11's oxygen today (06/14/2024)'s morning because she was very busy, and the potential harm was high oxygen level could cause toxin.</p> <p>Interview on 06/14/2024 at 9:43 am the DON confirmed Resident #11 should have had oxygen 2.0 Lpm via nasal cannula as the physician's order, and the nurses should have checked every shift as ordered.</p> <p>Record review of the facility policy and procedure, titled Oxygen Administration, dated 09/12/2014, revealed Procedure - 1. Verify physician order.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observations, interviews, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 1 of 2 (LVN C) nurses reviewed for competent nursing care.</p> <p>The facility failed to ensure LVN C followed the facility policy regarding checking the placement of Resident #46's Jejunostomy feeding tube by auscultation of growl sounds with injecting the air into the feeding port, but the facility policy indicated checking Jejunostomy feeding tube placement by the visualization and comparison of tube markings to prior check.</p> <p>These deficient practices affect residents who depend on nursing care and could place residents at risk for injury, infection, and harm.</p> <p>The findings included:</p> <p>Record review of Resident #46's electronic face sheet, dated 01/13/2024, reflected she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (characterized by one side weakness, but without complete paralysis by a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), dysphagia (difficulty swallowing), cerebral edema (brain swelling, or swelling that happens in part or all of brain because of excessive fluid buildup in the tissue), and diaphragmatic hernia without obstruction or gangrene (a hole that abdominal organs move upward into chest through in the diaphragm).</p> <p>Record review of Resident #46's significant change MDS assessment with an ARD of 04/10/2024 reflected she scored an 15/15 on her BIMS which signified she was cognitively intact, and feeding tube was marked as Yes.</p> <p>Record review of Resident #46's comprehensive care plan, dated on 12/26/2023, reflected Check for tube placement and monitor contents residual volume per facility protocol. Hold tube feedings and notify physician if residual volume is greater than threshold as dictated by the physician.</p> <p>Record review of Resident #46's physician's order, dated 04/08/2024, revealed every shift check tube placement prior to administration of meds and hanging enteral feedings.</p> <p>Record review of LVN C's competency evaluation tool for Gastrostomy feeding tube or Jejunostomy feeding tube continuous feeding and discontinuation of feeding, dated 04/05/2024, revealed LVN C was assessed and passed to . 6. Check Jejunostomy feeding tube placement by the visualization and compare tube markings to prior marking or check measurement of tube length outside the skin the length of the tube if there are no markings on the tube, compare with previous measurement.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 06/13/2024 at 11:00 am revealed LVN C turned off Resident #46's pump machine. LVN C checked the resident's Jejunostomy feeding tube placement by listening to growl sounds by injecting 20 milliliters of air into the feeding port with LVN C's stethoscope and flushed the Jejunostomy feeding tube with 30 milliliters of water by pushing the syringe gently, and then discontinued the Resident #46's Jejunostomy feeding tube.</p> <p>Interview on 06/13/2024 at 11:30 am with Resident #46 revealed the resident did not have any discomfort to her abdomen.</p> <p>Interview on 06/13/2024 at 12:00 pm with LVN C confirmed LVN C checked Resident #46's Jejunostomy feeding tube placement by listening to growl sounds by injecting 20 milliliters of air into the feeding port with LVN C's stethoscope. Further interview with LVN C on 06/13/2024 at 4:00 pm, LVN C stated the nurse did not know the facility policy regarding checking placement by visualization and comparison of tube markings to the prior check, but LVN C said she checked Resident #46's Jejunostomy feeding tube placement with her eyes when checking the tube placement by listening to injecting the air. LVN C stated she should have followed the facility policy regarding checking placement by visualization and comparison of tube markings to the prior check. Checking tube placement by auscultation of growl sounds by injecting the air into the feeding port was not part of the facility policy and it might cause discomfort to the resident. The LVN C stated, I forgot the policy regarding checking Jejunostomy feeding tube placement by visualization and comparison of tube markings to prior check. I might need to have more training related to Jejunostomy feeding tube because most of residents had gastrostomy feeding tube.</p> <p>Interview on 06/13/2024 at 12:05 pm the DON stated LVN C checked Resident #46's Jejunostomy feeding tube placement with visualization by seeing the tube and auscultation by listening to growl sounds by injecting the air into the feeding port. However, the facility policy did not say checking tube placement with auscultation by listening to growl sounds by injecting the air into the feeding port, and the DON checked LVN C's competency for Gastrostomy feeding tube or Jejunostomy feeding tube continuous feeding and discontinuation of feeding on 04/05/2024 because checking nurse's competency annually was DON's responsibility.</p> <p>Record review of the facility policy and procedure, titled G-Jejunostomy Tube, reviewed 02/14/2020, revealed Safety consideration - Check J-tube [Jejunostomy feeding tube] placement by the visualization and comparison of tube markings to prior check.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>28619</p> <p>Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 medication cart (400 Hall) and 1 Treatment cart of 4 carts observed for secure biologicals and drugs.</p> <p>LVN A left the medication cart and treatment carts unsecured on 400 Hallway on 06/13/2024 at 08:15 a.m. when she prepared to perform wound treatments for a resident.</p> <p>This deficient practice could place residents at risk for misappropriation, misuse or tampering of medications.</p> <p>The findings included:</p> <p>Observation on 06/13/2024 at 08:15 a.m. when LVN A came to get the surveyor to observe a treatment for a resident, the surveyor followed LVN A down 400 Hallway where the 400 Hall medication cart and treatment cart were both unsecured. Other staff were observed to be passing out breakfast trays and cleaning the floor near the two unsecured carts. LVN A then took her treatment supplies into the resident's room and left the surveyor in the hallway with the unsecured carts. The surveyor went to the ADON's office which was located on the same hallway and asked her to come and check the two unsecured carts. The ADON immediately secured both carts.</p> <p>During an interview on 06/13/2024 at 08:30 with the ADON, she stated the treatment and medication carts needed to be secured and she did not know why LVN A left them unsecured. She stated other people had access to treatment supplies and medications that could be harmful if taken and not prescribed. She stated misappropriation, misuse, and harm could happen if someone were to get into the cart and acquire something they should not have. She stated nurses were trained to keep the carts always secured.</p> <p>During an interview on 06/13/2024 at 4:12 p.m. with LVN A, she stated she had not left the carts unsecured before and must have been nervous. She stated the medication and treatment cart needed to be secured to prevent someone from taking medications or supplies that could be harmful. She stated she was trained and accountable for the security of her assigned carts.</p> <p>During an interview on 06/14/2024 at 09:30 a.m. with the DON, she stated it was important for the medication and treatment cart to be secured at times when the nurse or medication aide are not present. She stated anyone could have access to medications that could be harmful if taken and not prescribed.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy and procedure titled Medication Storage dated 01/21/2021 reflected, All drugs and biologicals will be stored in locked compartments, only authorized personnel will have access to the keys to locked compartments, during a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28619</p> <p>Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 residents (Residents #5 and #11) of 24 residents reviewed for infection control.</p> <p>1. CNA B hooked Resident #5's catheter urinary drainage bag to the low rail of his bed on 06/13/2024 at 2:00 PM, and the uncovered bottom of the bag, and loosened drainage spout touched the floor.</p> <p>2. LVN A re-entered Resident #11's room, who was on EBP on 06/13/2024 at 08:40 a.m., 3 times and failed to sanitize her hands prior to re-entering the room when she left and re-entered the room to get more treatment supplies when she performed wound treatments for Resident #11.</p> <p>These deficient practices affect residents who require assistance treatments and indwelling catheters and could place residents at risk for cross contamination and infections.</p> <p>The findings included:</p> <p>1. Record review of Resident #5's electronic face sheet dated 06/13/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), cognitive communication deficit, obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional and dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).</p> <p>Record review of Resident #5's quarterly MDS assessment with an ARD of 02/27/2024 reflected he had an indwelling catheter. He scored a 02 out of 15 on his BIMS which signified he was severely cognitively impaired.</p> <p>Record review of Resident #5's comprehensive person-centered care plan revised 05/21/2024 reflected Focus, has a suprapubic catheter and is at risk for urinary tract infections, Interventions, monitor for pain and discomfort due to catheter, position catheter bag and tubing below the level of the bladder and away from the entrance door.</p> <p>Observation on 06/13/2024 at 2:00 PM of CNA B assist Resident #5 out of his wheelchair and onto his bed so that LVN A could perform catheter care, he pulled the urinary drainage bag out of the privacy bag and hooked it onto the lower rail of the bed. The bottom of the urinary drainage bag and spout which was loose, were touching the floor.</p> <p>Interview on 06/13/24 at 2:05 PM with CNA B, he stated Resident #5 had a leg strap on the day prior and maybe someone took it off when they showered him and forgot to put one back on. He stated the strap holds the tubing in place so the catheter will not pull out. He stated the bag and tubing should not touch the floor because of cross contamination and potential for infection.</p> <p>(continued on next page)</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>During an interview on 06/13/2024 at 4:12 p.m. with LVN A, she stated Resident ##5's indwelling urinary catheter bag and open drainage spout should not have touched the floor because of the risk of cross contamination and infection.</p> <p>During an interview on 06/14/2024 at 09:30 a.m. with the DON, she stated it was important for Resident #5 to prevent cross contamination and infection, the drainage bag should be off the floor.</p> <p>Record review of the facility policy and procedure titled Indwelling Foley Catheter Guidelines reviewed dated 02/10/2021 reflected Properly secure indwelling catheters after insertion to prevent movement, do not rest the bag on the floor.</p> <p>2.Record review of Resident #11's electronic face sheet dated 06/13/2024 reflected she was admitted to the facility on [DATE] with diagnoses of pressure ulcer to left heel, Stage 3 (pressure ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue), osteoporosis (condition in which there is increased demineralization of long bones, making them weak) and cognitive communication deficit (trouble with one or more cognitive processes involved in communication.</p> <p>Record review of Resident #11's quarterly MDS assessment with an ARD of 03/01/2024 reflected she scored a 15 out of 15 on her BIMS which signified she was cognitively intact. She was dependent on staff for her ADL's. She had a pressure ulcer and received treatment.</p> <p>Record review of Resident #11's comprehensive person-centered care plan revised date 04/16/2024 reflected requires Enhanced Barrier precautions r/t implanted vascular access devise and pressure ulcers, Interventions, ensure EBP signage is posted outside the resident's room and above the head of the resident's bed.</p> <p>Record review of Resident #11's Active Orders as of: 06/13/2024 reflected Stage 3 to left heel, cleanse with W/C and pat dry and apply collagen (encourages cell proliferation) dressing and wrap with rolled gauze and secure with tape until healed.</p> <p>Record review of the EBP sign on Resident #11's door STOP, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Wear gloves and a gown for the following High-Contact Resident Care Activities .Changing briefs and assisting with toileting .Wound Care: Any skin opening requiring a dressing.</p> <p>Observation on 06/13/2024 at 08:30 a.m. of LVN A perform treatments for Resident #11 revealed she gathered her supplies, sanitized hands, wore a gown and glove since the Resident was on EBP. She later exited the room and re-entered twice more to get more treatment items, and did no sanitize her hands prior to re-entering the room as the sign on the door indicated for EBP. Everyone must sanitize hands upon entering and exiting the room.</p> <p>During an interview on 06/13/2024 at 4:12 p.m. with LVN A, she stated she should have sanitized her hands each time she went out of Resident #11's room and prior to entering. She stated EBP was important to assist in preventing the spread of infection. She stated she was trained on EBP but must have been in a hurry and forgot.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Whispering Oaks Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  105 Hospital Dr Cuero, TX 77954	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/14/2024 at 09:30 a.m. with the DON, she stated it was important for staff to adhere to the signs and LVN A needed to sanitize her hands each time she re-entered Resident #11's room. She stated the EBP sign is clear and posted and staff was trained on EBP precautions.</p> <p>Record review of facility training titled EBP dated 04/19/2024 reflected LVN A signed off that she had training.</p> <p>Record review of the facility's policy and procedure titled Enhanced Barrier Precautions dated 04/05/2024 reflected An order for Enhanced Barrier Precautions will be obtained for residents with any of the following, wounds, diabetic foot ulcers, unhealed surgical wounds, chronic venous stasis ulcers).</p> <p>Record review of CDC presentation titled Indwelling Urinary Catheter Insertion and Maintenance undated <a href="https://www.cdc.gov/infection-control/media/pdfs/Strive-CAUTI104-508.pdf">https://www.cdc.gov/infection-control/media/pdfs/Strive-CAUTI104-508.pdf</a> reflected Maintain Unobstructed Urine Flow .Keep the urine bag off the floor.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the maintenance of mechanical, electrical, and patient care equipment in safe operating condition for 1 (Residents #11) of 20 residents reviewed for safe environment, in that:</p> <p>Resident #11's wheelchair on 06/12/2024 at 9:39 a.m. had the left and right armrest vinyl torn and sharp and appeared worn and damaged.</p> <p>The deficient practice could affect residents who rely on facility equipment for mobilization and could result in skin tears or injuries.</p> <p>The findings included:</p> <p>Record review of Resident #11's electronic face sheet, dated 01/13/2024, reflected she was [AGE] years old (date of birth 11/16/1941) female and initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: end stage renal disease (kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), pressure ulcer of left heel-stage 3 (full thickness tissue loss and subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic obstructive pulmonary disease ( a common lung disease causing restricted airflow and breathing problems).</p> <p>Record review of Resident #11's quarterly MDS assessment with an ARD of 03/01/2024 reflected she scored an 15/15 on her BIMS which signified she was cognitively intact, and the resident required a manual wheelchair and could roll the wheelchair once seated in the chair.</p> <p>Record review of Resident #11's comprehensive person-centered plan of care 02/01/2024 reflected Wheelchair 50 feet with two turns: supervision or touching assistance, and Wheel 150 feet - partial/moderate assistance.</p> <p>Observation on 06/12/2024 at 9:39 a.m. and on 06/13/2024 at 3:50 p.m. revealed Resident #11 was sitting in her wheelchair and the right and left armrests' vinyl was torn with sharp ragged edges and appeared worn and damaged. Resident #11 did not have any scratch to her arms.</p> <p>Interview on 06/12/2024 at 9:39 a.m. with Resident #11 stated the torn vinyl on her left and right wheelchair armrests had many cracks. Resident #11 stated she sometimes had scratches on her arm from the vinyl. When asked why she did not ask the staff to repair it, she stated she did not want to bother anyone and did not complain.</p> <p>Interview on 06/13/2024 at 4:35 p.m. the DOR (Director of Rehab) stated therapy staff usually checked residents' wheelchair, but the therapy staff did not know Resident #11's wheelchair armrest had many cracks because the resident did not say anything regarding her wheelchair to therapy staff. However, checking residents' wheelchairs was all facility staff's responsibility.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/13/2024 at 4:40 p.m. the DON stated worn and torn armrests on Resident #11's wheelchairs were a safety issue and might discuss it at the care plan meeting. The DON stated she was not aware and had not noticed Resident #11's wheelchair needed the armrests replaced or repaired. The DON also stated she was not aware of any injuries from the torn vinyl on the armrests, but she might discuss it with a care team.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44020</b></p> <p>Based on observations, record reviews and interviews, the facility failed to ensure that 44 out of 44 resident rooms provided a minimum of 80 square feet of floor space per resident.</p> <p>Forty-Four of the two-bed resident rooms measured 155, 156 or 157 square feet per room leaving 77.5, 78 or 78.5 square feet per bed.</p> <p>This deficient practice could affect residents living in these rooms by restricting the amount of resident care equipment and resident's personal effects that could be accommodated in these rooms.</p> <p>The findings were:</p> <p>Per the facility Bed Classification Form 3740 dated 06/14/2024 as completed by facility Administrator revealed, Resident Rooms 100 through 108, 201 through 207, 300 through 305, 401 through 404, 500 through 509, and 600 through 608 were listed as two resident bedrooms.</p> <p>Observation on 06/12/2024 beginning at 1:00 p.m. of the measurements of resident bedrooms using a laser measuring tool by the Life Safety Code surveyor, revealed the following measurements:</p> <p>Hall A - room [ROOM NUMBER] -measured 155 square feet providing 77.5 square feet per bed.</p> <p>Hall A - Rooms 100, 102, 103, 104, 105, 106, 107, and 108 - measured 156 square feet, providing 78 square feet per bed.</p> <p>Hall B - Rooms 201, 202, 204, 205 206, and 207 - measured 155 square feet, providing 77.5 square feet per bed.</p> <p>Hall B - room [ROOM NUMBER] - measured 156 square feet, providing 78 square feet per bed.</p> <p>Hall C - Rooms 300, 301, 302, 303, 304, and 305 - measured 156 square feet, providing 78 square feet per bed.</p> <p>Hall D - room [ROOM NUMBER] - measured 157 square feet, providing 78.5 square feet per bed.</p> <p>Hall D - Rooms 401, 402, 403, and 404 - measured 156 square feet, providing 78 square feet per bed.</p> <p>Hall E - rooms [ROOM NUMBERS] - measured 155 square feet, providing 77.5 square feet per bed.</p> <p>Hall E - Rooms 502, 503, 504, 505, 506, 507 508, and 509 - measured 156 square feet, providing 78 square feet per bed.</p> <p>Hall E - room [ROOM NUMBER] - measured 157 square feet, providing 78.5 square feet per bed.</p> <p>(continued on next page)</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Hall F- Rooms 600, 601, 602, 603, 605 and 608 - measured 156 square feet, providing 78 sq. ft per bed.</p> <p>Hall F - room [ROOM NUMBER] - measured 155 square feet, providing 77.5 square feet per bed.</p> <p>During an interview on 06/13/2024 at 3:57 p.m., the Administrator confirmed the identified residents' rooms were 2-person rooms and did not provide a minimum of 80 square feet of floor space per resident. The Administrator requested a room size waiver for those resident rooms and completed Form 3762 Room Size Waiver for Facilities that reflected that all justification criteria for the wavier had been met which would not adversely affect the residents living in the rooms.</p>		