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	04/23/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview, and record review, the facility failed to provide services by sufficient numbers of nurse aides and licensed nurses on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans for 6 of 8 shifts (04/19/25 06:00 AM-06:00 PM, 04/19/25 06:00 PM-06:00 AM, 04/20/25 06:00 AM-06:00 PM, 04/20/25 06:00 PM-06:00 AM , 04/21/25 06:00 AM-06:00 PM , and 04/22/25 06:00 AM-06:00 PM) reviewed for sufficient nurse staffing. The facility failed to schedule nurse aides and licensed nurses in numbers consistent with the posted nurse staffing during the following shifts: 04/19/25 06:00 AM-06:00 PM, 04/19/25 06:00 PM-06:00 AM, 04/20/25 06:00 AM-06:00 PM, 04/20/25 06:00 PM-06:00 AM , 04/21/25 06:00 AM-06:00 PM , and 04/22/25 06:00 AM-06:00 PM. This failure placed residents at risk of not having their needs for assistance with activities of daily living and their medical needs met. Findings included: Review of the posted nurse staffing for 04/20/25, 04/21/25, and 04/22/25 reflected the resident census was 58. The day shift reflected the required staffing was one RN, two LVNs, one medication aide, and four nurse aides. The night shift required one RN, one LVN, and five nurse aides. Review of staffing schedules for 04/19/25 through 04/22/25 reflected the following staff were scheduled: 04/19/25 06:00 AM-06:00 PM three nurse aides, one medication aide, and one RN (missing one nurse aide and one LVN according to the posted nurse staffing) 04/19/25 06:00 PM-06:00 AM two nurse aides, two LVNs (missing three nurse aides according to the posted nurse staffing) 04/20/25 06:00 AM-06:00 PM three nurse aides, one medication aide, two LVNs (missing one nurse aide according to the posted nurse staffing) 04/20/25 06:00 PM-06:00 AM four nurse aides, one LVN, and one RN (missing one nurse aide according to the posted nurse staffing) (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/21/25 06:00 AM-06:00 PM two nurse aides, one medication aide, one LVN, and one RN (missing two nurse aides according to the posted nurse staffing) 04/21/25 06:00 PM-06:00 AM five nurse aides, one LVN, one RN (sufficient staffing according to the posted nurse staffing) 04/22/25 06:00 AM-06:00 PM three nurse aides, one medication aide, two LVNs, and one RN (missing one nurse aide according to the posted nurse staffing) 04/22/25 06:00 PM-06:00 AM five nurse aides, one LVN, one RN (sufficient staffing according to the posted nurse staffing) Review of time punches for the 06:00 PM to 06:00 AM shift from night of 04/20/25 to morning of 04/21/25 reflected three nurse aides, one LVN, and one RN were on duty. Review of the facility assessment dated [DATE] reflected the average resident census was 58. Review of Resident Council Minutes reflected the following: Meeting dated 02/11/25 Nursing Review Are call lights answered in a timely manner? Sometimes Are residents receiving scheduled showers? Sometimes, other times not Meeting dated 03/11/25 Nursing Review Are call lights answered in a timely manner? No Are residents receiving scheduled showers? Yes Meeting dated 04/11/25 Nursing Review Are call lights answered in a timely manner? No Are residents receiving scheduled showers? Yes, but not all the time Review of the grievance log for April 2025 reflected no related grievances. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/25 at 02:55 PM, the DOR stated there was a staffing problem at the facility that was well known. She stated the problem was scheduled staff calling in and not working. She stated her understanding was that the schedules were made to include sufficient numbers of nursing staff, but people called in. The DOR stated she and the therapy staff had to help provide incontinent care and transfers sometimes to ensure people were ready for their therapy sessions. She stated the team worked together to meet the needs of residents, and the staff who came to work did a great job, but the facility did not pay very well, and they were having a hard time keeping staff or hiring new staff. During a confidential interview on 04/22/25, an anonymous resident stated the staff did not answer call lights quickly or provide help quickly. They stated the staff treated them well, but there were not enough staff to provide care in a timely manner. They stated there had been no negative impact and nothing negative had occurred that they were aware of beyond the inconvenience of waiting. During a confidential interview on 04/22/25, an anonymous resident stated the facility hardly had any help. They stated everyone had quit. They stated new nursing staff stayed two weeks and then quit because they were overworked. They stated they had to stay in bed all day sometimes because there was not enough staff to get them up (this resident was up in a wheelchair and participating in various activities during all observations). They stated they were not aware of any specific negative impact on residents or anything negative that had occurred to them as a result of the short staffing. During a confidential interview on 04/22/25, an anonymous resident stated there was an ongoing problem with staffing at the facility, and they did not know what was causing it. They stated staff they have had working there for years had been quitting, and new staff that were hired were quitting after only a few weeks of work. They stated the other staff told them the delay in call response times was due to people calling in and quitting. They stated they had not heard of any specific negative impact of the staffing problem on residents, but everybody felt the strain. They did not elaborate on precisely what that meant. During a confidential interview on 04/22/25, an anonymous staff person stated the facility had a problem with sufficient nursing staff that was widely known by everyone who worked there. They stated the director of nursing had quit, the administrator had been terminated that morning, and they did not know exactly who was in charge. They stated they thought the team who worked did a great job and took care of resident needs, but people kept quitting because of the pay and being overworked. They stated the staff were all on a 12-hour shift, and there were a select few who would always show up to work, and those would be called to work when someone else did not show up to work their shifts. This meant they were always working a lot of extra hours. The anonymous staff person stated there was a notification system for all the facilities in the area owned by the same company, and other buildings sent notifications that aides could receive $250 bonuses for picking up shifts, while this facility would offer $25, $50, or $75 a shift. They stated the staff were aware of the difference, and it meant they were less likely to pick up shifts and that morale at this facility was low. They stated they were afraid of being quoted in case there was retaliation and they lost their job. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential interview on 04/22/25, an anonymous staff person stated there had been staffing issues at the facility the entire time they had worked there. They stated it was not just a one-time issue that there had been fewer CNAs than were required. They stated the charge nurses provided ADL care to make up for the absence of aides, but then the nurses were not able to do everything they were supposed to do. They stated the nurses ended up working extra hours, and that meant they got burned out more quickly and left to find other places of employment. They stated the same thing happened with the CNAs. They stated everyone who came to work each shift stressed out due to not knowing if they would be fully staffed. They stated they were about ready to quit and find work elsewhere. During a confidential interview on 04/22/25, an anonymous staff person stated the staffing was adequate as long as no one called in, but people called in frequently. They stated they did not know why people called in so often. During a confidential interview on 04/22/25, an anonymous staff person stated they did not notice a staffing problem if no one called in, but lots of people did call in. They stated the 12-hour shifts were hard for people, so the facility had a hard time keeping staff. During a confidential interview on 04/22/25, an anonymous staff person stated they were one of many staff people who came to work at the facility after being promised a sign on bonus of $2500 that would be distributed in monthly increments. They stated the bonus was never given, and when they inquired about it, they were told it was a mistake for the previous manager to have offered it. They stated they did not remember who they spoke to about the bonus, and they did not take pictures of the offer letter, because they did not know they needed to. They stated they trusted the management that hired them. They stated the CNAs made much less than CNAs at other facilities. They stated people always called in, so the facility was always short-staffed, and that made people quit or call in even more. They stated they were almost out the door. During a confidential interview on 04/22/25, an anonymous staff person stated people were quitting, because they were tired of being left at the facility with not enough help for more hours than they should have had to work. They stated they were afraid of retaliation if they spoke openly and allowed their name to be used. They stated the facility had adequate staffing currently because the State Agency was conducting an investigation. Observations on 04/22/25 between 09:30 AM to 03:30 PM revealed call lights were answered within two minutes, residents were up and engaged in activities, and there were no residents observed in soiled garments or with other needs going unmet. During an interview on 04/22/25 at 03:57 pm, the Area Director/Acting Administrator (AD/AA) stated the previous DON's last day was Friday 04/18/25 and the previous administrators had come in earlier that morning to be terminated. The AD/AA stated she had a role in staffing at the facility as of that day, 04/22/25. The AD/AA stated she had just gone over the schedule to see where they were for tonight and ensure the facility was fully staffed for that night and the rest of the week. She stated they were offering a sign on bonus and had staff appreciation events monthly at which they fed all the staff on all shifts. She stated the facility did have to run the staff which were listed on the posted nurse staffing, as they determined that was the sufficient number of staff to ensure all resident needs among the current census were met. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/22/25 from 07:30 PM to 08:30 PM revealed the facility was quiet with no unpleasant odors present. Most residents were in their rooms, and the ones not in their rooms were visiting with staff. CNAs B, C, D, E, and F were present caring for residents. Call lights were being answered and resident care was being provided swiftly during the observation. LVN G and RN H were present in the building and providing resident care. MA I was also present and passing out medication. RN A was still at the facility sitting in front of a computer. During an interview on 04/22/25 at 07:30 PM, RN A stated she was still at the facility because she had charting to do that she could not do during her 12-hour shift from 06:00 AM-06:00 PM. She stated this was because they had been short a CNA on the day shift, and she had been helping with ADL tasks when needed. She stated the facility experienced chronic short staffing, because everyone who worked there was so overworked they often called in or just did not show up. She stated this included RNs, LVNs, and CNAs who did not work their shifts. She stated it would only get worse as people became more and more worn out. During an interview on 04/23/25 at 10:27 AM, the AD/AA stated any sign on bonuses that were promised should have been delivered as agreed. She stated she was not aware of any concerns related to sign on bonuses and was not aware of an overall staffing shortage in the facility, but she would be conducting her own investigation into the matter and would rectify any problems she discovered. She stated the facility administrator and DON had been responsible for ensuring sufficient staffing in the facility, but they were both no longer employed, so now the responsibility would be hers until a new administrator and DON were hired. She stated the potential negative impact of not having enough nurse aides in the building was that resident needs might not be met. Review of facility policy titled :Facility Assessment and dated 08/08/24 reflected the following: The facility will use this facility assessment to: Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in S 483.35(a)(3). Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. Develop and maintain a plan to maximize recruitment and retention of direct care staff. Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care.