| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675391 | A. Building<br>B. Wing | 11/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Pine Arbor | 705 Hwy 418 W<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>(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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 2 of 5 residents (Resident #1 and Resident #2) reviewed for medical records accuracy. The facility did not accurately document every time Resident #1, and Resident #2 was provided with incontinent care or checked for incontinence on the CNA flow sheet dated November 2025. This failure could affect residents whose records are maintained by the facility and could place them at risk for not receiving needed care and treatment. The findings included: Record review of Resident #1's face sheet indicated she was admitted on [DATE] was a [AGE] year-old female with diagnosis including stroke and high blood sugar. Record review of the significant change MDS assessment dated [DATE] indicated Resident #1 required total care for toileting hygiene per staff. She was always incontinent with bowel and bladder. Resident #1's BIMS was 03 which indicated severely impaired cognition. Record review of Resident #1's care plan dated 10/13/25 indicated she was incontinent of bladder and bowel and required routine rounding to include incontinence care and brief changes. Record review of Resident #1's November 2025 CNA flowsheet had documentation to indicated she was frequently checked however with no documentation to indicate she was provided with incontinent care. Record review of Resident #2's face sheet indicated a [AGE] year-old female admitted to facility on 11/30/2018, with diagnosis including stroke and gastric tube feedings. Record review of the annual MDS assessment dated [DATE] indicated Resident #2's BIMS score was 00, which indicated severe impairment for cognitive abilities. Resident #2 required total care for toileting hygiene per staff. She was always incontinent with bowel and bladder. Record review of Resident #2's care plan dated 08/05/25 indicated a history of bladder and bowel incontinence and required routine rounding to include incontinence care and brief changes. Record review of Resident #2's CNA flowsheet dated November 2025 indicated interventions of clean peri-area with each incontinent episode, check resident frequently and assist with toileting as needed and provide peri care after each incontinent episode. During an interview and record review on 11/24/25 at 1:00 p.m., CNA A said she checked Resident #1 and Resident #2 every 2 hours and provided incontinent care as needed and said there was no place to chart each. She said you could chart one or two times per shift. She said there had been updates to electronic records in the past few months and she was not sure when it changed. She said she never asked about where to chart. During an interview on 11/24/25 at 1:30 p.m., the DON said the electronic record program had updates and incontinent care must have been removed. She said she was not sure how long the CNAs was not able to chart their checks every 2 hours for incontinent episodes and when they provided incontinent care. She said she was responsible for ensuring medical records were complete and accurate. She would have get with technical support to fix it so the CNAs would be able to chart the care given to the residents so the record would reflect care. Record review of the undated policy Electronic Medical Records indicated Electronic medical records are an acceptable form of medical record management and should be used in lieu of paper records when applicable. |