

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Fredericksburg Nursing and Rehabilitation LP		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 S Adams St Fredericksburg, TX 78624	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observations, interviews, and record reviews, the facility failed to ensure the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 3 (Residents #11, #15, and #18) of 20 residents reviewed for dignity. 1. Resident #11's wheelchair on 05/14/2024 at 10:00 a.m. had the left armrest vinyl torn and sharp and appeared worn and damaged. 2. Resident #15's wheelchair on 05/14/2024 at 10:12 a.m., had both armrests vinyl torn and worn on the edges. 3. Resident #18's wheelchair on 05/14/2024 at 10:15 a.m. had both armrests vinyl torn and worn. The left side armrest was missing vinyl and foam and the baseboard was exposed. These deficient practices affect residents who rely on facility equipment for mobilization and could result in loss of self-esteem, dignity, and increased lack of self-worth. The findings included: 1. Record review of Resident #11's electronic face sheet dated 05/14/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: abnormalities of gait and mobility (any deviations from normal walking or gait), thyrotoxicosis (a condition that happens when there is too much thyroid hormone in the body and can cause rapid weight loss and a rapid heartbeat), paroxysmal atrial fibrillation (type of irregular heartbeat), and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability). Record review of Resident #11's quarterly MDS assessment with an ARD of 04/02/2024 reflected he scored a 10/15 for his BIMS score which signified he was moderately cognitively impaired. He could understand and be understood. He required a manual wheelchair, and he could roll 150 feet once seated in the chair. Record review of Resident #11's comprehensive person-centered plan of care 09/29/2023 reflected Problem, ADL's Functional Status/Rehabilitation Potential, Approach, promote dignity, assist with ADL's as needed. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675169	Facility ID: 675169 If continuation sheet Page 1 of 50

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/14/2024 at 10:00 a.m., Resident #11 was sitting in his wheelchair and the left armrest vinyl was torn with sharp ragged edges and appeared worn and damaged. During an interview on 05/17/2024 at 1:30 p.m. with Resident #11, he stated he had the wheelchair for as long as he could remember. When asked why he did not ask the staff to repair it, he stated what good would it do? He stated he did not want to bother anyone. He stated the worn and torn armrest made him feel depressed. 2. Record review of Resident #15's electronic face sheet dated 05/14/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: hypothyroidism (the thyroid gland cannot make enough thyroid hormone to keep the body running normally), dementia (a loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and muscle weakness (when full effort does not produce a normal muscle contraction or movement). Record review of Resident #15's quarterly MDS review with an ARD of 03/25/2024 reflected he scored a 09/15 for his BIMS score which signified he was moderately cognitively impaired. He could usually understand and could usually be understood. He required a manual wheelchair, and he could move independently. Record review of Resident #15's comprehensive person-centered care plan dated 03/24/2024 reflected Problem, ADLs Functional Status/Rehabilitation Potential, Approach, promote dignity, assist with ADL's as needed. Observation and interview on 05/14/2024 at 10:12 a.m., Resident #15 was sitting in his wheelchair and both the armrests vinyl was torn and worn which caused him to feel a loss of dignity. During an observation and interview on 05/17/2024 at 2:00 p.m. with Resident #15, who was sitting in his wheelchair in the 300 hallway, he had new armrests on his wheelchair which were replaced on 05/16/2024 after the state surveyor spoke with the RNC. He stated the old armrests made him feel bad. When asked why he did not mention the worn and torn armrests to the staff, he stated he did not want to bother anyone. He stated he had the wheelchair since he was admitted to the facility. 3. Record review of Resident #18's electronic face sheet dated 05/14/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: fibromyalgia (a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory, and mood issues), weakness (lacking strength), unspecified abnormalities of gait (any deviations from normal walking or gait), and mobility and spinal stenosis (space inside the backbone is too small and can cause pain, tingling, and weakness). Record review of Resident #18's quarterly MDS assessment with an ARD of 03/21/2024 reflected he scored a 10/15 for his BIMS score which signified he was moderately cognitively impaired. He could understand and be understood. He required a manual wheelchair and could move independently. Record review of Resident #18's comprehensive person-centered care plan dated 08/14/2023 reflected Problem, ADLs Functional Status/Rehabilitation Potential, Approach, promote dignity, assist with ADL's as needed. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/14/2024 at 10:15 a.m. of Resident #18, he was sitting in his wheelchair, and both the armrests had torn and worn vinyl and the left armrest was missing foam which exposed the baseboard. During an interview on 05/14/2024 at 10:17 a.m. with Resident #18, he stated he had the wheelchair since his admission and the vinyl wore and tore. He stated he did not want to bother the staff and did not complain. He stated the torn and worn vinyl and missing foam on the armrests bothered him and made him feel down and not dignified. Observation on 05/17/2024 of Resident #18 at 3:00 p.m. sitting in his wheelchair in the 300 hall, he had new armrests. The new armrests were the result of the state surveyor intervention, who spoke with the RNC on 05/16/2024 about the torn and worn armrests. During an interview on 05/17/2024 at 3:02 p.m. with Resident #18, he stated the new armrests on his wheelchair were soft and comfortable, and he felt much better. During an interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated worn and torn armrests on resident's wheelchairs were a safety and dignity issue. She stated she had been at the facility for less than a year and the company just hired a DON who had not started work. She stated she was not aware and had not noticed the resident wheelchairs needed armrests replaced or repaired. She stated if staff saw something that required repair, they needed to write it down in the Maintenance book at the nurse's station, and she presumed no one had noticed since the residents did not complain. She stated she would get them replaced right away. She stated a resident could feel embarrassed, undignified, or have a lack of self-esteem because of the torn armrests. Record review of the facility policy and procedure titled Quality of Life-Dignity, dated revised August 2009 reflected Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality, Treated with dignity means that residents will be assisted in maintaining and enhancing his or her self-esteem and self-worth.		

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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** 28619 Based on interviews and record review, the facility assessments failed to accurately reflect the resident's status for 2 (Resident #14 and #21) of 20 residents reviewed for assessments. 1. Resident #14's significant change MDS assessment with an ARD of 02/08/2024 inaccurately reflected the resident had significant weight loss, but she did not have significant weight loss. 2. Resident #21's quarterly MDS assessment with an ARD of 03/17/24 did not reflect she had a fall, and inaccurately reflected she was taking an antidepressant and diuretic. These deficient practices affect residents at the facility who require assistance with services and ADL's and could result in missed or inaccurate care. The findings were: 1. Record review of Resident # 14's electronic face sheet dated 05/17/2024 reflected she was admitted to the facility on [DATE]. The resident's diagnoses included: hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left dominant side (paralysis of partial body function on one side of the body, and hemiparesis was characterized by one-sided weakness, but without complete paralysis), cerebrovascular diseases (a group of conditions that affect blood flow and the blood vessels on the brain), abnormal weight loss, dysphagia (difficulty swallowing), and Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior). Record review of Resident #14's significant change MDS assessment with an ARD of 02/08/2024 reflected weight loss of 5% or more in the last month or loss of 10% or more in last 6 months was checked Yes when reviewing section K Swallowing/Nutritional Status. Record review of Resident #14's weight Variance Report dated from 09/06/2023 to 05/17/2024 indicated Resident #14 had -1.01 % weight loss for one month (01/05/2024 weight 148.5 pounds and 02/06/2024 weight 147.0 pounds) and -3.80 weight loss for six months (09/06/2023 weight 152.8 pounds and 02/06/2024 weight 147.0 pounds). Interview with MDS Consultant RN B on 05/17/2024 at 9:57 a.m. confirmed checking Yes to weight loss of 5% or more in the last month or loss of 10% or more in last 6 months of Resident #14's significant change MDS dated [DATE] was inaccurate. Resident #14 did not have weight loss of 5% in the last month and 10% in the last six months. Further interview with the MDS Consultant RN B stated it was very important for the MDS assessment to be accurate because it affected care plans and finally could provide incorrect care to the resident. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #21's electronic face sheet dated 05/14/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: edema (swelling caused by too much fluid trapped in the body's tissue), acute respiratory failure (occurs when the lungs cannot release enough oxygen into the blood), anxiety (a feeling of worry, nervousness, or unease), peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage, or spasms in a blood vessel), and spinal stenosis (space inside the backbone is too small and can cause pain, tingling and weakness). Record review of Resident #21's quarterly MDS assessment with an ARD of 03/17/2024 reflected she scored a 09/15 on her BIMS which signified she was moderately cognitively impaired. She could understand and be understood. She required moderate to extensive assistance with her ADL's. Review of Section J1800 Any Falls Since Admission or Prior Assessment, No was checked. Review of Section N0415, High-Risk Drug Classes: Use and Indication.' The areas checked for Is taking and Indication noted were antianxiety, antidepressant, and diuretic. Record review of Resident #21's Event Report dated 12/20/2023 reflected she had a fall at 10:34 a.m. in her restroom. Record review of Resident #21's Physician Order Report: 03/01/2024 - 04/30/2024 reflected she only took an antianxiety medication during the week of 03/12/2024 to 03/17/2024. She was not ordered an antidepressant and did not receive an order for a diuretic until she was ordered Furosemide (diuretic) on April 19, 2024. Record review of Resident #21's EMAR dated 03/01/2024 - 03/31/2024 reflected she received Ativan (antianxiety medication) 0.5mg TID, with a start date of 02/09/2024. Record review of Resident #21's comprehensive person-centered care plan dated 12/21/2024 reflected Problem, Falls, resident has experienced a fall r/t self-transfer, unsteady gait, not using call light. Resident #21's comprehensive person-centered care plan did not reflect she took antianxiety medication. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated it was important for the MDS assessments to be accurate because it communicated resident needs to the person-centered care plan, and care provided could be inaccurate and harmful to a resident if the information was inaccurate. Interview on 05/17/2024 at 05:22 PM with the Corporate MDS Nurse, she stated she was so busy with MDS's and care plans, she did not know how she missed Resident #21's fall and she thought the resident was on an antidepressant and diuretic during the week of 03/12/2024 to 03/17/2024. She stated she was mistaken. Review of the facility policy and procedure titled Certifying Accuracy of the Resident Assessment revised date December 2009 reflected All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, October 2019 reflected The RAI process has multiple regulatory requirements . (1) the assessment accurately reflects the resident's status. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39049		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 26869 Based on observations, interviews, 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 includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, for 7 of 20 residents (Residents #11, #15, #16, #19, #21, #22, and #29) reviewed for care plans. 1. The facility failed to ensure Resident #11's incontinence was reflected in his care plan. 2. The facility failed to ensure Resident #15's pacemaker information was in his care plan. 3. The facility failed to ensure Resident #16's bowel incontinence was reflected in her care plan. 4. The facility failed to ensure Resident #19's did not have a care plan for handrails in bed. 5. The facility failed to ensure Resident #21's diagnoses, compression stockings, and diuretic were reflected in her care plan. 6. The facility failed to ensure Resident #22's care plan regarding prevention of falls were measurable to meet the resident's current medical, nursing, mental, and psychosocial needs. 7. The facility failed to ensure Resident #29's had handrails care planned. These deficient practices could place residents at risk of not receiving proper care and services. The findings included: 1.Record review of Resident #11's electronic face sheet dated (05/14/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: abnormalities of gait and mobility (any deviations from normal walking or gait), thyrotoxicosis (a condition that happens when there is too much thyroid hormone in the body and can cause rapid weight loss and a rapid heartbeat), paroxysmal atrial fibrillation (type of irregular heartbeat), and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability). Record review of Resident #11's quarterly MDS assessment with an ARD of 04/02/2024 reflected he scored a 10/15 on his BIMS which signified he was moderately cognitively impaired. He could understand and be understood. He was frequently incontinent of urine and occasionally incontinent of bowel. Record review of Resident #11's comprehensive person-centered plan of care 09/29/2023 failed to reflect he was frequently incontinent of urine and occasionally incontinent of bowel. Observation on 05/14/2024 at 10:00 a.m., Resident #11 was sitting in his wheelchair, and required moderate assistance with his care. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/17/2024 at 1:30 p.m. with Resident #11, he stated he sometimes would be incontinent of urine or bowel. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated Resident #11's incontinence needed to be care planned. She stated the care plan was a tool to communicate care required by the resident, and if it were not care planned, he could receive inaccurate or missed care. In an interview on 05/17/2024 at 05:22 PM with the Corporate MDS Nurse, she stated she was so busy with MDS's and care plans, she did not know why Resident #11's incontinence was not care planned. She stated it was important because he could miss care he required. 2. Record review of Resident #15's electronic face sheet dated 05/14/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: hypothyroidism (the thyroid gland cannot make enough thyroid hormone to keep the body running normally), dementia (a loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), muscle weakness (when full effort does not produce a normal muscle contraction or movement), and presence of cardiac pacemaker (small, battery powered device that prevents the heart from beating too slowly). Record review of Resident #15's quarterly MDS review with an ARD of 03/25/2024 reflected he scored a 09/15 for his BIMS score which signified he was moderately cognitively impaired. He could usually understand and could usually be understood. He had an active diagnosis of cardiac pacemaker. Record review of Resident #15's comprehensive person-centered care plan dated 03/29/2023 reflected Problem, Resident has a pacemaker/defibrillator and may be at risk for decreased cardiac output and irregular pulse; and potential for pacemaker/defibrillator malfunction, pace maker type_____, model_____, serial #_____, insertion date:_____, next operational check_____. _____ During an interview on 05/17/2024 at 2:00 p.m. with Resident #15, who was sitting in his wheelchair in the 300 hallway, he stated he had his cardiac pacemaker for 6 years, and had follow-up appointments with his cardiologist. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated Resident #15's pacemaker information needed to be care planned. She stated the care plan was a tool to communicate care required by the resident, and if the cardiac pacemaker information were not care planned, it would be difficult to quickly find information in case of a malfunction. In an interview on 05/17/2024 at 05:22 PM with the Corporate MDS Nurse, she stated she was so busy with MDS's and care plans, she did not know why Resident #15's pacemaker information was not completed in his care plan. She stated it was important because he could miss care he required. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of Resident #16's electronic face sheet dated 05/15/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to general deterioration of brain), age related osteoporosis (deterioration in bone mass, increasing risk for fracture), contracture (condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity and rigidity of joints) of right and left shoulder, and psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality). Record review of Resident #16's quarterly MDS assessment with an ARD of 02/24/2024 reflected she was not a candidate for a BIMS which signified she was severely cognitively impaired. She could rarely understand and rarely be understood. She required extensive assistance with her ADL's. She was always incontinent of bowel and bladder. Record review of Resident #16's comprehensive person-centered care plan dated 09/29/2016 reflected Problem, Urinary Incontinence. Resident #16's bowel incontinence was not reflected in the residents comprehensive person-centered care plan. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated Resident #16's bowel incontinence needed to be in the care plan because it was an important aspect of the resident's care. In an interview on 05/17/2024 at 05:22 PM with the Corporate MDS Nurse, she stated she care planned Resident's bladder incontinence, but must have forgotten to care plan her bowel incontinence. She stated it was important to be able to communicate the right care for a resident and to have it in the care plan. 4. Record review Resident #19's face sheet dated 5/16/2024 reflected he was admitted on [DATE], he was [AGE] years old. His diagnoses were multiple sclerosis, need for assistance with personal care, muscle weakness, and depression. Record review Resident #19's Quarterly MDS dated [DATE] reflected he was cognitively intact, required supervision with eating, he was dependent with showers, toileting upper/lower body extremity with dressing, and he used a motorized wheelchair. Record review Resident #19's care plan dated 5/16/2024 revealed no care plan for his handrail. Record review Resident #19's handrail consent/assessment was dated 2/24/2024 for bed mobility and positioning. Observation on 5/14/2024 at 10:40 AM in Resident #19's room revealed he had a handrail on his bed. Observation on 5/14/24 at 5:31 PM in Resident #19's room revealed he had a handrail on his bed. In an interview on 5/14/2024 at 5:32 PM with Resident #19 he stated he had a handrail on his bed to hold on too, while moving in bed. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/16/24 at 09:57 AM RN corporate MDS nurse confirmed the handrail on Resident #19's bed was not in his care plan and she was not sure why it was not in his care plan. The Corporate MDS nurse stated the resident MDS's were completed by the ADON. The corporate MDS nurse stated the ADON was out and was not sure when she would return . 5. Record review of Resident #21's electronic face sheet dated 05/14/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: edema (swelling caused by too much fluid trapped in the body's tissue), acute respiratory failure (occurs when the lungs cannot release enough oxygen into the blood), anxiety (a feeling of worry, nervousness, or unease), peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), and spinal stenosis (space inside the backbone was too small and can cause pain, tingling, and weakness). Record review of Resident #21's quarterly MDS assessment with an ARD of 03/17/2024 reflected she scored a 09/15 for her BIMS score which signified she was moderately cognitively impaired. She could understand and be understood. She required moderate to extensive assistance with her ADL's. She was assessed to have an active diagnosis of edema. She was inaccurately coded to be on a diuretic. Record review of Resident #21's comprehensive person-centered care plan did not reflect she had edema as a problem or compression stockings placed twice a day and prescribed a diuretic for interventions. Record review of Resident #21's Physician Order Report: 03/01/2024 - 04/30/2024 reflected she was ordered a diuretic on 04/19/2024 for edema and she had an order for compression hose BLE on in AM, off at HS, for edema with a start date of 03/26/2024. Record review of Resident #21's EMAR dated 04/17/2024 to 05/17/2024 reflected Compression Hose to BLE on in AM off at HS, and was initialed off as having them put on in the AM and taken off in the PM. Observation on 05/14/2024 at 10:30 a.m. of Resident #21 revealed she was sitting in the dining room and had compression hose on both her lower legs. Observation on 05/15/2024 at 10:00 a.m. of Resident #21 revealed she was sitting in her room with her feet on her footrests of the wheelchair and her ankles appeared swollen. During an interview on 05/15/2024 at 10:02 a.m. with CNA A she stated Resident #21 wears special stockings, and she puts them on the resident's lower legs in the morning. During an interview on 05/17/2024 at 11:20 p.m. with Resident #21, she stated she gets special stockings every day, but someone must put them on her. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated Resident #21's edema needed to be care planned. She stated the edema was an active problem and the resident received medication and compression stockings to treat the swelling. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/17/2024 at 05:22 PM with the Corporate MDS Nurse, she stated she was so busy with MDS's and care plans, she did not know why Resident #21's edema was missed. She stated the care plan was a main communication tool about the resident's needs and required care and care could be missed. 6. Record review of Resident # 22's electronic face sheet dated 05/17/2024 reflected he was admitted to the facility on [DATE]. The resident's diagnoses included: hypokalemia (low level of potassium in the blood), cerebral infarction (damage to tissues on the brain due to a loss of oxygen to the area), reduced mobility, abnormalities of gait and mobility (change to walking pattern), history of falling, anxiety disorder (persistent feeling of anxiety or dread), and impaired vision (poor vision to blindness). Record review of Resident #22's quarterly MDS assessment with an ARD of 04/29/2024 reflected he scored an 8/15 on his BIMS which signified he was moderately cognitively impaired. He could understand and be understood. Record review of Resident #22' comprehensive person-centered plan of care, dated 03/01/2024, reflected Problem: Resident was at risk for falls due to poor safety awareness, Goal: Resident will be free of falls, and Approach: for nursing, increased staff supervision with intensity based on resident need. In an interview with CNA A on 05/16/2024 at 8:14 a.m. she stated Resident #22 had high risk of fall because the resident did not use the call light even though teaching every time, so the CNA checked the resident every 30 minutes when the CNA worked on daytime. The facility CNAs generally check residents at least every two hours. In an interview with LVN D on 05/16/2024 at 8:24 a.m. she stated Resident #22 was confused so tried to transfer from the bed to the wheelchair by himself without requesting helps. The facility staff taught the resident every time about using a call light, but the resident forgot. The LVN D just told every CNA checking the resident at least every hour. The LVN D did not know how often the facility CNAs should check the resident per his care plan. In an interview with MDS consultant RN B on 05/16/2024 at 9:21 a.m. confirmed Resident #22's comprehensive person-centered plan of care regarding increased staff supervision with intensity based on resident need was not measurable. It should have been developed measurable, for example, increased staff supervision from every two hour to every one hour, so every staff could provide same supervision to the resident. Further interview with the MDS consultant RN B stated she was so busy with MDSs and care plans, so she did not know it was not measurable, and it affected the resident could not receive proper care and services. 7. Record review of Resident #29's face sheet dated 5/16/2024 reflected he was admitted on [DATE] and he was [AGE] years old. He had a diagnoses of cerebral infarction, muscle weakness, heart failure, and need for assistance with personal care. Record review of Resident #29's Admission MDS dated [DATE] reflected he had moderate cognitive impairment, he had impairment to upper/lower extremity for range of motion, he used a manual wheelchair, he required partial/moderate assistance with eating, he was dependent with showers and toileting, and he required substantial/maximize assistance with upper body dressing. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #29's care plan dated 4/25/2024 reflected no handrail for bed mobility. Record review of Resident #29's handrail consent /assessment was dated 4/2/2024 for bed mobility and positioning. Observation on 5/14/2024 at 10:42 AM reflected he had 2 handrails on his bed. Observation on 5/14/2024 at 12:17 PM reflected he had 2 handrails on his bed. In an interview on 5/14/2024 at 12:18 PM Resident #29 stated he used the 2 handrails to move in his bed. In an interview on 5/16/24 at 9:50 AM with the RN corporate MDS nurse stated there was no care plan for Resident #29's handrail . Record review of the Facility policy Care Plans-Preliminary dated August 2006 revealed, A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within 24 hours of admission, 3. The preliminary care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary care plan. Record review of the Facility Care Planning- Interdisciplinary Team dated September 2013 reflected Our Facility's Care Planning/Interdisciplinary Team is responsible for the development of an individuated comprehensive care plan for each resident. 1. A comprehensive care plan for each resident is developed with 7 days of completion of the resident assessment. 28619 39049		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on interviews and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 2 (residents #21, and #22) of 20 residents reviewed for care plans. 1. Resident #21's comprehensive person-centered care plan was not revised after her quarterly MDS assessment with an ARD of 03/17/24 to reflect she had taken antianxiety medication. 2. Resident #22's comprehensive person-centered care plan was not revised or updated based on the facility policy to not use chair and bed alarms for prevention of fall, but the care plan reflected continually using chair and bed alarms. These deficient practices affect residents who receive assessments and could result in an inaccurate comprehensive person-centered care plan and missed care. The findings included: 1. Record review of Resident #21's electronic face sheet dated 05/14/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: edema (swelling caused by too much fluid trapped in the body's tissue), acute respiratory failure (occurs when the lungs cannot release enough oxygen into the blood), anxiety (a feeling of worry, nervousness, or unease), peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), and spinal stenosis (space inside the backbone is too small and can cause pain, tingling and weakness). Record review of Resident #21's quarterly MDS assessment with an ARD of 03/17/2024 reflected she scored a 09/15 for her BIMS score which signified she was moderately cognitively impaired. She could understand and be understood. She required moderate to extensive assistance with her ADL's. Review of Section N0415, High-Risk Drug Classes: Use and Indication. An area checked Is taking and indication noted was antianxiety. Record review of Resident #21's comprehensive person-centered care plan revised dated 04/09/2024 did not reflect Resident #21's antianxiety medication she took three times a day. Record review of Resident #21's Physician Order Report: 03/01/2024 - 04/30/2024 reflected she took an antianxiety medication during the week of 03/12/2024 to 03/17/2024. Ativan (antianxiety medication) 0.5mg TID, with a start date of 02/09/2024. Record review of Resident #21's EMAR dated 03/01/2024 - 03/31/2024 reflected she received Ativan (antianxiety medication) 0.5mg TID, with a start date of 02/09/2024. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated Resident #21's antianxiety medication ordered in February and indicated on the March 17 MDS assessment. This needed to be updated on her care plan and it was not. She stated a resident's care plan was a map of how a resident gets what care they need and without it, they may miss or receive inappropriate care. In an interview on 05/17/2024 at 05:22 PM with the Corporate MDS Nurse, she stated she was so busy with MDS's and care plans, she did not know how the psychoactive medication, Ativan, was not updated on the care plan after her quarterly assessment dated [DATE]. Could result in care missed. 2. Record review of Resident # 22's electronic face sheet dated 05/17/2024 reflected he was admitted to the facility on [DATE]. The resident's diagnoses included: hypokalemia (low level of potassium in the blood), cerebral infarction (damage to tissues on the brain due to a loss of oxygen to the area), reduced mobility, abnormalities of gait and mobility (change to walking pattern), history of falling, anxiety disorder (persistent feeling of anxiety or dread), and impaired vision (poor vision to blindness). Record review of Resident #22's quarterly MDS assessment with an ARD of 04/29/2024 reflected he scored an 8/15 for his BIMS score which signified he was moderately cognitively impaired. He could understand and be understood. Record review of Resident #22' comprehensive person-centered plan of care, dated 03/01/2024, reflected Evaluate need for bed/chair alarms for prevention of fall. In an interview with CNA A on 05/16/2024 at 8:14 a.m. she stated, Per our facility policy, we never use chair or bed alarms. In an interview with LVN D on 05/16/2024 at 8:24 a.m. she stated He [Resident #22] did not have chair or bed alarms because we never use chair or bed alarms per our policy. In an interview with MDS consultant RN B on 05/16/2024 at 9:21 a.m. confirmed the facility did not use chair or bed alarms per their policy. Resident #22' comprehensive person-centered plan of care for Evaluate need for bed/chair alarms for prevention of fall should have revised or updated based on the facility policy. She stated it was very important that the care plan was revised or updated correctly to reflect current Resident #22's status because the care plan was the blueprint regarding how to provide correct care to residents. Record review of the facility policy and procedure titled Care Planning - Interdisciplinary Team revised September 2013 reflected A comprehensive care plan is developed within 7 days of completion of the resident MDS assessment .The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Record review of the facility policy, titled Quality of Life - Homelike environment, revised 02/2014, revealed The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include Chair and bed alarms. 39049		

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interviews and record review the facility failed to ensure that when the facility anticipated discharge, a resident must have a discharge summary that included, but was not limited to, the following: A recapitulation of the resident's stay that included, but was not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results for 1 of 3 (#31) closed records. Resident #31's discharge summary was not signed by a physician. This could affect all discharge residents and could result in record errors. The Findings were: Record review of Resident #31's face sheet dated 5/17/2024 revealed she was admitted on [DATE] and discharged on [DATE]. Record review of Resident #31's discharge MDS dated [DATE] reflected this was a planned discharge, to home/community and she was cognitively intact. Record review of Resident #31's discharge summary dated 5/17/2024 revealed Resident #31 went home with home health and no physician signature or date. Record review of Resident #31's progress note date 2/27/2024 reflected she was discharged home on home health. In an interview on 5/17/24 at 4:36 PM with the RN corporate MDS nurse stated she was not sure why the discharge summary for Resident #31 did not have a physician signature. She stated she would investigate it, but no response before exit. In an interview on 5/17/2024 at 5 PM with ADM stated she did not have a policy for resident discharge summary.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observations, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident choices for 1 (Resident #16) of 20 residents observed for quality of care. The facility failed to obtain an order for barrier cream to be applied to Resident #16's buttocks and peri area after incontinent care. The findings included: Record review of Resident #16's electronic face sheet dated 05/15/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to general deterioration of brain), age related osteoporosis (deterioration in bone mass, increasing risk for fracture), contracture (condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity and rigidity of joints) of right and left shoulder, and psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality). Record review of Resident #16's quarterly MDS assessment with an ARD of 02/24/2024 reflected she was not a candidate for a BIMS score which signified she was severely cognitively impaired. She could rarely understand and rarely be understood. She required extensive assistance with her ADL's. She was always incontinent of bowel and bladder. Record review of Resident #16's comprehensive person-centered care plan dated 09/29/2016 reflected Problem, Urinary Incontinence. Record review of Resident #16's Active Orders: dated 04/01/2024 to 04/30/2024 reflected she did not have a physician's order for barrier cream to be applied to her buttocks and peri area after incontinent care. Observation on 05/15/2024 at 01:36 PM of CNA A performing incontinent care for Resident #16 revealed she had CNA E take a tube of barrier cream out of the resident's bedside stand and she applied it over the resident's buttocks to include 3 open wound areas. Record review of the barrier cream tube reflected Calmoseptine Ointment, indicated it was a skin barrier and apply peri-wound. Interview on 05/16/2024 at 2:00 PM with CNA A, she stated she did not know if there was an order for the barrier cream. She stated Hospice lady brought it in and said to put in on Resident #16's bottom after incontinent care. She could not recall the Hospice lady's name. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated Resident #16 needed to have a physician's order for barrier cream because it is considered a treatment. She stated she did not know why there was not an order since getting an order for a treatment was standard practice. She stated Hospice orders were integrated with the facility orders and should be the same orders. Record review of the facility policy and procedure titled Medication and Treatment Orders revised July 2016 reflected Orders for medications and treatments will be consistent with principles of safe and effective order writing.		

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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** 39049 Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 of 3 resident (Resident #6) reviewed for incontinent care. CNA G failed to spread and clean within Resident #6's labial folds after an incontinent episode. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident # 6's electronic face sheet dated 05/17/2024 reflected she was admitted to the facility on [DATE]. The resident's diagnoses included: cerebral infarction (damage to tissues on the brain due to a loss of oxygen to the area), dementia (loss of memory, language, problem-solving, and other thinking abilities that were severe), hypothyroidism (thyroid gland does not make enough thyroid hormone), neuropathy (weakness, numbness, and pain form nerve damage), and glaucomatous flecks (disease that damages eye). Record review of Resident #6's quarterly MDS, dated [DATE], indicated she did not have a BIMS score which she had impaired cognition. The MDS also indicated Resident #6 was always incontinent for bladder and bowel. Observation on 05/15/2024 at 4:55 p.m. revealed while providing incontinent care for Resident #6, CNA G cleaned the perineal area and did not separate and clean between the labial folds. In an interview on 05/15/2024 at 5:14 p.m. CNA G revealed she was supposed to open and clean the labia (labia minor-inner fold) and confirmed she did not. CNA G stated she was supposed to clean between the folds to remove germs and prevent infections. In an interview with the RNC on 05/15/2024 at 5:20 p.m., the RNC said that during incontinent care the labial folds need to be cleaned to make sure they are properly cleaned and to remove any bacteria in the area. Record Review of annual skills check for CNA G revealed CNA G passed competency for Perineal care/incontinent care on 03/27/2024. Record review of the facility policy, titled Perineal care, revised 10/2010, revealed Steps in the Procedure . 9. For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area, wiping from front to back (1) Separate labia and wash area downward from front to back.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 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 4 (Residents #6, #16, #26, and #134) of 20 residents reviewed for competent nursing care. 1. CNA G failed to spread and cleaned within Resident #6's labial folds after an incontinent episode. 2. CNA A applied barrier cream to Resident #16's open wounds. CNA A reapplied Resident #16's wound dressing that had fallen off into the soiled brief. 3. LVN D failed to follow facility procedure when she instilled eye drops for Residents #26. 4. LVN C crushed medications for Resident #134, that were noted to be Do Not Crush. These deficient practices affect residents who depend on nursing care and could place residents at risk for injury, infection, and harm. The findings included: 1. Record review of Resident # 6's electronic face sheet dated 05/17/2024 reflected she was admitted to the facility on [DATE]. The resident's diagnoses included: cerebral infarction (damage to tissues on the brain due to a loss of oxygen to the area), dementia (loss of memory, language, problem-solving, and other thinking abilities that were severe), hypothyroidism (thyroid gland does not make enough thyroid hormone), neuropathy (weakness, numbness, and pain form nerve damage), and glaucomatous flecks (disease that damages eye). Record review of Resident #6's quarterly MDS, dated [DATE], indicated she did not have a BIMS score which she had impaired cognition. The MDS also indicated Resident #6 was always incontinent for bladder and bowel. Observation on 05/15/2024 at 4:55 p.m. revealed while providing incontinent care for Resident #6, CNA G cleaned the perineal area and did not separate and clean between the labial folds. In an interview on 05/15/2024 at 5:14 p.m. CNA G revealed she was supposed to open and clean the labia (labia minor-inner fold) and confirmed she did not. CNA G stated she was supposed to clean between the folds to remove germs and prevent infections. In an interview with the RNC on 05/15/2024 at 5:20 p.m., the RNC said that during incontinent care the labial folds need to be cleaned to make sure they are properly cleaned and to remove any bacteria in the area. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of annual skills check for CNA G revealed CNA G passed competency for Perineal care/incontinent care on 03/27/2024. Record review of the facility policy, titled Perineal care, revised 10/2010, revealed Steps in the Procedure . 9. For a female resident: a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area, wiping from front to back (1) Separate labia and wash area downward from front to back. 2. Record review of Resident #16's electronic face sheet dated 05/15/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to general deterioration of brain), age related osteoporosis (deterioration in bone mass, increasing risk for fracture), contracture (condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity and rigidity of joints) right and left shoulder and psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality). Record review of Resident #16's quarterly MDS assessment with an ARD of 02/24/2024 reflected she was not a candidate for a BIMS which signified she was severely cognitively impaired. She could rarely understand and rarely be understood. She required extensive assistance with her ADL's. She was always incontinent of bowel and bladder. Record review of Resident #16's comprehensive person-centered care plan dated 09/29/2016 reflected Problem, Urinary Incontinence. Record review of Resident #16's Active Orders as of 04/01/2024 to 04/30/2024 did not reflect an order for barrier cream. Observation on 05/15/2024 at 01:45 PM during incontinent care for Resident #16, her wound dressing which was a 4X4 inch dressing with 4 strips of adhesive tape fell off into the dirty brief. CNA A picked up the dirty wound dressing and placed it back onto Resident #16's wound area after putting barrier cream over the open wound areas. During an interview with CNA A on 05/16/2024 at 2:00 PM she stated she screwed up, and she was not supposed to put the dirty dressing back onto Resident #16's bottom. She stated she was supposed to call the nurse when the dressing came off, and she did not think, and placed it back onto the resident. She stated her job was to tell the nurse if the dressing came off. She stated she did not know there was not an order for barrier cream. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated CNA A needed to call the nurse when Resident #16's wound dressing fell off, and not to put it back onto the resident. She stated the barrier cream required an order, because it was noted to be a treatment, and the wound may not heal with other solutions not ordered. She stated she needed to report any changes that were nursing care related to the licensed nurse. She stated she was not trained to put the dressing back on or to apply ointment to wound areas because that was not in her job description. Record review of the facility Job Description, Certified Nursing Assistant (CNA) dated February 2024 reflected Essential functions, assist residents with all aspects of activities of daily living, no nursing duties were in the job description. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Fredericksburg Nursing and Rehabilitation LP		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 S Adams St Fredericksburg, TX 78624	
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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Nurse Aide Performance record dated 06/28/2022 reflected she was trained on applies principles of standard precautions. No where on the skills training checklist related to applying a dressing to a resident. 3. Record review of Resident #16's electronic face sheet dated 05/15/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to general deterioration of brain), age related osteoporosis (deterioration in bone mass, increasing risk for fracture), contracture (condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity and rigidity of joints) of right and left shoulder, and psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality). Record review of Resident #16's quarterly MDS assessment with an ARD of 02/24/2024 reflected she was not a candidate for a BIMS score which signified she was severely cognitively impaired. She could rarely understand and rarely be understood. She required extensive assistance with her ADL's. She was always incontinent of bowel and bladder. Record review of Resident #16's comprehensive person-centered care plan dated 09/29/2016 reflected Problem, Urinary Incontinence. Observation on 05/15/2024 at 03:13 PM of RN F performed wound care for Resident #16 and revealed she did not wear a gown. Observation on 05/15/2024 at 01:45 PM during incontinent care for Resident #16, her wound dressing which was a 4X4 inch dressing with 4 strips of adhesive tape fell off into the dirty brief. CNA A picked up the dirty wound dressing and placed it back onto Resident #16's wound area after putting barrier cream over the open wound areas. During an interview with CNA A on 05/16/2024 at 2:00 PM she stated she screwed up, and she was not supposed to put the dirty dressing back onto Resident #16's bottom. She stated she was supposed to call the nurse when the dressing came off, and she did not think, and placed it back onto the resident. She stated her job was to tell the nurse if the dressing came off. She stated she did not know there was not an order for barrier cream and the wound would get infected. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated CNA A needed to call the nurse when Resident #16's wound dressing fell off, and not to put it back onto the resident. She stated the barrier cream required an order, because it was noted to be a treatment, and the wound may not heal with other solutions not ordered. She stated she needed to report any changes that were nursing care related to the licensed nurse. She stated she was not trained to put the dressing back on or to apply ointment to wound areas because that was not in her job description. This could cause harm for the resident. Record review of the facility Job Description, Certified Nursing Assistant (CNA) dated February 2024 reflected Essential functions, assist residents with all aspects of activities of daily living, no nursing duties were in the job description. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Nurse Aide Performance record dated 06/28/2022 reflected she was trained on applies principles of standard precautions. Nothing on the skills training checklist related to the application of a dressing to a resident. 4. Record review of Resident #26's electronic face sheet dated 05/16/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: cognitive communication deficit (trouble participating in conversations), adult failure to thrive (loss of interest, depressive symptoms), and social exclusion and rejection (detaching from individuals, groups, and social relationships). Record review of Resident #26's quarterly MDS assessment with an ARD of 02/27/2024 reflected he scored a 05/15 for his BIMS score which signified he was severely cognitively impaired. He could sometimes understand and sometimes be understood. He required moderate amount of assistance with his ADL's. Record review of Resident #26's comprehensive person-centered care plan dated 09/28/2023 reflected Problem, ADL's, self-care deficit, administer medications and treatments as ordered. Record review of Resident #26's Active Orders as for 04/01/2024 to 04/30/2024 reflected he received artificial tears, one gtt ou, twice a day. Observation on 05/16/2024 at 07:30 a.m. of LVN D applying artificial tears for Resident #16 revealed, she did not wear gloves, and had the resident tilt his head a little bit and she placed the drops of artificial tears directly into one eye and then the other. In an interview on 05/16/2024 at 3:00 PM, with LVN D she stated she was not aware that was not the way to administer eye drops. She stated she was not familiar with the facility policy and procedure on eye drop administration, but she knew she was trained. She stated she understood after the procedure was explained to her, that Resident #26's eye drops would not provide the most therapeutic effect if most of the solution ran out of the eyes after administration. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated LVN D did not follow the facility policy and procedure for administering eye drops and she would retrain her. She stated the resident would not get the effectiveness of the medication if the medication was not administered properly, and in this situation. Resident #26's eyes could be irritated and dry. Record review of LVN D's Skills checklist-Licensed Nurse dated 03/24/2024 reflected she completed med pass. Record review of the facility policy and procedure titled Instillation of Eye Drops revised January 2014 reflected put on gloves, have resident tilt head back slightly, gently pull the lower eyelid down, instruct resident to look up, drop the medication into the mid lower eyelid to allow even distribution of the drops. Instruct the resident not to blink or squeeze the eyelids shut, which forces the medicine out of the eye. 5. Record review of Resident #134's electronic face sheet dated 05/15/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: encephalopathy, chronic obstructive pulmonary disease, poisoning by cardiac-stimulant glycosides and drugs of similar action, congestive heart failure, and cognitive communication deficit. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #134's EMR reflected he was not at the facility long enough for an MDS assessment. Record review of Resident #134's baseline care plan dated 05/13/2024 reflected Resident admitted for skilled care, cognition, require orientation to surroundings reminders, and assistance with medication management. Record review of Resident #134 physician orders dated 05/16/2024 reflected potassium chloride (to treat or prevent low amounts of potassium in the blood) tablet extended release; 20meq; 1 tablet oral once a day, tamsulosin (treatment for men with large prostate gland) capsule; 0.4mg; 1 tablet 0.4mg, oral one time a day and omeprazole capsule, delayed release (DR/EC) (indicated for short-term treatment of active benign gastric ulcer); 40mg, 1 capsule oral one time a day with start dates of 05/11/2024. Record review of the medication cards for 3 of the medications: potassium chloride (to treat or prevent low amounts of potassium in the blood) tablet extended release; 20meq; 1 tablet oral once a day, tamulosin (treatment for men with large prostate gland) capsule; 0.4mg; 1 tablet 0.4mg, oral one time a day and omeprazole capsule, delayed release (DR/EC) (indicated for short-term treatment of active benign gastric ulcer); 40mg, 1 capsule oral one time a day had blue stickers which read Warning DO NOT CRUSH on the front of the packet. Observation on 05/16/2024 at 08:34 a.m. of LVN C during medication pass for Resident #134 revealed she took Resident #134's medications into his room in a cup and was ready to administer them, when she asked the resident, would you like these crushed? Resident #134 responded yes, and LVN C departed the resident's room, crushed the tablets, opened the capsules, and mixed the crushed contents into in a medication cup with applesauce. LVN C administered the applesauce and medications to Resident #134 with water. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated LVN C needed to check the medication card for the do not crush and check the Do Not Crush List. She stated LVN C should have called the physician or pharmacist, as she was trained. In an interview with LVN C on 05/16/2024 at 1:00 PM she stated she crushed Resident #134's medications before, and had not noticed the warning, do not crush sticker. She stated that too much of a dose could taste bad or cause too much medication to be released too soon and cause distress. She stated she was trained to not crush medications unless the provider had an order to crush, and she had medication skills review annually. Record review of LVN C's Skills checklist-Licensed Nurse dated 03/24/2024 reflected she completed med pass. Record review of the facility Medications Not to Be Crushed list dated revised 12/22 reflected Omeprazole, Potassium Chloride, and Tamsulosin were on the list. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy and procedure titled Medication Administration, Oral dated 2007 reflected Check for specific prescriber order to crush medications if required by state regulation. Crush medications if indicated for this resident only after referring to the Medications Not to Be Crushed List. For products that appear on the Medication Not to Be Crushed List, check with the pharmacist regarding a suitable alternative, and request a new prescriber order if appropriate. 39049		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observation, interview and record review the facility failed to ensure its medication error rates were not 5% or greater. The facility had a medication error rate of 11.54%, based on 3 errors out of 26 opportunities which involved 1 of 6 residents (Resident #134) reviewed for medication administration and medication errors. LVN C crushed 3 medications, 2 capsules and 1 tablet that were on the Do Not Crush list during medication pass for Resident #134. This deficient practice places residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: Record review of Resident #134's electronic face sheet dated 05/15/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: encephalopathy (a group of conditions that cause brain dysfunction), chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), poisoning by cardiac-stimulant glycosides and drugs of similar action, congestive heart failure (the heart cannot pump or fill adequately), and cognitive communication deficit (difficulty communicating). Record Review of Resident #134's baseline care plan dated 5/13/24 revealed, Resident #134 was not at the facility long enough for an MDS assessment. Record review of Resident #134's baseline care plan dated 05/13/2024 reflected Resident admitted for skilled care, cognition, require orientation to surroundings reminders, and assistance with medication management. Record review of Resident #134 physician orders dated 05/16/2024 reflected potassium chloride (to treat or prevent low amounts of potassium in the blood) tablet extended release; 20meq; 1 tablet oral once a day, Tamsulosin (treatment for men with large prostate gland) capsule; 0.4mg; 1 tablet 0.4mg, oral one time a day, and omeprazole capsule, delayed release (DR/EC) (indicated for short-term treatment of active benign gastric ulcer); 40mg, 1 capsule oral one time a day with start dates of 05/11/2024. Record review of the medication cards for 3 of the medications: potassium chloride (to treat or prevent low amounts of potassium in the blood) tablet extended release; 20meq; 1 tablet oral once a day, tamulosin (treatment for men with large prostate gland) capsule; 0.4mg; 1 tablet 0.4mg, oral one time a day and omeprazole capsule, delayed release (DR/EC) (indicated for short-term treatment of active benign gastric ulcer); 40mg, 1 capsule oral one time a day had blue stickers which read Warning DO NOT CRUSH on the front of the packet. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/16/2024 at 08:34 a.m. of LVN C during medication pass for Resident #134 revealed she took Resident #134's medications into his room in a cup and was ready to administer them, when she asked the resident, would you like these crushed? Resident #134 responded yes, and LVN C departed the resident's room, crushed the tablets, opened the capsules, and mixed the crushed contents into in a medication cup with applesauce. LVN C administered the applesauce and medications to Resident #134 with water. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated LVN C needed to check the medication card for the do not crush and check the Do Not Crush List. She stated LVN C should have called the physician or pharmacist, as she was trained. Interview on 05/16/2024 with LVN C, at 1:00 PM she stated she crushed Resident #134's medications before, and had not noticed the warning, do not crush sticker. She stated that too much of a dose could taste bad or cause too much medication to be released too soon and cause distress. She stated she was trained to not crush medications unless the provider had an order to crush, and she had medication skills review annually. Record review of the facility Medications Not to Be Crushed list dated revised 12/22 reflected Omeprazole, Potassium Chloride and Tamsulosin were on the list. Record review of the facility policy and procedure titled Medication Administration, Oral dated 2007 reflected Check for specific prescriber order to crush medications if required by state regulation. Crush medications if indicated for this resident only after referring to the Medications Not to Be Crushed List. For products that appear on the Medication Not to Be Crushed List, check with the pharmacist regarding a suitable alternative, and request a new prescriber order if appropriate.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 Based on observations, interviews, and record review, the facility failed to ensure 1 out of 6 residents (Resident #134) were free of any significant medication errors when observed for medication pass. LVN C crushed 3 medications for Resident #134 that had Do Not Crush labeled on them during medication administration pass. This deficient practice affects residents with medications that are not recommended to be crushed and could result in physical harm or distress. The findings included: Record review of Resident #134's electronic face sheet dated 05/15/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: encephalopathy, chronic obstructive pulmonary disease, poisoning by cardiac-stimulant glycosides and drugs of similar action, congestive heart failure and cognitive communication deficit. Resident #134 was not at the facility long enough for an MDS assessment. Record review of Resident #134's baseline care plan dated 05/13/2024 reflected Resident admitted for skilled care, Cognition, require orientation to surroundings reminders, and assistance with medication management. Record review of Resident #134 physician orders dated 05/16/2024 reflected potassium chloride (to treat or prevent low amounts of potassium in the blood) tablet extended release; 20meq; 1 tablet oral once a day, tamulosin (treatment for men with large prostate gland) capsule; 0.4mg; 1 tablet 0.4mg, oral one time a day and omeprazole capsule, delayed release (DR/EC) (indicated for short-term treatment of active benign gastric ulcer); 40mg, 1 capsule oral one time a day with start dates of 05/11/2024. Observation on 05/16/2024 at 08:34 a.m. of LVN C during medication pass for Resident #134 revealed she took Resident #134's medications into his room in a cup and was ready to administer them, when she asked the resident, would you like these crushed? Resident #134 responded yes, and LVN C departed the resident's room, crushed the tablets, opened the capsules, and mixed the crushed contents into in a medication cup with applesauce. LVN C administered the applesauce and medications to Resident #134 with water. Record review of the medication cards for 3 of the medications: potassium chloride (to treat or prevent low amounts of potassium in the blood) tablet extended release; 20meq; 1 tablet oral once a day, tamulosin (treatment for men with large prostate gland) capsule; 0.4mg; 1 tablet 0.4mg, oral one time a day and omeprazole capsule, delayed release (DR/EC) (indicated for short-term treatment of active benign gastric ulcer); 40mg, 1 capsule oral one time a day had blue stickers which read Warning DO NOT CRUSH on the front of the packet. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated LVN C needed to check the medication card for the do not crush and check the Do Not Crush List. She stated LVN C should have called the physician or pharmacist, as she was trained. Interview on 05/16/2024 with LVN C, at 1:00 PM she stated she crushed Resident #134's medications before, and had not noticed the warning, do not crush sticker. She stated that too much of a dose could taste bad or cause too much medication to be released too soon and cause distress. She stated she was trained to not crush medications unless the provider had an order to crush, and she had medication skills review annually. Record review of the facility Medications Not to Be Crushed list dated revised 12/22 reflected Omeprazole, Potassium Chloride and Tamsulosin were on the list. Record review of the facility policy and procedure titled Medication Administration, Oral dated 2007 reflected Check for specific prescriber order to crush medications if required by state regulation. Crush medications if indicated for this resident only after referring to the Medications Not to Be Crushed List. For products that appear on the Medication Not to Be Crushed List, check with the pharmacist regarding a suitable alternative, and request a new prescriber order if appropriate. Record review of https://journals.lww.com/nursing/fulltext/2004/10000/don_t_crush_these_drugs.46.aspx, Lippincott's Nursing2024 Do Not Crush reflected Many drug forms, such as slow-release, enteric-coated, and encapsulated beads are made to release their active ingredients over a certain period of time or at preset points after administration. the disruptions caused by crushing or chewing these drug forms can dramatically affect the absorption rate and increase risk of adverse reactions. Other reasons not to crush or chew these drug forms include such considerations as taste, tissue irritation and unusual formulation.		

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 26869 Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 facility, in that: The Dietary Manager (DM) did not have the appropriate certification, education, or qualifications to serve as the Director of Food and Nutrition Services. This deficient practice could place the residents who consume food prepared from the kitchen at risk of food borne illness and not receiving adequate nutrition. The findings included: Observation on 5/14/2024 at 9:50 AM in the kitchen with the DM revealed no pasteurized eggs or shelled eggs in refrigerator. Interview on 5/14/2024 at 3:55 PM the Dietary Manager (DM) stated he was not certified, and he was not trained as a kitchen manger. The DM stated he used to be a dietary aide and was promoted. (not sure of date). Interview on 5/14/2024 at 3:56 PM in the kitchen with DM revealed he had no bananas, no bread and no onions for the meals for this day. The DM stated he had to discuss with the dietary consultant for the out-of-stock items. The DM stated he was not trained on ordering food for the kitchen menu food items. Interview on 5/14/2024 at 9:51 AM with the DM revealed no pasteurized eggs in refrigerator. The DM stated he did not have pasteurized eggs for the last 3 days. The DM stated there were 2 (#29, #17) residents that he could think of that prefer fried eggs for breakfast. The DM stated that he did not get the order in on time for the delivery service. The DM stated they get their food delivery every Wednesday. The DM stated he did not do any Resident Food Preference assessments, since he started working on 2/1/2024. Interview on 5/14/2024 at 4:15 PM the ADM stated the DM was not certified and was promoted to this position on 2/1/2024. ADM stated she was aware DM was in classes but was not sure of the time requirements the DM had to get certified in the kitchen. No other response. Record review of the Job description for Dietary Manager dated February 2024 under Qualifications credentialed in Dietary Management. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2-102.12.		

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record review the facility failed to ensure Menus and nutritional adequacy. Menus must Meet the nutritional needs of residents in accordance with established national guidelines.; Be prepared in advance; Be followed for 1 of 1 kitchen, in that: 1. Food items were not in the kitchen, pasteurized eggs or shelled eggs, bananas, bread and onions. Resident #29 and #17 preferred fried eggs. Resident group stated they would prefer fried eggs (#17, #24, #13) and Resident #18 preferred hard-boiled eggs for chef salad . 2. Kitchen cook J served residents for breakfast 1 slice of bacon, instead to two slices. Resident #2, #4, #13, #24, #29 had 1 slice of bacon for breakfast. 3. The facility failed to post of the weekly at a glance menu. This could affect all residents that eat in the dining area and could result in residents not aware of what will be on menu for the week. This could affect all residents that eat from the kitchen and place them at risk of improper food handling. The Findings were: Record review of Breakfast menu for Wednesday and Friday included scrambled eggs and bacon portion size, 2 slices. Record review of Lunch menu included peas with sauteed onions and peaches and bananas for dessert. 1. Observation on 5/14/2024 at 9:50 AM in the kitchen with the DM revealed no pasteurized eggs or shelled eggs in refrigerator. Interview on 5/14/2024 at 1:35 PM group, Resident #13, #17, #24 and #29 stated they preferred fried eggs and Resident #18 preferred hard-boiled eggs for his chef salad. Residents stated they had discussed this with the kitchen but had not listened to them. Record review of Resident #2's face sheet dated 5/16/2204 reflected she was admitted on [DATE], age was 71. Her diagnoses included polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body) in disease, muscle weakness, dysphagia (difficulty or discomfort in swallowing, as a symptom of disease.), feeding difficulties, cognitive communications deficit. Record review of Resident #2's consolidated physician orders for May 2024 reflected her diet, regular mechanical soft, ground meat and pureed fruits and vegetables, diagnoses Dysphagia. Record review of Resident #2's quarterly MDS dated [DATE] reflected she was moderately cognitively impaired, she required a manual wheelchair to mobilize, and she required partial/moderate assistance with eating. Record review of Resident #2's care plan dated 3/31/2024 reflected to serve diet and fluids as ordered. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #13's face sheet dated 5/16/2024 reflected she was admitted on [DATE], readmitted on [DATE] she was [AGE] years old. Resident #13 Quarterly MDS dated [DATE] reflected she had a BIMS score of 9/15 (moderate cognitive impairment). Record review of Resident #13's food preference assessment was dated 9/29/2021, reflected no preference at this time. Record review of Resident #13's care plan dated 2/27/2024 reflected no food preferences. Record review of Resident # #13's diet card reflected under notes section no eggs. Record review of Resident #17's face sheet dated 5/16/2024 reflected she was admitted on [DATE], readmitted on [DATE], she was [AGE] years old. Resident #17's Quarterly MDS dated [DATE] reflected she has a BIMS score of 12/15 (moderate cognitive impairment). Record review of Resident #17's care plan dated 2/27/2024 reflected no food preferences. Record review of #17's chart revealed no food preference assessment. Record review of Resident # #17's diet card reflected under notes section: fried eggs. Record review of Resident #18's face sheet dated 5/14/2024 reflected he was admitted to the facility on [DATE]. Record review of Resident #18's Quarterly MDS assessment was dated 3/21/2024 reflected his BIMS scored was 10/15 (moderate cognitive impairment). Record review of Resident #18's care plan dated 5/16/2024 reflected no food preferences for eggs. Resident #18's chart revealed no food preference assessment. Record review of Resident # #18's diet card reflected under notes section extra eggs. Record review of Resident #24's face sheet dated 5/16/2024 reflected she was admitted on [DATE], readmitted on [DATE], she was [AGE] years old. Resident #24's quarterly MDS dated [DATE] reflected she had a BIMS score of 9/15 (moderate cognitive impairment). Record review of Resident #24's care plan dated 2/27/2024 chart revealed no food preference assessment. Record review of Resident # #24's diet card reflected under notes section, no preferences. Record review of Resident #29 face sheet dated 5/16/2024 reflected he was admitted on [DATE], he was [AGE] years old. Resident #29's Admission MDS dated [DATE] reflected he had a BIMS score was 9/15 (moderate cognitive impairment). Record review of Resident #29's care plan reflected no food preferences for eggs. Resident #29's chart revealed no food preference assessment. Record review of Resident # #29's diet card reflected under notes section scrambled eggs. Observation on 5/14/2024 11:51 AM of Resident #2 at lunch time revealed she had pureed potatoes, peas and peaches. No bananas or sauteed onions were seen with any of the resident trays. Residents did not voice a concern about the missing items. Observation on 5/14/2024 at 12:03 PM revealed Resident #24's plate had meatloaf, potatoes, peas (no onion), peaches, 2 drinks, she had no bread or bananas today . Observation on 5/14/2024 at 12:12 PM in Resident # 29's room revealed he was eating lunch in his room. Resident # 29's plate had peas (no onions), meatloaf, potatoes, coffee, drinks, water, and no bread on plate. Observation on 5/14/2024 at 3:55 PM in the kitchen with DM revealed he had no bananas, no bread and no onions for the meals for this day. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 5/15/24 at 7:46 AM breakfast service: Resident #2 plate had 1 small scoop of scrambled eggs, one slice of toast and one slice of bacon or small serving of ground sausage . Nurse D appeared to be checking the trays and handing them out. Observation on 5/15/24 at 10:13 AM with Resident #13 revealed her plate had no bread and no onions. Interview on 5/14/24 at 12:04 PM revealed Resident #24's stated she had no onions in peas, no bread or bananas today. interview on 5/15/24 at 10:14 AM with Resident #13 stated too many green beans and spinach, potatoes, she did not get bread in every meal. Resident #13 stated she would like boiled eggs or fried eggs and staff excuse was they cannot go over the budget . 2. Record review of Resident #19's face sheet dated 5/16/2024 reflected he was admitted on [DATE], he was [AGE] years old. Resident #19 Quarterly MDS dated [DATE] reflected he had a BIMS score of 13/15 (cognition intact). Record review of Resident #19's care plan dated 5/16/2024 reflected no food preferences. Resident #19's chart revealed no food preference assessment. Record review of Resident #19's diet card reflected under notes section no preferences. Observations on 5/17/24 at 7:25 AM in the kitchen during breakfast service, cook J was serving breakfast and served 1 slice of bacon on each resident plate. Cook J looked at the menu for the day and observed to serve resident 2 slices of bacon. Cook J stated she was not aware that she was supposed to serve residents 2 slices of bacon. Observations on 5/17/24 7:40 AM Resident #24 had 1 slice of bacon a never received 2 strips of bacon. Observations on 5/17/24 7:42 AM Resident #13 had 1 slice of bacon on her plate. res ident stated she never gets 2 slices of bacon. . Observations on 5/17/24 7:48 AM Resident #19 had 1 slice of bacon on her plate. Resident stated he could not remember the last time he was served 2 bacon slices for breakfast. Interview on 5/14/2024 at 3:56 PM in the kitchen with DM revealed he had no bananas, no bread and no onions for the meals for this day. The DM stated he had to discuss with the dietary consultant for the out-of-stock items. The DM stated he was not trained on ordering food for the kitchen menu food items. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/14/2024 at 9:51 AM with the DM revealed no pasteurized eggs in refrigerator. The DM stated he did not have pasteurized eggs for the last 3 days. The DM stated there were 2 (#29, #17) residents that he could think of that prefer fried eggs for breakfast. The DM stated that he did not get the order in on time for the delivery service. The DM stated they get their food delivery every Wednesday. The DM stated he did not do any Resident Food Preference assessments, since he started working on 2/1/2024. Interview on 5/14/2024 at 3:40 PM the ADM stated she was not aware of food items missing for a meal. The ADM stated the Dietary manager could use the credit card to get food items from the store. The ADM stated she will do some training. Interview on 5/16/2024 at 11 AM the ADM stated no concerns with supplies, she orders extra, if they are out of any supplies they can always go to the local store. The ADM stated she was not made aware that some food items were not delivered. She stated the dietary manager was required to be certified. The ADM stated dietary manger was promoted on 2/1/2024. Interview on 5/17/24 at 7:50 AM the ADM stated the regional staff and she had gone in kitchen at random times and has trained the dietary manager. Record review of the Facility policy Resident Nutrition Services dated November 2010 reflected, Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service and appropriate feeding assistance. 2. Nursing personnel will ensure that residents are served the correct food tray. 3. Prior to service the food tray, the nurse aide/feeding assistant must check the tray card to ensure that the correct food tray is being served to the resident. 3. Observation on 5/15/2024 at 9:50 AM no week at a glance menu's posted and no breakfast posted. Observation on 5/15/2024 at 8:59 AM no week at glance menus posted, no breakfast menu posted. Interview on 5/15/2024 at 9:00 AM with ADM stated she did not see a weekly menu posted and no breakfast menu posted. Interview on 5/15/2024 at 11:54 AM with DM confirmed no weekly or breakfast menu posted. The DM stated the ADM let him know that he was required to post a week at a glance menu and have all 3 meals posted, so residents can see it, this day. The risk would be residents not knowing what they would eat. Interview on 5/16/24 at 10:48 AM with the dietary consultant stated the DM was taking classes and was hired on 2/1/2024, he stated he did talk to the DM about posting the weekly menus. Interview on 5/17/24 at 7:50 AM with ADM stated the regional staff and she had gone in kitchen at random times and had trained the dietary manager on how to manage the kitchen. (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Facility Menu, dated December 2008, reflected Menu shall a) meet the nutritional needs of residents; b) be prepared in advance; and c) be followed. 2. Menu and available snacks shall be adjusted to meet individual caloric and nutrient intake needs of the resident. 3. Menus for regular and therapeutic diets are written and Atlas 2 weeks in advance and are dated and posted in the kitchen as least 1 week in advance. 13. copies of menus will be posted in at least 2 resident areas. in positions and in print large enough for resident to read them.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record reviews the facility failed to ensure Food prepared in a form designed to meet individual needs for 1 of 8 (#2) residents, in that: Resident #2 was served a puree meat, instead of mechanical soft. This could affect all resident with diet orders that were prescribed by a physician and could result in residents not served the correct diet texture. The Findings were: Record review of Resident #2's face sheet dated 5/16/2024 reflected she was admitted on [DATE], age was 71. Her diagnoses included polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body) in disease, muscle weakness, dysphagia (difficulty or discomfort in swallowing, as a symptom of disease.), feeding difficulties, cognitive communications deficit. Record review of Resident #2's consolidated physician orders for May 2024 reflected her diet, regular mechanical soft, ground meat and pureed fruits and vegetables, diagnoses Dysphagia. Record review of Resident #2's quarterly MDS dated [DATE] reflected she was moderately cognitively impaired, she required a manual wheelchair to mobilize, and she required partial/moderate assistance with eating. Record review of Resident #2's care plan dated 3/31/2024 reflected to serve diet and fluids as ordered. Record review of Resident #2's Speech Therapy note dated 1/19/2024 reflected she was on a precautions/contraindications: Fall aspiration and reflux, puree fruits and vegetables/ground meat regular liquids. Record review of her meal ticket read mechanical soft texture, ground beef, pureed vegetables and fruit. Observation on 5/14/24 at 11:51 AM of Resident #2, at lunch time revealed she was served pureed meatloaf when her diet was ordered mechanical soft ground meat, and pureed vegetables and fruit. She had pureed potatoes, peas and peaches. She had pureed meatloaf instead of mechanical soft. Interview on 5/14/2024 at 11:52 AM LVN D stated, they must have ground it too much. Interview on 5/14/2024 at 3:55 PM the DM stated cook J was working on 5/14/2024 for lunch and he was aware that Resident #2 was served puree meat, instead of mechanical soft meat. The DM stated cook J ran out of mechanical soft meat, so she served puree meat to Resident #2; no other response. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/16/24 at 10:20 AM cook J stated she did not have enough mechanical soft meat for Resident #2, so she served her puree meat; no other response. Cook J stated she measured the food types for residents. Cook J had no response. Interview on 5/16/24 at 10:48 AM the Dietary Consultant stated the DM was a new DM in the kitchen. The Dietary Consultant stated the ADM/DM did talk to him about Resident #2's served pureed meat, instead of mechanical soft meat. The Dietary Consultant stated the resident was not at risk choking due to a decrease in the texture of the meal. Dietary Consultant stated no weight loss for Resident #2 and had a good appetite. Interview on 5/16/2024 at 11:00 AM the ADM stated no concerns with supplies, she orders extra, if they are out of any supplies they can always to local store. The ADM stated she was not made aware staff provided the wrong diet texture to residents. She stated dietary manager required to be certified. The ADM stated the dietary manger was promoted on 2/1/2024. Interview on 05/17/24 at 7:50 AM the ADM stated the regional staff and she had gone in the kitchen at random times and has trained the dietary manager. Record review of the Facility policy Resident Nutrition Services dated November 2010 reflected, Each resident shall receive the correct diet, with preferences accommodated as feasible and shall receive prompt meal service and appropriate feeding assistance. 2. Nursing personnel will ensure that residents are served the correct food tray. 3. Prior to service the food tray, the nurse aide/feeding assistant must check the tray card to ensure that the correct food tray is being served to the resident. Record review of the Facility Therapeutic Diets policy, dated December 2008, reflected Therapeutic dies shall be prescribed by eh Attending Physician. The facility will strive for the fewest possible dietary restrictions. 1. Mechanically altered diets, as well as dies modified for medial or nutritional needs, will be considered Therapeutic diets. 5. The food Service Manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interviews, and record review the facility failed to ensure each resident receives and the facility provides-Food that accommodates resident preferences for 5 of 16 (#13, #17, #18, #24 and #29) reviewed for preferences, in that: Residents #13, #17, #18, #24 and #29 were not served their preferences. No documentation of dietary assessment with preferences. This could affect all residents with food preferences and could result in a decrease in resident choices and diminished interest in meals. The Findings were: Interview on 5/14/2024 at 1:35 PM in a group meeting, Resident #13, #17, #24 and #29 stated they preferred fried eggs and Resident #18 preferred hard-boiled eggs for his chef salad. 1. Record review of Resident #13's face sheet dated 5/16/2024 reflected she was admitted on [DATE], readmitted on [DATE] she was [AGE] years old. Resident #13 Quarterly MDS dated [DATE] reflected she had a BIMS score of 9/15 (moderate cognitive impairment). Record review of Resident #13's food preference assessment was dated 9/29/2021, reflected no preference at this time. Record review of Resident #13's care plan dated 2/27/2024 reflected no food preferences. Record review of Resident #13's diet card reflected under notes section no eggs. 2. Record review of Resident #17's face sheet dated 5/16/2024 reflected she was admitted on [DATE], readmitted on [DATE], she was [AGE] years old. Resident #17's Quarterly MDS dated [DATE] reflected she has a BIMS score of 12/15 (moderate cognitive impairment). Record review of Resident #17's care plan dated 2/27/2024 reflected no food preferences. Record review of #17's chart revealed no food preference assessment. Record review of Resident #17's diet card reflected under notes section: fried eggs . 3. Record review of Resident #18's face sheet dated 5/14/2024 reflected he was admitted to the facility on [DATE]. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #18's Quarterly MDS assessment was dated 3/21/2024 reflected his BIMs scored was 10/15 (moderate cognitive impairment). Record review of Resident #18's care plan dated 5/16/2024 reflected no food preferences for eggs. Resident #18's chart revealed no food preference assessment. Record review of Resident #18's diet card reflected under notes section extra eggs. 4. Record review of Resident #24's face sheet dated 5/16/2024 reflected she was admitted on [DATE], readmitted on [DATE], she was [AGE] years old. Resident #24's quarterly MDS dated [DATE] reflected she had a BIMS score of 9/15 (moderate cognitive impairment). Record review of Resident #24's care plan dated 2/27/2024 chart revealed no food preference assessment. Record review of Resident #24's diet card reflected under notes section, no preferences. 5. Record review of Resident #29 face sheet dated 5/16/2024 reflected he was admitted on [DATE], he was [AGE] years old. Resident #29's Admission MDS dated [DATE] reflected he had a BIMS score was 9/15 (moderate cognitive impairment). review of Resident #29's care plan reflected no food preferences for eggs. Resident #29's chart revealed no food preference assessment. Record review of Resident #29's diet card reflected under notes section scrambled eggs. Interview on 5/14/2024 at 9:51 AM with the DM stated there were 2 (#29, #17) residents that he could think of that prefer fried eggs for breakfast. The DM stated he did not do any Resident Food Preference assessments, since he started working on 2/1/2024. Interview on 5/16/2024 at 11 AM ADM stated the dietary manager required to be certified. The ADM stated dietary manger was promoted on 2/1/2024. The ADM stated the regional staff and she had gone in kitchen random times and has trained the dietary manager. ADM did respond to who and why the resident preferences were not completed. The ADM did not provide dietary assessment/preferences policy.		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 26869 Based on observation, interview, and record review, the facility failed to ensure there were no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack was served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal spa: the failure to ensure residents were made aware of how to obtain a snack when desired for 4 of 9 residents (confidential residents in group) reviewed for frequency of meals. The facility failed to ensure residents were offered snacks at bedtimes as required due to mealtimes being more than 14 hours apart. This failure could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for, unplanned weight loss, and side effects from medication given without food, and diminished quality of life. Findings included: Record review of the resident snack list, no date was provided by the DM. There were 27 residents that received morning and afternoon snacks. There was no resident list with HS snacks provided. Record review of the resident roster dated on 5/14/2024 reflected a census of 31 residents. Observation on 5/14/2024 at 9:50 AM, of the posted Meal Service Times in the dining room revealed the following: Breakfast - 7:30 -7:45 AM Lunch - 11:30-11:45 AM Evening meal - 5:30 -5:45 PM- There is no posting to advise any resident a snack or availability of type of snack after specified times. During interview on 5/14/2024 at 1:35 PM with residents in group of 6 residents, it was brought to the attention of the state surveyors that they have not been made aware of options of a snack which are available to residents. Residents said they were not offered any HS snacks . Interview on 5/16/2024 at 10:48 AM with dietary consultant stated he was not aware of residents not offered snacks after dinner. The Dietary consultant stated the effects of residents not offered snacks by staff would be a potential for weight loss, the resident might be diabetic, resident blood sugar levels and resident morale. Interview on 5/14/2024 at 4:00 PM the DM stated the resident that received snacks had orders and or have some weight loss. The DM provided a list of 27 out of 31 residents that received snacks . (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 5/14/2024 at 4:15 PM the ADM stated they give snacks to the residents and snacks are available when resident ask the nurse. The ADM stated the residents that were diabetic or have an order get snacks from kitchen. The ADM stated that residents were provided snacks by the nurse if they ask for snacks. Interview on 5/15/2024 at 5:15 PM LVN G stated resident get snacks at the nurse's station. LVN G stated when residents ask for snacks, they provide residents with snacks. Interview on 5/15/2024 at 5:24 PM with CNA I who worked the 6 AM to 6 PM shift during the week. CNA I stated not all resident get snacks when they come out from the kitchen. CNA I stated the resident that are offered snacks are residents with physician orders and diabetic residents . CAN I stated the snack that had labels were brought out by kitchen and the nurses' stations always had snacks for residents, at resident request. CNA I stated the residents had refrigerators that had snacks they bought our was brought in by the family. Record Review of Facility Policies and Procedures Snacks dated September 2017, reflected The purpose of this procedure is to provide the resident with adequate nutrition.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 26869 Based on observation, interview, and the facility failed to ensure garbage was disposed of properly for 1 of 1 facility, in that: The area near the facility's two dumpsters was on dirt and not concrete slab . This deficient practice could lead to an unsanitary environment and encourage the presence of pests. The findings were: Observation on 5/13/2024 at 10:02 AM., of the area near the facility's 2 dumpsters reflected there were on dirt and not concrete slab. Observation of a concrete slab big enough for 1 dumpster near the 2 dumpsters. Interview on 5/14/2024 at 10:03 AM with the DM stated the 2 dumpsters had been moved to a dirt ground due to only had room for 1 dumpster on a concrete slab. DM was not sure how long the 2 dumpsters were moved to the dirt. Interview on 5/16/2024 at 5:33 PM with ADM stated she was not aware of the 2 dumpsters in dirt, instead of a concrete slab. ADM stated no policy on dumpsters that required to be on concrete slab. Record review of FDZ Food code, 5-5 Refuse, Recycles, and Returnables section- 5-501.11 Outdoor Storage Surface. An outdoor storage surface for REFUSE, recyclables, and returnables shall be constructed of nonabsorbent material such as concrete or asphalt and shall be SMOOTH, durable, and sloped to drain.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Fredericksburg Nursing and Rehabilitation LP		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 S Adams St Fredericksburg, TX 78624	
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 39049 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 3 (#16, #29 and #134) of 20 residents reviewed for infection control, in that: 1. CNA A, and CNA E failed to follow EBP signage instructions for Resident #16 by not sanitizing hands prior to entering or reentering Resident #16's room, and CNA #16 put the dirty dressing back onto Resident #16's buttock wound after the dressing fell on to the dirty brief during incontinent care. RN F performed a dressing change for Resident #16 without wearing a gown. 2. The facility failed to have signage on Resident #29's room door to indicate he was on EBP. 3. Resident #134's nebulizer mask and oxygen tubing with nasal cannula was left unbagged when not in use. These deficient practices could affect residents and place them at risk for cross contamination and infections. The findings included: 1. Record review of Resident #16's electronic face sheet dated 05/15/2024 reflected she was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive mental deterioration that can occur in middle or old age, due to general deterioration of brain), age related osteoporosis (deterioration in bone mass, increasing risk for fracture), contracture (condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity and rigidity of joints) right and left shoulder and psychosis (severe mental condition in which thought and emotions are so affected that contact is lost with external reality). Record review of Resident #16's quarterly MDS assessment with an ARD of 02/24/2024 reflected she was not a candidate for a BIMS which signified she was severely cognitively impaired. She could rarely understand and rarely be understood. She required extensive assistance with her ADL's. She was always incontinent of bowel and bladder. Record review of Resident #16's comprehensive person-centered care plan dated 09/29/2016 reflected Problem, Urinary Incontinence. Observation on 05/15/2024 at 01:43 PM of Resident #16's room revealed she had a sign which indicated she was on EBP. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the EBP sign on Resident #16's door reflected 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. Observation on 05/15/2024 at 3:27 PM of RN F, she reviewed the EBP sign on Resident #16's door, put a gown on and proceeded to finish Resident #16's dressing change. Observation on 05/15/2024 at 01:36 PM of CNA A and CNA E prepare for incontinent care for Resident #16 who was on EBP and had a sign on her door, CNA E put on a gown and did not sanitize his hands prior to entering Resident #16's room. CNA A, once in Resident #16's room needed to leave the room to get gowns per the EBP guidelines out of a plastic bin with drawers stationed in the hallway. She left Resident #16's room, went to the bin, took out 2 gowns and re-entered Resident #16's room without sanitizing her hands. Observation on 05/15/2024 at 01:45 PM during incontinent care for Resident #16, her wound dressing which was a 4X4 inch dressing with 4 strips of adhesive tape fell off into the dirty brief. CNA A picked up the dirty wound dressing and placed it back onto Resident #16's wound area. During an interview on 05/15/2024 at 3:00 p.m. with CNA E, he stated he should have sanitized his hands prior to going into Resident #16's room because she was on EBP, and staff were trained. He stated not sanitizing hands could cause cross contamination and give the resident an infection. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated CNA A needed to call the nurse when Resident #16's wound dressing fell off, and not to put it back onto the resident. She stated EBP was now in effect and CNA A and CNA E needed to sanitize their hands when they entered Resident #16's room or if they left for something and then re-entered. She stated by not following the guidance or infection control practices, cross contamination could occur and the residents could acquire infections. She stated RN F was trained on EBP and knew she needed to wear a gown. Observation on 05/15/2024 at 03:13 PM of RN F perform wound care for Resident #16 revealed she did not wear a gown. During an interview on 05/15/2024 at 03:25 PM with RN F, she stated she did not think about wearing a gown, she stated it could cause cross contamination not to use PPE properly. She stated she was trained on the new EBP guidelines which included to wear a gown when working with a resident who had a wound and dressing change. During an interview with CNA A on 05/16/2024 at 2:00 PM she stated she screwed up, and she was not supposed to put the dirty dressing back onto Resident #16's bottom. She stated she was supposed to call the nurse when the dressing came off, and she did not think, and placed it back onto the resident. She stated the staff were trained on EBP, and she should have sanitized her hands when she reentered Resident #16's room after getting the gowns. She stated cross contamination could occur and the Resident could get an infection. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #29's electronic face sheet dated 05/16/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: metabolic encephalopathy (a series of neurological disorders not caused by primary structural abnormalities), cerebral infarction (occurs because of disrupted flow to the brain due to problems with the blood vessels that supply it), dehydration (occurs when there is a loss of more fluid than what is taken in and the body does not have enough water and other fluids to carry out normal functions) and pressure ulcer of unspecified buttock, unspecified stage (warmth, itching, swelling, and blistering, and the skin around the affected area may change color). Record review of Resident #29's admission MDS assessment dated [DATE] reflected he scored a 09/15 on his BIMS which signified he was moderately cognitively impaired. He could usually understand and usually be understood. He required moderate assistance with ADL's and he had pressure sores. Record review of Resident #29's comprehensive care plan dated 04/04/2024 reflected Problem, pressure injury, long term goal, will show signs of healing and remain free of infection. Observation on 05/15/2024 at 03:57 PM of LVN C and LVN H prepare to enter Resident #29's room to perform a dressing change revealed a plastic bin with drawers containing PPE was outside of the room. No signage was on the door to indicate Resident #29 was on EBP. During an interview on 05/15/2024 at 4:00 PM with LVN H, she stated the EBP sign was in the top drawer of the plastic bin. She stated it should be posted on Resident #29's door to let people know he was on EBP. She stated the sign must have come off, and no one put it back on the door. She stated it was important because infection control practices needed to be followed or there could be cross contamination and the resident could become sick. She stated she had not noticed the sign was down. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated the staff needed to put the EBP sign back up if it came off the door. She stated it was important for staff to follow the EBP guidelines to prevent cross contamination. 3. Record review of Resident #134's electronic face sheet dated 05/15/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: encephalopathy (a group of conditions that cause brain dysfunction), chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), poisoning by cardiac-stimulant glycosides and drugs of similar action, congestive heart failure (the heart cannot pump or fill adequately), and cognitive communication deficit (difficulty communicating). Record review of Resident #134's baseline care plan dated 05/15/2024 reflected Resident requires oxygen therapy r/t Hypoxemia (low oxygen in blood). Further review revealed that Resident #134 was not at the facility long enough for an MDS assessment. Record review of Resident #134 physician orders dated 05/16/2024 reflected albuterol sulfate solution for nebulization; 2.5mg/3ml inhalation every 4 hours PRN, Continuous oxygen at 2L. Observation on 05/16/2024 at 08:36 with LVN C in Resident #134's room during medication pass revealed an oxygen mask for a nebulizer and oxygen tubing with nasal cannula attached to an E tank which were not in use and not in plastic bags. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/16/2024 at 08:40 a.m. with LVN C, she stated that the tubing must have been from his treatment during the night, but she did not check it and missed the nasal cannula tubing and nebulizer mask were not bagged. She stated it was important to put the oxygen tubing when not in use in a plastic bag to prevent dust and contaminants to enter it and cause an infection for the resident. During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated oxygen tubing and masks when not in use need to be bagged to keep contaminants from entering to protect a resident using the equipment from cross contamination. Record review of facility policy and procedure titled the Departmental (Respiratory Therapy) Prevention of Infection revised 2011 reflected The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff .Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. Record review of facility In-service Attendance Record revealed the EBP training was acquired after the discrepancy in procedure was noted. Record review of facility policy and procedure titled Enhanced Barrier Precautions dated 2024 reflected It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .all staff receive training .an order for enhanced barrier precautions will be obtained for residents with any of the following: wounds .High-contact resident care activities include: . changing briefs or assisting with toileting .wound care; any skin opening requiring a dressing.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28619 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 3 (Residents #11, #15 and #18) of 20 residents reviewed for safe environment, in that: 1. Resident #11's wheelchair on 05/14/2024 at 10:00 a.m. had the left armrest vinyl torn and sharp and appeared worn and damaged. 2. Resident #15's wheelchair on 05/14/2024 at 10:12 a.m., had both armrests vinyl torn and worn on the edges. 3. Resident #18's wheelchair on 05/14/2024 at 10:15 a.m. had both armrests vinyl torn and worn. The left side armrest was missing vinyl and foam and the baseboard was exposed. These deficient practices could affect residents who rely on facility equipment for mobilization and could result in skin tears or injuries. The findings included: 1. Record review of Resident #11's electronic face sheet dated (05/14/2024) reflected he was admitted to the facility on [DATE]. His diagnoses included: abnormalities of gait and mobility (any deviations from normal walking or gait), thyrotoxicosis (a condition that happens when there is too much thyroid hormone in the body and can cause rapid weight loss and a rapid heartbeat), paroxysmal atrial fibrillation (type of irregular heartbeat) and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability) Record review of Resident #11's quarterly MDS assessment with an ARD of 04/02/2024 reflected he scored a 10/15 on his BIMS which signified he was moderately cognitively impaired. He could understand and be understood. He required a manual wheelchair and could roll 150 feet once seated in the chair. Record review of Resident #11's comprehensive person-centered plan of care 09/29/2023 reflected Problem, ADL's Functional Status/Rehabilitation Potential, Approach, promote dignity, assist with ADL's as needed. Observation on 05/14/2024 at 10:00 a.m., Resident #11 was sitting in his wheelchair and the left armrest vinyl was torn with sharp ragged edges and appeared worn and damaged. During an interview on 05/17/2024 at 1:30 p.m. with Resident #11, he stated the torn vinyl on his left wheelchair armrest was sharp. He stated he had cut his arm on the vinyl. He stated he had the wheelchair for as long as he could remember. When asked why he did not ask the staff to repair it, he stated what good would it do? He stated he did not want to bother anyone. He stated the worn and torn armrest made him feel depressed. (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #15's electronic face sheet dated 05/14/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: hypothyroidism (the thyroid gland cannot make enough thyroid hormone to keep the body running normally), dementia (a loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and muscle weakness (when full effort does not produce a normal muscle contraction or movement). Record review of Resident #15's quarterly MDS review with an ARD of 03/25/2024 reflected he scored a 09/15 on his BIMS which signified he was moderately cognitively impaired. He could usually understand and could usually be understood. He required a manual wheelchair and could move independently. Record review of Resident #15's comprehensive person-centered care plan dated 03/24/2024 reflected Problem, ADLs Functional Status/Rehabilitation Potential, Approach, promote dignity, assist with ADL's as needed. Observation on 05/14/2024 at 10:12 a.m. Resident #15 was sitting in his wheelchair and both the armrests vinyl was torn and worn which caused him to feel a loss of dignity. During an interview on 05/17/2024 at 2:00 p.m. with Resident #15, who was sitting in his wheelchair in 300 hallways, he had new armrests which on his wheelchair which were replaced on 05/16/2024 after the surveyor spoke with the RNC. He stated the new armrests were nice, and he could wear short sleeve shirts now, because the old armrests scratched his arms. He stated the old armrests made him feel bad. When asked why he did not mention the worn and torn armrests to the staff, he stated he did not want to bother anyone. He stated he had the wheelchair since he was admitted to the facility. 3. Record review of Resident #18's electronic face sheet dated 05/14/2024 reflected he was admitted to the facility on [DATE]. His diagnoses included: fibromyalgia (a disorder characterized by widespread musculoskeletal pain accompanied by fatigue, sleep, memory, and mood issues), weakness (lacking strength), unspecified abnormalities of gait (any deviations from normal walking or gait) and mobility and spinal stenosis (space inside the backbone is too small and can cause pain, tingling and weakness). Record review of Resident #18's quarterly MDS assessment with an ARD of 03/21/2024 reflected he scored a 10/15 on his BIMS which signified he was moderately cognitively impaired. He could understand and be understood. He required a manual wheelchair and could move independently. Record review of Resident #18's comprehensive person-centered care plan dated 08/14/2023 reflected Problem, ADLs Functional Status/Rehabilitation Potential, Approach, promote dignity, assist with ADL's as needed. Observation on 05/14/2024 at 10:15 a.m. of Resident #18, he was sitting in his wheelchair, and both the armrests had torn and worn vinyl and the left armrest was missing foam which exposed the baseboard. During an interview on 05/14/2024 at 10:17 a.m. with Resident #18, he stated he had the wheelchair since his admission and the vinyl was worn and torn. He stated he did not want to bother the staff and did not complain. (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview on 05/16/2024 at 11:59 a.m. with the RNC, she stated worn and torn armrest on resident's wheelchairs were a safety and dignity issue. She stated she had only been at the facility for less than a year and the company just hired a DON who had not started work. She stated she was not aware and had not noticed the resident wheelchairs needed armrests replaced or repaired. She stated if staff saw something that required repair they needed to write it down in the Maintenance book at the nurse's station, and she presumed no one had noticed since the residents did not complain. She stated she would get them replaced right away. She stated she was not aware of any injuries from the torn vinyl on the armrests, but the potential was there. Observation on 05/17/2024 of Resident #18 at 3:00 p.m. sitting in his wheelchair in the 300 halls, he had new armrests. The new armrests were the result of the surveyor intervention, who spoke with the RNC on 05/16/2024 about the torn and worn armrests. During an interview on 05/17/2024 at 3:02 p.m. with Resident #18, he stated the new armrests on his wheelchair were soft and comfortable, and he felt much better. The Maintenance Director was not available for interview. Record review of the facility incident and accident reports from 03/1/2024 to 05/01/2024 reflected residents had skin tears, but not related to any equipment issues. Upon Request on 05/16/2024 of the RNC, the facility did not provide a policy or procedure to address safe equipment or maintenance of wheelchairs. Record review of the facility policy and procedure titled Equipment-General Use for All Residents dated revised August 2006 reflected Our facility shall provide routine equipment for the general use of the resident population.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record review, the facility failed to provide a minimum of 80 square feet per resident for residents in 10 of 10 multiple occupancy resident rooms (Rooms 109, 111, 112, 201, 204, 209, 210, 211, 315, and 317). Rooms 109, 111, 112, 201, 204, 209, 210, 211, 315, and 317 did not have the required 80 square feet per resident. This deficient practice could affect the residents placed in these multiple occupancy rooms and place them at-risk by reducing their living space and posing problems in their activities of daily living. The findings were: Record review of Form 3740 Bed Classifications, completed by the Administrator on 2/26/2020, revealed rooms 109, 111, 112, 201, 204, 209, 210, 211, 315 and 317 were classified to have 3 resident beds in each room. Observation on 02/26/2020 from 11:00 AM to 11:17 AM with the Maintenance Director revealed the measurements of the rooms 109, 111, 112, 201, 204, 209, 210, 211, 315 and 317 were as follows: 1. room [ROOM NUMBER] (3person room - 2 residents in room) 73.9 sq. ft/resident 2. room [ROOM NUMBER] (3-person room - 2 residents in room) 73.6 sq. ft/resident 3. room [ROOM NUMBER] (3-person room - 0 residents in room) 73.8 sq. ft/resident 4. room [ROOM NUMBER] (3-person room - 2 resident in room) 74.2 sq. ft/resident 5. room [ROOM NUMBER] (3-person room - 0 residents in room) 73.7 sq. ft/resident 6. room [ROOM NUMBER] (3-person room - 0 residents in room) 73.7 sq. ft/resident 7. room [ROOM NUMBER] (3-person room - 0 residents in room) 74.3 sq. ft/resident 8. room [ROOM NUMBER] (3-person room - 0 residents in room) 73.3 sq. ft/resident 9. room [ROOM NUMBER] (3-person room - 2 residents in room) 74 sq. ft/resident 10. room [ROOM NUMBER] (3-person room - 1 residents in room) 73.7 sq. ft/resident Interview on 5/15/24 at 4:37 PM with the Maintenance director stated still need room waivers for rooms 109, 111, 112, 201, 204, 209, 210 , 211, 315 and 317.		