STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675391	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Arbor	705 Hwy 418 W Silsbee, TX 77656

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse for 4 of 6 residents (Resident #2, Resident #3, Resident #4 and Resident #5) reviewed for abuse. 1. The facility failed to ensure Resident #2 was free from physical abuse when Resident #2 was slapped on the neck by Resident #3 on 01/21/2025. 2. The facility failed to ensure Resident #2 was free from physical abuse when Resident #2 was punched on the arm by Resident #3 on 05/18/2025. 3. The facility failed to ensure Resident #5 was free from physical abuse when Resident #4 pushed Resident #5 causing him to fall on 07/02/2025. These failures could place residents at risk for emotional distress, fear, decreased quality of life and further abuse.Findings included: Resident #2Record review of Resident #2's admission Record dated 09/08/2025 indicated she was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses which included Huntington's disease (causes nerve cells in the brain to decay over time and the disease affects a person's movements, thinking ability and mental health), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), anxiety disorder (persistent and excessive worry that interferes with daily activities), and muscle spasms. Record review of Resident #2's quarterly MDS assessment, dated 04/09/2025, indicated resident had a BIMS score of 07 which indicated she had severely impaired cognition and was sometimes able to make self-understood and usually understood others. She had no behaviors indicated. The functional abilities self-care indicated she required partial assistance with eating, oral care, upper body dressing and required maximal assistance with shower/bathing, lower body dressing, putting on/taking of footwear and personal hygiene. The Functional abilities mobility indicated she required maximum assistance with all tasks except walking greater than 50 feet which required totally dependent and used a manual wheelchair for mobility. Record review of Resident #2's care plan, dated 02/04/2025, indicated she had diagnosis of schizophrenia of a bipolar type with psychotic features, Huntington's disease and is at risk for disturbed thought processes, and alteration in mood or exhibitions of behavioral symptoms. She has potential for impaired skin related to risk of falls, involuntary movements related to Huntington's Disease and alteration in musculoskeletal status related to Huntington's Disease. Interventions included communication techniques, effective strategies, monitor for confounding problems, frustration levels, physical/nonverbal indications, monitor and document behaviors, 1:1 interaction as needed, administer medications as needed, referrals for therapy and psych services and report to MD if changes were identified. Resident #3Record review of Resident #3's admission Record dated 09/09/2025 indicated he was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses which included including Alcohol induced Dementia (loss of cognitive functioning), psychosis disorder (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), anxiety disorder (persistent and excessive worry that interferes with daily activities) and depressive disorder (mental illness that negatively affects how you feel, the way you think and how you act). He was discharged on 06/11/2025 to an acute care behavioral hospital. Record review of Resident #3's quarterly MDS assessment, dated 05/08/2025, indicated he had a BIMS score of 03 which indicated he had severely impaired cognition and was sometimes able to make self-understood and sometimes understood others. He had behaviors of inattention and disorganized thinking which fluctuates (comes and goes, changes in severity). The functional abilities self-care indicated he required set-up or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral care, upper body dressing, shower/bathing, lower body dressing, putting on/taking of footwear and personal hygiene. The Functional abilities mobility indicated he required set-up or clean up assistance with all tasks and used a manual wheelchair for mobility. Record review of Resident #3's care plan, dated 02/04/2025, indicated he had episodes of inappropriate behaviors and is at risk for further increased episodes and injury related to dementia with behaviors and psychosis. Interventions included communication techniques, redirection, effective strategies, monitor for confounding problems, frustration levels, physical/nonverbal

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all alleged violations involving abuse were reported, immediately but not later than 2 hours after the allegation was made, if the events that cause the allegation involves abuse or results in serious bodily injury, to the State Survey Agency for 1 of 5 residents (Residents #2) reviewed for reporting allegations of abuse. The facility failed to report an allegation of abuse to the state agency within 2 hours after Resident #3 punched Resident #2 in the arm on 05/18/2025. The failures could place residents at risk of not having allegations reported within the required timeframes. Findings included: Record review of Resident #2's admission Record dated 09/08/2025 indicated she was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses which included Huntington's disease (causes nerve cells in the brain to decay over time and the disease affects a person's movements, thinking ability and mental health), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), anxiety disorder (persistent and excessive worry that interferes with daily activities), and muscle spasms. Record review of Resident #2's quarterly MDS assessment, dated 04/09/2025, indicated she had a BIMS score of 07 which indicated she had severely impaired cognition and was sometimes able to make self-understood and usually understood others. She had no behaviors indicated. The functional abilities self-care indicated she required partial assistance with eating, oral care, upper body dressing and required maximal assistance with shower/bathing, lower body dressing, putting on/taking of footwear and personal hygiene. The Functional abilities mobility indicated she required maximum assistance with all tasks except walking greater than 50 feet which required totally dependent and used a manual wheelchair for mobility. Record review of Resident #2's care plan, dated 02/04/2025, indicated she had diagnosis of schizophrenia of a bipolar type with psychotic features, Huntington's disease and is at risk for disturbed thought processes, and alteration in mood or exhibitions of behavioral symptoms. She has potential for impaired skin related to risk of falls; involuntary movements related to Huntington's Disease and alteration in musculoskeletal status related to Huntington's Disease. Interventions included communication techniques, effective strategies, monitor for confounding problems, frustration levels, physical/nonverbal indications, monitor and document behaviors, 1:1 interaction as needed, administer medications as needed, referrals for therapy and psych services and report to MD if changes were identified. Record review of Resident #3's admission Record dated 09/09/2025 indicated he was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses which included including Alcohol induced Dementia (loss of cognitive functioning), psychosis disorder (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), anxiety disorder (persistent and excessive worry that interferes with daily activities) and depressive disorder (mental illness that negatively affects how you feel, the way you think and how you act). He was discharged on 06/11/2025 to an acute care behavioral hospital. Record review of Resident #3's quarterly MDS assessment, dated 05/08/2025, indicated he had a BIMS score of 03 which indicated he had severely impaired cognition and was sometimes able to make self-understood and sometimes understood others. He had behaviors of inattention and disorganized thinking which fluctuates (comes and goes, changes in severity). The functional abilities self-care indicated he required set-up or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral care, upper body dressing, shower/bathing, lower body dressing, putting on/taking of footwear and personal hygiene. The Functional abilities mobility indicated he required set-up or clean up assistance with all tasks and used a manual wheelchair for mobility. Record review of Resident #3's care plan, dated 02/04/2025, indicated he had episodes of inappropriate behaviors and is at risk for further increased episodes and injury related to dementia with behaviors and psychosis. Interventions included communication techniques, redirection, effective strategies, monitor for confounding problems, frustration levels, physical/nonverbal indications, monitor and document behaviors, 1:1 interaction as needed, administer medications as needed, referrals for

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment, were thoroughly investigated for 4 of 6 residents (Resident #2, Resident #3, Resident #4 and Resident #5) reviewed for abuse and neglect. 1. The facility did not thoroughly investigate an incident in which Resident #2 was slapped on the neck by Resident #3 on 01/21/2025. 2. The facility did not investigate an incident in which Resident #2 was punched on the arm by Resident #3 on 05/18/2025. 3. The facility did not thoroughly investigate an incident in which Resident #4 pushed Resident #5 causing him to fall on 07/02/2025. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: Resident #2Record review of Resident #2's admission Record dated 09/08/2025 indicated she was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses which included Huntington's disease (causes nerve cells in the brain to decay over time and the disease affects a person's movements, thinking ability and mental health), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), anxiety disorder (persistent and excessive worry that interferes with daily activities), and muscle spasms. Record review of Resident #2's quarterly MDS assessment, dated 04/09/2025, indicated resident had a BIMS score of 07 which indicated she had severely impaired cognition and was sometimes able to make self-understood and usually understood others. She had no behaviors indicated. The functional abilities self-care indicated she required partial assistance with eating, oral care, upper body dressing and required maximal assistance with shower/bathing, lower body dressing, putting on/taking of footwear and personal hygiene. The Functional abilities mobility indicated she required maximum assistance with all tasks except walking greater than 50 feet which required totally dependent and used a manual wheelchair for mobility. Record review of Resident #2's care plan, dated 02/04/2025, indicated she had diagnosis of schizophrenia of a bipolar type with psychotic features, Huntington's disease and is at risk for disturbed thought processes, and alteration in mood or exhibitions of behavioral symptoms. She has potential for impaired skin related to risk of falls; involuntary movements related to Huntington's Disease and alteration in musculoskeletal status related to Huntington's Disease. Interventions included communication techniques, effective strategies, monitor for confounding problems, frustration levels, physical/nonverbal indications, monitor and document behaviors, 1:1 interaction as needed, administer medications as needed, referrals for therapy and psych services and report to MD if changes were identified. Resident #3Record review of Resident #3's admission Record dated 09/09/2025 indicated he was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses which included including Alcohol induced Dementia (loss of cognitive functioning), psychosis disorder (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), anxiety disorder (persistent and excessive worry that interferes with daily activities) and depressive disorder (mental illness that negatively affects how you feel, the way you think and how you act). He was discharged on 06/11/2025 to an acute care behavioral hospital. Record review of Resident #3's quarterly MDS assessment, dated 05/08/2025, indicated resident had a BIMS score of 03 which indicated he had severely impaired cognition and was sometimes able to make self-understood and sometimes understood others. He had behaviors of inattention and disorganized thinking which fluctuates (comes and goes, changes in severity). The functional abilities self-care indicated he required set-up or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral care, upper body dressing, shower/bathing, lower body dressing, putting on/taking of footwear and personal hygiene. The Functional abilities mobility indicated he required set-up or clean up assistance with all tasks and used a manual wheelchair for mobility. Record review of Resident #3's care plan, dated 02/04/2025, indicated he had episodes of inappropriate behaviors and is at risk for further increased episodes and injury related to dementia with behaviors and psychosis. Interventions included communication techniques, redirection, effective strategies, monitor for confounding problems

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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 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. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to review and revise resident's comprehensive care plans by the interdisciplinary team after each assessment to reflect the current condition for 2 of 12 (Resident #2 and Resident #3) residents reviewed for comprehensive care plans. The facility failed to ensure Resident #2's care plan was updated to indicate Resident #2 had received aggression during a resident-to-resident incident on 01/21/2025 and 05/18/2025. The facility failed to ensure Resident #3's care plan was updated to indicate Resident #3 had an incident of resident-to-resident aggression on 01/21/2025 and 05/18/2025. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: Resident #2Record review of Resident #2's admission Record dated 09/08/2025 indicated she was a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses which included Huntington's disease (causes nerve cells in the brain to decay over time and the disease affects a person's movements, thinking ability and mental health), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), anxiety disorder (persistent and excessive worry that interferes with daily activities), and muscle spasms. Record review of Resident #2's quarterly MDS assessment, dated 04/09/2025, indicated she had a BIMS score of 07 which indicated she had severely impaired cognition and was sometimes able to make self-understood and usually understood others. She had no behaviors indicated during the 7 day look back period prior to completing the MDS assessment. The functional abilities self-care indicated she required partial assistance with eating, oral care, upper body dressing and required maximal assistance with shower/bathing, lower body dressing, putting on/taking of footwear and personal hygiene. The Functional abilities mobility indicated she required maximum assistance with all tasks except walking greater than 50 feet which required totally dependent and used a manual wheelchair for mobility. Record review of Resident #2's care plan, dated 02/04/2025, indicated she had history of alteration in mood or exhibition of behavioral symptoms related to bipolar disorder, major depressive disorder, anxiety, schizoaffective disorder and behavioral problems regarding smoking and smoking times. Interventions included communication techniques, effective strategies, monitor for confounding problems, frustration levels, physical/nonverbal indications, monitor and document behaviors, 1:1 interaction as needed, administer medications as needed, referrals for therapy and psych services and report to MD if changes were identified. The care plan did not indicate Resident #2 had an updated or revised care plan for receiving aggressive behavior from another resident during a resident-to-resident aggression on 01/21/2025, 05/18/2025 and/or updated or revised care plan for behavior problems of voicing suicidal ideation related to smoking break omitted due to weather conditions Resident #3Record review of Resident #3's admission Record dated 09/09/2025 indicated he was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses which included including Alcohol induced Dementia (loss of cognitive functioning), psychosis disorder (a severe mental condition in which thoughts and emotions are so affected that contact is lost with external reality), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), anxiety disorder (persistent and excessive worry that interferes with daily activities) and depressive disorder (mental illness that negatively affects how you feel, the way you think and how you act). He was discharged on 06/11/2025 to an acute care behavioral hospital. Record review of Resident #3's quarterly MDS assessment, dated 05/08/2025, indicated he had a BIMS score of 03 which indicated he had severely impaired cognition and was sometimes able to make self-understood and sometimes understood others. He had behaviors of inattention and disorganized thinking which fluctuates (comes and goes, changes in severity). The functional abilities self-care indicated he required set-up or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral care, upper body dressing, shower/bathing, lower body dressing, putting on/taking of footwear and personal hygiene. The Functional abilities mobility indicated he required set-up or clean up assistance with all tasks and used a manual wheelchair for mobility. Record review of Resident #3's care plan, dated 02/04/2025, indicated he had episodes of behavioral problems at times and

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 3 residents reviewed for accidents and supervision. (Resident #1)The facility failed to provide adequate supervision for Resident #1 who was assessed as a high risk for elopement. On 03/23/25 CNA B who was assigned to cover the unit left the unit leaving the residents unattended. Resident #1 eloped from the unit and was found at his previous home address sitting on the porch steps approximately 1 mile from the facility. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 03/23/25 and ended on 03/27/25. The facility had corrected the non-compliance before the survey began. This failure could prevent residents from receiving appropriate supervision which could lead to resident sustaining serious injury or harm. Findings included: Record review of a face sheet dated 09/09/25 indicated Resident #1 was a [AGE] year-old male admitted on [DATE]. His diagnosis included dementia (loss of cognitive functioning), hypertension (a condition in which the force of the blood against the artery walls is too high), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar), anxiety (persistent and excessive worry that interferes with daily activities) , and depression (mental illness that negatively affects how you feel, the way you think and how you act). Record review of a Baseline Care Plan dated 03/17/25 indicated Resident #1 resided on the secured unit with an intervention to conduct frequent checks on the resident, especially during high-risk times and he was at risk for elopement with an intervention to monitor resident. Record review of a Clinical Risk assessment dated [DATE] the Elopement Risk section indicated Resident #1 was a high risk. Record review of an admission MDS form dated 03/27/25 indicated Resident #1 had a BIMS score of 07 indicating he had severely impaired cognition. He had clear speech and understood others. He had other behavioral symptoms not directed towards others that occurred 1 to 3 days during the lookback period. He had no impairment of the upper and lower extremities. He used no mobility devices. The Functional self-care assessment indicated supervision/touching assistance with most ADLs. The Functional mobility assessment indicated he required supervision/touching assistance with ambulation. Record review of Nurse Notes for Resident #1 indicated the following:* an entry on 3/21/25 at 05:56 a.m., Resident restless this shift. Residing on memory care unit, attempted to follow RCS off unit and began banging on the double doors. Resident had been observed pacing from double doors back to room stating that he needs to go home. Resident upset that he is locked behind double doors. Writer was able to talk to and calm resident at this time.* an entry on 3/22/25 at 06:00 a.m., Resident resides on memory care unit. Resident does not understand why he is locked up and wants to go home and will stand at double doors in an attempt to walk out with someone.* an entry on 3/23/25 at 05:02 p.m., Patient was observed being aggressive today, patient banged on doors today. Nurse observed patient throwing belongings on the floor, when asked patient what was wrong, patient stated aggressively to leave him alone and to get out the room. Nurse was able to give patient his morning medications. Nurse continued to monitor and do routine rounds on patient. Patient continued to bang on unit doors, nurse redirected patient and explained to patient that he couldn't bang on doors, patient started hallucination sand told nurse that his mother was on the other side, and he needed to get to her. Nurse went to do routine round on patient, patient was not in room or any of the available beds on the unit, nurse notified administrator, DON, ADON to let them know that patient was not on the unit. Observed findings of a chair near fence that is said to believe what patient used to climb over fence, available Staff immediately took action, loaded cars to look for patient. Patient was found at last known address sitting on his porch, patient was not hurt, no bruising noted. Patient was accompanied by three staff members, patient refused to load the vehicle, after advising him that we need to get him home to safety, patient reconsidered and got in the vehicle. Patient was transported back to facility and was assessed by nurse, patient does not c/o any pain at this time, when asked patient what he was doing out he said that he needed to go to his mother house and cook for tomorrow, but he is back to facility now. Family Notified and is fully aware and was not upset about the situation. Family agreed to send patient out.Record review of a Provider Investigation Report dated 03/27/25 indicated the following:* LVN C reported that she saw Resident #1 at approximately 3:00pm and he was banging on the locked doors. She went to the door and calmed him down by talking to him.* At about 3:15pm, LVN C rounded on the unit and did not find Resident #1. LVN C and LVN F went directly to the unit to check on the two residents that were residing in the unit. They couldn't find Resident #1 in his room on the

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675391	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Arbor	705 Hwy 418 W Silsbee, TX 77656

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 1 of 4 residents (Resident #6) reviewed for controlled medications. * LVN X and RN Y did not count the narcotic medications during the shift change to ensure the count was correct and all narcotics had an Inventory Sheet. * Resident #6's hydrocodone 5 mg /acetaminophen 325 mg (narcotic pain medication for moderate or severe pain) were not counted and did not have an Inventory Sheet on 10/04/24. This failure could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. Findings included: Record review of the face sheet dated 09/10/25 indicated Resident #6 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included fracture of the hip (broken bone in the hip). Record review of the MDS dated [DATE] indicated Resident #6 was able to hear without difficulty, able to be understood and could understand others, had clear speech, had severely impaired cognition, and received opioid medications. Record review of the September and October 2024 physician orders indicated Resident #6 had an order for hydrocodone 5 mg /acetaminophen 325 mg. Record review of the September and October 2024 MARs indicated Resident #6 had received hydrocodone 7.5mg /acetaminophen 325 mg. Record review of the Provider Investigation Report dated 10/09/24 indicated: .On 10/04/24 at 1:00 p.m., the Administrator was notified that we had an alleged drug diversion involving Resident #6's hydrocodone 5/325, per [RP]'s statement to Administrator and DON, he stated he brought the pills up to the building on 09/29/24, the pills were counted by charge nurses LVN W and UM and there were 84 total pills and narcotic sheet was created. We received the blister pack for the resident's pain medication and only one has been given from it and there is a [narcotic] sheet for them. And this pill is accounted for. Furthermore, the [RP] stated he had received a call yesterday to come pick up the bottle of pills and today at around 10:30 am, he asked the nurse for the pills. The resident's [RP] counted the pills at the nurses' station after the nurse LVN X stated she counted 62 pills, and he counted 42. So initially, we were missing 20 pills. Further investigation revealed, LVN W in her statement said there were 76 on 10/3/24 when she counted with RN Y. Again, according to LVN W she stated the count yesterday was 76; however, the MAR only shows 5 given out of the bottle. The [narcotic] sheet is missing for the bottle of pills, but it was in the building yesterday per LVN W and RN Y who counted together last night on 10/03/24. RN Y stated she did not count with the nurse, LVN X day charge nurse on 10/04/24. But she stated she did count with LVN W. Hence, there is a discrepancy of 76 minus 42 is 34 missing pills, yet 84 minus 5 which show on the MAR is 79, but the count was 76. Hence, the total number of pills missing from the pill bottle is 37. The bottle was signed back to the [RP] and taken home with him. During an interview on 09/09/25 at 02:05 p.m. the UM said she and LVN W had counted Resident #6's hydrocodone/acetaminophen when the resident's husband brought them the bottle to the facility. She said she made a count sheet since it was from an outside pharmacy and did not have a count sheet. She said she remember there was eighty something tablets in the bottle. During an interview on 09/09/25 at 02:35 p. m. the DON said during the investigation RN Y admitted she did not count with LVN X at shift change but accepted the keys for the narcotics. She said both nurses were drug tested and suspended. She said RN Y was negative, but LVN X tested positive for other substances than the opioid. She said LVN X quit. She said she expected nurses to always count the narcotics before accepting the keys to the cart. She said not counting them could lead to medication not being administered to the resident. She said not having the Inventory Sheet for a narcotic could lead to drug diversion. During an interview on 09/09/25 at 04:25 p.m. the Administrator said she expected staff to follow policy regarding narcotic medications to prevent drug diversions and ensure residents receive their medication. Attempts were made to contact LVN X but recording indicated the caller was not taking calls. Attempts were made to contact RN Y and a message was left with no return call. Record review of the Narcotic Count policy revised 11/22 indicated the following: Policy: It is the policy of this facility to mitigate the risk of drug diversion by developing, implementing, and maintaining a narcotic count process. Procedures: The Narcotic Count and Inventory: 1. Controlled drugs will be counted every eight (8) - or twelve (12) -hour shift by authorized staff reporting on duty with the authorized staff reporting off duty.2. The inventory of controlled substances/drugs will be recorded on the Narcotic Records and signed for correctness of count Process:1. At the end of every eight (8) - or twelve (12) -hour