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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675277	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Inn of LA Grange	457 N Main St LA Grange, TX 78945

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to consult with the resident's physician when there was a need for an in and out catheter and a foley catheter for 1 (Resident #1) of three residents reviewed for physician notification. 'The facility failed to notify Resident #1's provider of the need for in and out catheter and for a foley catheter on 12/21/2025.This failure could result in decreased continuity of care, and a delay in needed treatment and services. Findings include:Record review of Resident #1's face sheet, dated 1/13/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic kidney disease, stage 3B (kidneys had moderate to severe damage, filtering blood at 30-44% of normal, indicated by an eGFR of 30-44 ml/min, requiring closer management to slow progression, with potential symptoms such as: swelling, fatigue, or changes in urination, and increased risk of complications of blood pressure), gout due to renal impairment, multiple sites (a form of arthritis caused by the accumulation of uric acid crystals in several joints of the body, where the root cause of this buildup is a problems with the kidney's ability to filter out uric acid), and vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (caused by damage to blood vessels in the brain which disrupts blood flow and deprives brain cells of oxygen and nutrients without any behavior symptoms). Record review of Resident #1's Quarterly MDS Assessment, dated 10/22/2025, reflected Resident #1 had a BIMS score of 99, which indicated Resident #1 was unable to complete the interview. He had poor short- and long-term memory recall. Resident #1's decision making ability was severely impaired. He was dependent on staff with hygiene, showers, dressing, and transfers. Resident #1 was incontinent of bowel and bladder.Record review of Resident #1's Comprehensive Care Plan, reflected Resident #1 had chronic kidney disease and at risk for kidney failure, fluid overload, and electrolyte imbalance. Interventions: Diet as ordered. Monitor labs per orders and report to Medical Doctor. Provide good skin care. Weigh Resident #1 per orders. Resident #1 had hypertension (abnormally high blood pressure) and was at risk for renal failure (when your kidneys can no longer effectively filter waste, extra fluid, and minerals from your blood, leading to dangerous buildup in the body), and was at risk renal failure (when your kidneys can no longer effectively filter waste, extra fluids, and minerals from blood). Interventions: Encourage adequate fluid intake and a healthy diet. Give medications as ordered. Monitor and document any edema (swelling caused by excess fluid). Monitor and document abnormalities for urinary output. Report significant changes to the MD. Monitor, document and report to MD as needed any signs and symptoms of dizziness, fainting, lack of concentration, blurred vision, nausea, fatigue, and/or cold clammy pale skin. Monitor/ document/ report to MD as needed any signs or symptoms of hypertension, headache, confusion, lethargy, vomiting, and/or irritability. Resident #1 had potential fluid volume deficient related to inadequate intake, reduced activity, and fluid loss. Intervention: Encourage fluids. Evaluate and (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer IV hydration as prescribed. Monitor intake/output and hydration markers. Labs per orders. Record review of Resident #1's nurses notes, dated 12/21/2025 at 3:14 p.m., reflected collected U/a (collected urine) using sterile technique, using in and out catheter; Resident #1 noted to have 1000ml of tea color urine with sediment and odor; 16 Fr with 10 mL balloon inserted at this time. Will continue with plan of care. Signed by RN A.Record review of Resident #1's nurses notes, dated 12/21/2025 at 6:57 p.m., reflected Resident #1 had output in foley catheter 400 mL of amber urine with mucus; will continue with plan of care.Record review of Resident #1's physician orders for the month of November and December 2025 reflected Resident #1 did not have a physician order or an in and out catheter or for a foley catheter.Record review of Resident #1 nurses' notes dated 12/21/2025 at 2:47 pm, reflected on call physician was contacted and new orders received to collect U/A.Interview on 01/13/2026 at 9:55 a.m., RN A stated Resident #1 needed an in and out catheter to obtain urine for U/A. She stated Resident #1 was having difficulty with the in and out catheter and she inserted a foley catheter. RN A stated she did not contact the physician for the in and out catheter or the foley catheter. She stated this was a protocol to contact the physician anytime a resident may need a catheter. RN A stated she made a mistake, and she had been in-service on obtaining physician orders anytime a resident needed an IV, catheter or any type of new treatment. RN A stated there was a possibility Resident #1 did not need a catheter or the physician may have wanted another type of treatment. She did not recall the date of the in-service. Interview on 01/13/2026 at 1:30 p.m., the ADON stated RN A was expected to contact the physician to obtain a physician order for the in and out catheter and the foley catheter. She stated the physician orders were to ensure care was not missed and possibly the care may need to be monitored, and this would need to be documented on the physician order. The ADON stated anytime a resident needed any type of medical device the physician was to make that decision upon what the nurse reported to the physician about the resident's physical status. She stated there was not a physician order for an in and out catheter or for a foley catheter and there was not any documentation indicated the physician was contacted about Resident #1 needing catheters.Interview on 01/13/2026 at 3:15 pm the Medical Doctor stated Resident #1 health was declining and if he was transferred to the hospital any sooner it would not have made a difference in his overall physical condition. He stated antibiotics would not have helped him with UTI (urinary tract infection and sepsis) his diagnosis when he was admitted to the hospital on [DATE]. He stated he was not notified of Resident #1 needing any type of catheter. The Medical Doctor did not respond to any further questions about the catheters.Record review of the facility's Policy on Physician Orders, dated 2001, reflected The purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services. Physician orders are essential for the comprehensive care of the residents.

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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** Based on interview and record review the facility failed to ensure, a resident based on comprehensive assessment of a resident, that the resident received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan, and the residents' choices for one of four residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1 had orders for in and out catheter and a foley catheter when resident began retaining urine on 12/21/2025. This deficient practice could place residents at risk of not receiving adequate care, harm, or injuries. Findings include:Record review of Resident #1's face sheet, dated 1/13/2026, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included chronic kidney disease, stage 3B (kidneys had moderate to severe damage, filtering blood at 30-44% of normal, indicated by an eGFR of 30-44 ml/min, requiring closer management to slow progression, with potential symptoms such as: swelling, fatigue, or changes in urination, and increased risk of complications of blood pressure), gout due to renal impairment, multiple sites (a form of arthritis caused by the accumulation of uric acid crystals in several joints of the body, where the root cause of this buildup is a problems with the kidney's ability to filter out uric acid), and vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (caused by damage to blood vessels in the brain which disrupts blood flow and deprives brain cells of oxygen and nutrients without any behavior symptoms).Record review of Resident #1's Quarterly MDS Assessment, dated 10/22/2025, reflected Resident #1 had a BIMS score of 99, which indicated Resident #1 was unable to complete the interview. He had poor short- and long-term memory recall. Resident #1's decision making ability was severely impaired. He was dependent on staff with hygiene, showers, dressing, and transfers. Resident #1 was incontinent of bowel and bladder.Record review of Resident #1's Comprehensive Care Plan, reflected Resident #1 had chronic kidney disease and at risk for kidney failure, fluid overload, and electrolyte imbalance. Interventions: Diet as ordered. Monitor labs per orders and report to Medical Doctor. Provide good skin care. Weigh Resident #1 per orders. Resident #1 had hypertension (abnormally high blood pressure) and was at risk for renal failure (when your kidneys can no longer effectively filter waste, extra fluid, and minerals from your blood, leading to dangerous buildup in the body), and was at risk renal failure (when your kidneys can no longer effectively filter waste, extra fluids, and minerals from blood). Interventions: Encourage adequate fluid intake and a healthy diet. Give medications as ordered. Monitor and document any edema (swelling caused by excess fluid). Monitor and document abnormalities for urinary output. Report significant changes to the MD. Monitor, document and report to MD as needed any signs and symptoms of dizziness, fainting, lack of concentration, blurred vision, nausea, fatigue, and/or cold clammy pale skin. Monitor/ document/ report to MD as needed any signs or symptoms of hypertension, headache, confusion, lethargy, vomiting, and/or irritability. Resident #1 had potential fluid volume deficient related to inadequate intake, reduced activity, and fluid loss. Intervention: Encourage fluids. Evaluate and administer IV hydration as prescribed. Monitor intake/output and hydration markers. Labs per orders.Record review of Resident #1's nurses notes, dated 12/21/2025 at 3:14 p.m., reflected collected U/a (collected urine) using sterile technique, using in and out catheter; Resident #1 noted to have 1000ml of tea color urine with sediment and odor; 16 Fr with 10 mL balloon inserted at this time. Will continue with plan of care. Signed by RN A.Record review of Resident #1's nurses notes, dated 12/21/2025 at 6:57 p.m., reflected Resident #1 had output in foley catheter 400 mL of amber urine with mucus; will continue with plan of care.Record review of Resident #1's physician orders for the month of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November and December 2025 reflected Resident #1 did not have a physician order or an in and out catheter or for a foley catheter. Record review of Resident #1 nurses' notes dated 12/21/2025 at 2:47 pm, reflected on call physician was contacted and new orders received to collect U/A. Interview on 01/13/2026 at 9:55 a.m., RN A stated Resident #1 needed an in and out catheter to obtain urine for U/A. She stated Resident #1 was having difficulty with the in and out catheter and she inserted a foley catheter. RN A stated she did not contact the physician for the in and out catheter or the foley catheter. She stated this was a protocol to contact the physician anytime a resident may need a catheter. RN A stated she made a mistake, and she had been in-service on obtaining physician orders anytime a resident needed an IV, catheter or any type of new treatment. RN A stated there was a possibility Resident #1 did not need a catheter or the physician may have wanted another type of treatment. She did not recall the date of the in-service.Interview on 01/13/2026 at 1:30 p.m., the ADON stated RN A was expected to contact the physician to obtain a physician order for the in and out catheter and the foley catheter. She stated the physician orders were to ensure care was not missed and possibly the care may need to be monitored, and this would need to be documented on the physician order. The ADON stated anytime a resident needed any type of medical device the physician was to make that decision upon what the nurse reported to the physician about the resident's physical status. She stated there was not a physician order for an in and out catheter or for a foley catheter and there was not any documentation indicated the physician was contacted about Resident #1 needing catheters.Interview on 01/13/2026 at 3:15 pm the Medical Doctor stated Resident #1 health was declining and if he was transferred to the hospital any sooner it would not have made a difference in his overall physical condition. He stated antibiotics would not have helped him with UTI (urinary tract infection and sepsis) his diagnosis when he was admitted to the hospital on [DATE]. Record review of the facility's Policy on Physician Orders, dated 2001, reflected The purpose of this procedure is to establish uniform guidelines in the receiving and recording of physician orders to ensure the resident receives the necessary care and services. Physician orders are essential for the comprehensive care of the residents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 1 of 2 medication carts (Medication Cart #1) reviewed for medication storage. The facility failed to ensure Medication Cart #1 was locked and medications were secure and not accessible to other staff, residents or visitors.This failure could place residents at risk of having unauthorized access to prescriptions, biologicals, and over-the-counter medications. Findings include:Observation on 01/13/2026 at 8:35 AM revealed medication cart #1 was unlocked against the wall near the entrance to the dining room. The back of the cart was against the wall with the drawers facing the hallway. The locking mechanism was protruding outward on the medication cart. The State Surveyor opened the drawers and captured photos. The nurse responsible (RN A) for the medication cart was in the dining room passing out meal trays to residents and unable to view the medication cart.Observation on 01/13/2026 at 8:43 a.m. revealed RN A walked from the dining room toward the unlocked medication cart #1. There were visitors walking down the hall near the unlocked medication cart #1.Interview on 01/13/2026 at 8:45 a.m., RN A stated she thought she had locked the medication cart before she entered the dining room to assist with the breakfast meal. She stated she could not believe the cart was unlocked. RN A stated she had the only set of keys for that cart. She stated residents and visitors had access to the medications in the medication cart. RN A stated if a resident had ingested another residents' medications there was a possibility the resident may overdose, have an allergic reaction, and may require further care at the hospital. RN A stated there was a possibility a resident may die from ingesting another residents' medication. She stated she was in-serviced on locking medication carts when she was not obtaining medications from the cart. RN A stated she did not recall the date of the in-service.Interview on 01/13/2026 at 3:15 p.m., the Director of Nurses stated the medication carts were expected to be locked unless the nurse was standing at the cart administering medications. She stated if the medication carts were in the hallway and the nurse was not standing at the medication cart there it was expected to be locked, no exceptions. She stated a resident had the opportunity to take medications out of the medication cart and if the resident ingested the medications there was a potential a resident may be allergic or overdose on another resident's medications. The Director of Nurses stated there was a possibility the medication could have an interaction with the current medication the resident had been prescribed and may cause a resident to need hospitalization for further assessment and treatment. She stated it was a possibility a resident may die if they were severely allergic to the medication. She stated the staff were in-serviced on locking medication carts. She did not recall the date of the in-service.Record review of the facility's policy on Medication Labeling and Storage, dated 2001, reflected The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.