STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675399	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navasota Nursing & Rehabilitation	1405 E Washington Navasota, TX 77868

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45957 Based on observations, interviews, and record reviews, the facility failed to ensure residents received services in the facility with reasonable accommodations of each resident's needs for 3 of 6 residents (Residents #1, #2, & #3) reviewed for resident rights in that: Residents #1, #2, & #3 's call lights was not within reach on 01/30/2025. This failure could affect residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: 1.Record review of Resident #1's admission record dated 01/30/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 diagnosis of Alzheimer's Disease (a brain disorder that causes memory and thinking skills to decline over time. Record review of Resident #1's Quarterly MDS assessment, dated 01/22/2025, revealed the resident had a BIMS score of 03, which indicated severe impairment. The MDS also revealed Resident #1 was dependent in the areas of toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and personal hygiene. Record review of Resident #1's care plan, dated 01/30/2025, revealed Resident #1 was care planned for communication problems r/t dx of Alzheimer's/Dementia, cognitive deficit, minimal hearing deficit and had an intervention of call light in reach. During an observation and interview on 01/30/2025 at 8:50am., Resident #1's call light was observed behind the head of her bed and out of her reach. Resident #1 stated she did not know where her call light was or how long it was behind her bed. Resident #1's stated she could not reach her call light. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Record review of Resident #2's admission record dated 01/30/2025, reflected an [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #2 diagnoses included: hemiplegia affecting right nondominant side (paralysis on one side of the body), reduced mobility (limited ability to move but can do so under certain circumstances), contracture of muscle (when a muscle becomes permanently shortened and tight, making it difficult to move the joint it's connected to), repeated falls (falling multiple times, usually within a short period), and muscle weakness (when your muscles don't have the strength they normally do). Record review of Resident #2's Quarterly MDS assessment, dated 12/21/2024, reflected the resident had a BIMS score of 10, which indicated moderated cognitive impairment. The MDS also revealed Resident #2 was dependent in the areas of toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and personal hygiene. Record review of Resident #2's care plan, dated 01/30/2025, revealed Resident #2 was care planned for risk of falls r/t confusion, unaware of safety needs and had an intervention be sure Resident #2 call light was within reach and encourage the resident to use it for assistance as needed. During an observation and interview on 01/30/2025 at 9:00am., Resident #2's call light was observed behind the head of his bed and out of his reach. Resident #2 stated he could not reach his call light and he would have to wait for someone to come by his room for assistance. Resident #2 stated his call light was often out of reach. 3. Record review of Resident #3's face sheet dated 01/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3's diagnoses included: unspecified dementia (a condition that cause a decline in thinking, memory, and reasoning abilities) and aphasia (a language disorder that makes it difficult to communicate) A record review of Resident #3's Quarterly MDS assessment, dated 01/12/2025, reflected the resident had a BIMS score of 12, which indicated mildly impaired. Resident #3's Quarterly MDS reflected she required partial/moderate assistance for shower/bathe self and supervision or touch assistance for personal hygiene. A record review of Resident #3's care plan, dated 01/30/2025, reflected Resident #3 was care planned for communication problem r/t aphasia with an intervention of ensure/provide a safe environment: call light in reach. Resident #3's care plan also reflected she was care planned for falls d/t confusion, poor safety awareness r/t dementia with an intervention of be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During an interview and observation with Resident #3 at 01/30/2025 at 9:06am, Resident #3's call light was observed on floor by the left side of her recliner and out of her reach. Resident #3 stated she could not reach her call light and was not aware it was on the floor next to her recliner. Resident #3 stated she would have to wait for staff to come in her room for assistance due to her call light being out of reach. During an interview with the CNA A on 01/30/2025 at 1:15pm, CNA A stated that CNAs make round every two hour or as needed. CNA A stated during rounds CNAs are taught to ensure the resident call lights are in reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 01/30/2025 at 3:50pm, the DON stated all residents call lights should be always within reach. The DON stated it everyone's responsibility to ensure residents call lights are always within reach. The DON stated if a resident's call light was not within reach the resident would not be able to receive assistance if they needed it. During an interview with the RCN on 01/30/2025 at 4:00pm, the RCN stated that call lights should always be within reach. The RCN stated that it was everyone's responsibility to ensure the call light are within reach. The RNC stated that if a resident call light was not within reach, then the resident may not be able to call for assistance. The RNC stated her expectation were for all resident's call lights to be always within reach. The facility does not have a call light policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45957 Based on 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 included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 6 residents (Resident #3) reviewed for comprehensive care plans. Resident #3's comprehensive care plan did not reflect Resident #3's received psych service. This deficient practice could place residents at risk for not receiving proper care and services due to inaccurate care plans. Findings include: A record review of Resident #3's face sheet dated 01/30/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3's diagnoses included: unspecified dementia (a condition that cause a decline in thinking, memory, and reasoning abilities), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), and aphasia (a language disorder that makes it difficult to communicate) A record review of Resident #3's Quarterly MDS assessment, dated 01/12/2025, reflected the resident had a BIMS score of 12, which indicated mildly impaired. Resident #3's Quarterly MDS reflected she required partial/moderate assistance for shower/bathe self and supervision or touch assistance for personal hygiene. A record review of Resident #3's care plan, dated 01/30/2025, Resident #3's care plan did not reflect she was receiving psych services. A record review of Resident #3's physician orders dated 01/30/2025, reflected Resident #3 had a physician order date 11/01/2023 for psych services to eval and treat PRN. A record review of Resident #3 psych services notes dated 01/06/2025 & 01/20/2025 reflected Resident #3 was seen by psych service on 01/06/2025 & 01/20/2025. During an interview with the DON on 01/30/2025 at 3:50pm, the DON stated Resident #3 does receive psych services and the psych services should be care planned. The DON stated that the facility did not have a MDS coordinator. The DON stated he expected for all care plans to reflect the most current information so the resident can be provided the highest level of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RCN on 01/30/2025 at 4:00pm, the RCN stated that Resident #3 does receive psych service and that should have been care planned. The RCN stated the facility does not have a MDS coordinator so it would be the IDT team's responsibility to ensure that Resident #3's psych services were care planned. The RCN stated if the resident's care plan was not accurate it could cause the resident to not receive the appropriate services. The RCN stated her expectations were for all resident's care plans to be accurate so the residents at the facility could receive the highest level of care. A record review of the facility's Comprehensive Care Planning policy, not dated, reflected The facility will 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 are identified in the comprehensive assessment. The comprehensive care plan will describe the following- The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45957 Based on interview and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 6 residents (Resident #4) reviewed for care plans. The facility failed to ensure Resident #4's care plan was updated to reflect the resident's recent falls on 12/20/2024, 01/24/2025 & 01/25/2025. This failure could place residents at risk of not receiving appropriate care to meet their current needs. Findings include: Record review of a facility face sheet for Resident #4 dated 01/30/2025, reflected a [AGE] year-old male who was readmitted to the facility on [DATE]. Resident #4's diagnoses included: unspecified dementia ((a condition that cause a decline in thinking, memory, and reasoning abilities), repeated falls (falling multiple times, usually within a short period), lack of coordination (not being able to move different parts of your body smoothly together), and muscle weakness (when your muscles don't have the strength they normally do). Record review of Resident #4's Quarterly MDS assessment dated [DATE], reflected the resident had a BIMS score of 99, which indicated severe cognitive impairment. Resident #4's Quarterly MDS reflected he was dependent in the following areas: eating, oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene. Resident #4's MDS Section J1800 reflected that Resident #4 has had falls since admission/entry or reentry or the prior assessment with no injuries. Record review of Resident #4s Care Plan dated 01/30/2025 revealed Resident #4 was care planned for risks of falls, dx of dementia and has impaired cognition, and dx of epilepsy. Resident #4's care plan did not reflect he had falls on 12/20/2024. 01/24/2025, & 01/26/2025. Record review or Resident #4's progress notes dated 12/20/2024, reflected Resident #4 was observed on the fall mat next to his low bed by CNA. No injuries noted. Record review of Resident #4's progress noted dated 01/24/2025, reflected Resident #4 on floor near w/c with over bed table in his hand laying on his back on the floor, smiling. No injuries noted. Record review of Resident #4's progress noted dated 01/26/2025, reflected Resident #4 on knees beside bed. Assisted back to bed with assist of 2 staff members. No injuries noted. Attempted to interview Resident #4 on 01/30/2025 at 1:45pm but was not successful due to his severe cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 01/30/2025 at 3:50pm, the DON stated that Resident #4's care plan should have been updated to reflect his most recent falls. The DON stated if a resident's care plan was updated then the resident might not be getting the most efficient care. During an interview with the RCN on 01/30/2025 at 4:00pm, the RCN stated that Resident #4's care plan should have been updated after each fall. The RCN stated that a care plan needs to be updated so the additional intervention could be added to prevent the resident from falling. The RCN stated the facility currently doesn't have a MDS coordinator so it's the IDT's responsibility to update a resident's care plan. The RCN stated if a resident's care is not updated after a fall the resident would not be receiving the highest level of care. A record review of the facility's Comprehensive Care Planning policy, not dated, reflected The facility will 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 are identified in the comprehensive assessment. Comprehensive care plans may include but not limited to resident Kardex records, baseline care plans, and task listings. The comprehensive care plan will describe the following- The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; Comprehensive Care Plans A comprehensive Care Plan will be - The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45957 Based on observation and interview, and record review the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 7 (01/24/2025, 01/25/2025. 01/26/2025. 01/27/2025. 01/28/2025. 01/29/2025, and 01/30/2025) of 8 days reviewed for nurse staffing posting. The facility failed to post the daily staffing information in a prominent place on 01/24/2025, 01/25/2025, 01/26/2025, 01/27/2025, 01/28/2025, 01/29/2025, and 01/30/2025. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings: Record review of the facility's nursing staff information reflected the facility failed to complete and post the nursing staff information on the following dates 01/24/2025, 01/25/2025. 01/26/2025. 01/27/2025. 01/28/2025. 01/29/2025, and 01/30/2025 During an observation on 01/30/2025 at 8:50 am, revealed the nursing staffing information posted outside out the administrators office was dated 01/23/2025. During an interview with the DON on 01/30/2025 at 3:50 pm, the DON stated he was new to long term care was not aware that he was supposed to be posting the nursing staffing information. The DON stated the resident would not be affected by the nursing information not being posted. The DON stated the nursing staffing show transparency of the number of staff present for each shift. The DON stated the facility does not have a policy about posting the nursing staff information. During an interview with the RCN on 01/30/2025 at 4:00 pm, the RCN stated the nursing staffing information should be posted daily. RCN stated it was the DON's responsible to ensure it posted daily. The RCN stated on the weekends it was the weekend supervisor's responsibility to ensure it was posted. The RCN stated the DON has only worked in the facility for 8 days and the administrator had been posting the nursing staffing information. The RCN stated with the administrator out sick and the DON was not aware the nursing staffing information needed to be posted. The RCN stated the purpose of posting the nursing staffing information was to show that the facility had adequate staffing. The RCN stated the resident would not suffer any adverse effects if the nursing staff information was not posted. The RCN stated the facility does not have a policy regarding the posting of the nursing staff information. The facility does not have a policy regarding posting the nursing staffing information.