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	05/09/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 9 (Resident # 39) residents in 1 of 3 dining rooms. The facility failed to promote Resident # 39's dignity while dining when staff did not serve his lunch tray for 20 minutes after his tablemate was served. This failure could affect all residents who were eating in the dining room, by contributing to poor self-esteem, and unmet needs. Findings included: Record review of Resident #39's Face Sheet dated 05/08/2024 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses of intermittent explosive disorder (repeated, sudden bouts of impulsive, aggressive, violent behavior, or angry verbal outbursts), unspecified protein-calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), and hypovolemia (when your body doesn't have enough fluid (blood) volume due to injury. Record review of Resident #39's Annual MDS Assessment, dated 01/14/2024, reflected the staff assessed cognitive status of Resident #39 and he had poor short- and long-term memory recall. He was able to recall the current season, the location of his room, and that he was in a nursing home. Resident #39 did not have any behavior problems. Record review of Resident # 39's Comprehensive Care Plan dated 04/04/2024 reflected Resident # 39 had a potential to demonstrate verbally and abusive behaviors. Intervention: Assess and anticipate resident's needs such as food, thirsty, comfort level, toileting, pain, etc. Resident #39 had potential to demonstrate physical behaviors due to poor impulse control. Intervention: provide physical and verbal cues to alleviate anxiety,; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out to staff member when agitated. Observed on 05/06/2024 at 8:45 AM Resident #3 was eating in the C Hall dining room. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/06/2024 at 12:17 PM revealed Resident # 39 entered the C hall dining room and was stating I am hungry. When are we going to eat. He propelled himself to a table. Resident #3 was sitting across from Resident #39. In an interview on 05/06/2024 at 12:21 PM Resident # 39 stated he did not want to talk he wanted something to eat. He stated he was hungry and to get him some food. Observation on 05/06/2024 at 12:23 PM revealed the staff were standing in the hallway/doorway entering C dining room and was not near Resident #39. Observation on 05/06/2024 at 12:40 PM Resident #3 received his meal tray and was eating in front of Resident #39. Resident #39 stated he wanted some food he was hungry and why did he not have any food. Observation on 05/06/2024 at 12:45 PM Resident #39 continued to say, I am hungry where is my food. He would continue to say he wanted something to eat. Observation on 05/06/2024 at 12:50 PM Resident #39 watched Resident #3 eat his meal. Resident #39 became angry (his fists were clenched, furrowed brows, and tense jaws/lips) and stated, why did he not get something to eat? Resident #39 also stated, is that man (Resident #3) better than me? Why is he eating, and no one will give me any food? He also stated he felt no one was going to give him any food. Observation on 05/06/2024 at 12:52 PM the staff continued to stand in the open area leading into the dining room. They were not near Resident #39. Observation on 05/06/2024 at 1:00 PM the meal trays came to C dining room. In an interview on 05/06/14 at 1:45 PM CNA P stated Resident #3 decided each day where he preferred to eat his meals in the C dining room or the dining room near the administrator's office. She stated on 05/06/2024 he decided to eat in the C dining room. She stated he had eaten breakfast in the C dining room. She stated whenever a resident eats in various areas of the facility, she was informed by nurse supervisors (different nurse supervisors over the past several months did not recall names of the supervisors) it was the nursing staff's responsibility to alert the dietary department where Resident #3 was eating his meal. She also stated this helped dietary staff to know where to send Resident #3's meal. CNA P stated she did not know why this information was not communicated with dietary staff on 5/06/24. She stated Resident # 39 can become agitated and angry very fast over anything. CNA P also stated if a resident did not have a meal tray and observed another resident eating, a resident may have felt he was not going to receive a meal tray or felt the staff did not care about him. There was a possibility Resident #39 may have feelings of anger or become agitated due to not receiving the meal and having to observe Resident #3 eating for long period of time prior to Resident # 39 received his meal. She also stated Resident #39 may have felt left out and forgotten. She also stated other residents could grab food off the other resident's tray if they were tired of waiting on their meal. CNA P stated the food the resident grabbed might not be on their diet, There was a possibility a person may choke if the resident was on a pureed diet and they grabbed a piece of meat that was not pureed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2024 at 9:15 AM LVN C stated the nursing staff were expected to communicate with the dietary staff where a resident was eating their meals for the day if the resident does not always eat in the same dining room. She stated Resident #3 does change where he eats his meals. She also stated some days he will eat in the main dining room near the administrator office/ front door, or he would eat in the C hall dining room. She stated nursing staff were expected to serve meals one table at a time and ensure all residents at one table received their meals prior to serving residents at another table. She stated if a resident was not served their meal and their table mate had their meal tray, the other resident may become frustrated, feel the staff forgot about them, and possibly feel they were not going to get a meal tray. LVN also stated Resident # 39 can become easily agitated and have outbursts if he was angry or upset about anything including not receiving meal tray. She stated she was not working on 05/06/2024. She stated if someone brought Resident #3's meal tray to the dining room and observed other residents did not have a tray, that person was expected to return the tray to the dirty area of the kitchen. The staff was to request Resident #3 meal tray come out the same time as the residents in the C hall dining room. She stated she had been in-serviced on meal service and during the in-service the staff discussed each resident at one table was served their meal prior to serving residents at another table. She stated she did not recall when she received this in-service. In an interview on 05/09/2024 at 8:53 AM the ADON stated the staff were expected to serve all residents at one table before serving residents sitting at a different table. She stated if Resident #3 was eating in C dining hall and the staff were aware he was eating there, the nurse supervisor was expected to designate someone to communicate this to the dietary staff in the kitchen. She stated if the dietary department was aware of Resident #3 eating in C dining room his meal tray would have been delivered the same time as the other residents in the C dining room. She stated the person that carried Resident #3's tray from the main dining room to C dining room was expected to notice the other residents did not have their meal trays. The staff was expected to return Resident #3's tray to the dining room dirty dish room and report to the dietary staff that Resident #3 was eating in C hall dining room. Staff was expected to request a new tray to be placed on the C hall meal tray cart. The ADON stated if Resident #39 observed Resident #3 eating and he complained of being hungry and wanted to know why he did not receive a meal, she stated there was a potential Resident #34 would have become very angry and had outburst of verbal or physical behavior. She stated Resident #34 does have outbursts of behaviors and any situation can contribute to his outbursts. The ADON also stated he may feel that the staff was ignoring him, or he may have felt he was left out of receiving any food for lunch. She stated there was a possibility he may have felt isolated from his table mate by not receiving a meal tray at the same time as his table mate. She also stated if Resident #39 waited 20 minutes before he received his meal tray that was too long, and this was a dignity issue. She stated the Nurse Supervisor was responsible for overseeing the meal service in the dining room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER: Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2024 at 9:30 AM the Administrator stated the nursing staff was expected to communicate with the dietary staff where a resident was eating their meal if the resident did not always eat in the same dining room every day. She stated if Resident #3 was in the C hall dining room for lunch and the meal trays had not been delivered, the nursing supervisor was expected to designate someone to go to the kitchen and report Resident #3 was eating in C dining room for his lunch meal. She stated the kitchen staff was expected to place Resident #3's tray in the dirty dish area and request a new tray to be carried to Resident #3 if the meal cart was full the same time the meal cart was delivered to the C hall dining room. She stated if Resident #39 sat and watched his tablemate eat his meal approximately 20 minutes prior to him getting his meal, Resident #39 had a potential of feeling angry, or like staff were ignoring him, or he may have felt he was not going to get a meal. She stated it was the nurse supervisor's responsibility to monitor the dining room. The Administrator stated the expectations were that each resident received their meal at the same table before serving meals to another table. She stated this was the facility expectations of meal service. She also stated this was against Resident #39's resident rights of dignity. She stated she there were several resident rights affected in this situation and she was not going to elaborate on anything else about this situation. Record Review of Facility Policy on Guidelines on Dining Room Etiquette, not dated, reflected please serve all residents at one table before moving on to another table.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40884 Based on observations, interviews, and record review the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs for 2 (Resident #45 and Resident #46) out of 14 reviewed for call lights. The facility failed to ensure Resident #45 and Resident #46's call lights were within reach. This failure could affect all residents who needed assistance with activities of daily living and could result in needs not being met. Findings included: Record review of Resident #45's Face Sheet dated, 05/08/2024, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of essential tremor (a condition that affects the nervous system, causing involuntary and shaking or trembling), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety (a mild cognitive impairment has yet to be diagnosed with no behaviors), repeated falls (fall more than once a year), and fatigue (extreme tiredness). Record review of Resident #45's Admission MDS Assessment, dated 03/18/2024 reflected Resident #45 usually understood (difficulty communicating some words or finishing thoughts) and he usually understands (may miss some part/intent of message but comprehends most conversation). Resident #45 was assessed to have poor short- and long-term memory recall. He was able to recall current season, location of his room, and that he was residing in a nursing home. He required assistance with ADLs. Record review of Resident #45's Comprehensive Care Plan, revised on 05/06/2024 and 05/07/2024, reflected Resident #45 had an ADL self-care performance deficit. Resident #45 had a communication problem. Intervention: Encourage Resident #45 to continue stating thoughts even if resident was having difficulty. Monitor/document frustration level. Observation and interview on 05/06/2024 at 9:29 AM revealed Resident #45 were lying in bed. He stated he did not know where the button to call for help was located. Resident #45's call light was lying on the nightstand approximately 3-4 feet from Resident #45's reach, from his bed. He stated, I see the button now it is on the table. He also stated he could not reach it from his bed and he was afraid he would bump his head on the table trying to reach the button. Resident #45 stated he did use the button when he needed something. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	Record review of Resident #46's Face Sheet dated, 05/08/2024, reflected an [AGE] year-old female admitted to the facility on [DATE] with a diagnoses of lymphedema, not elsewhere classified (swelling in the body's tissues), major depressive disorder, single episode, unspecified (is used when the symptoms of depression cause significant distress or impairment in social, occupational, or other important areas of functioning but do not meet the full criteria for any of the depressive disorder diagnoses - that causes a persistent feeling of sadness and loss of interest and can interfere with your normal daily activity), essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition), and atherosclerotic heart disease of native coronary artery without angina pectoris (when fats, cholesterol and other substances collect on the inner wall of the heart arteries and can cause the arteries to narrow and block flood flow and cause a blood clot). Record review of Resident #46's Quarterly MDS Assessment, dated on 04/13/2024 reflected Resident #46 had a BIMS score of 10 which indicated the resident's cognition was moderately impaired. Resident #46 did not reject care. She was also assessed to require assistance from staff with ADLs such as: personal hygiene, dressing, bathing, toileting, chair to bed/ bed to chair transfers, toilet transfers, and shower transfers. Record review of Resident #46's Comprehensive Care Plan, dated 04/20/2024, reflected Resident #46 was at risk for falls and had poor safety awareness. Intervention: be sure Resident #46's call light was within reach and encourage resident to use it for assistance as needed. Resident #46 required one staff to assist with transfers. She also had an ADL self-care performance deficit. Intervention: she required assistance with transfers, bathing, bed mobility, personal hygiene, dressing, and toileting. Observation and interview on 05/06/2024 at 9:02 AM revealed Resident #46 were in her room. Upon entrance into Resident #46's room she was sitting in her recliner. Resident #46 stated, I cannot find my call light. Her call light was behind her recliner. Resident #46 stated she had been looking for the button to call for help. She stated she did not need any assistance. Resident #46 stated she never knew when she may need some help and she depended on using the button to get help (referring to the call light). Resident #45 stated she was afraid she would fall if she tried to get up from her chair. In an interview on 05/09/2024 at 9:15 AM LVN C stated if a resident's call light was not within reach of resident there was a possibility a resident may fall and break a hip or hit their head on the floor attempting to reach the call light. She stated if the resident had an emergency, the resident may be able to yell for help but there were some residents that would not be able to yell very loud and it would be difficult to hear those residents. LVN C stated Resident #45 and Resident #46 would be difficult to hear if staff were not near their rooms. She stated it was the responsibility of all staff in the facility to check call lights when they entered a resident room to ensure the call light was attached where the residents had easy access to use the call light. She stated she had been in-serviced on call lights and placing the call light within reach of the resident when they were in their room. LVN C did not recall the last time she received the in-service. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	In an interview on 05/09/2024 at 8:53 AM the ADON stated it was all staff's responsibility when they entered a resident room to ensure the call light was within reach of the resident. She stated if the call light was not within reach, it would be difficult for a resident to obtain the help they may need in a timely manner. She stated some residents were able to yell for help and some residents would not be able to yell loud enough. The ADON also stated it would be difficult to hear Resident #45 and Resident #46 well if someone was not near their door. She also stated a resident had a potential to fall if the resident attempted to reach for their call light. She stated a resident may fracture their hip, break their leg, or arm. The ADON stated it was safe practice for all staff to ensure call lights were within reach of all residents. She stated an in-service had been given to all staff on call light placement. She stated she did not recall the date when the in-service was given to the staff. In an interview on 05/09/2024 at 9:15 AM CNA J stated all staff were responsible to check call lights when they entered a resident's room. She stated if the call light was not in reach the resident may fall attempting to reach the call light or try to find the call light. CNA J stated a resident may break a bone or have a laceration on their head if they fell . She stated all call lights were expected to be within reach of all residents when they were in their room. CNA J stated it would be difficult to hear Resident #45 and Resident #46 if they attempted to yell for help and the staff were not standing near their rooms. She stated she had been in serviced on call lights and attach call lights where residents can reach it when in their room. CNA J did not recall the date of the last in-service she had on call lights. In an interview on 05/09/2024 at 9:30 AM the Administrator stated her expectations were for call lights to be within reach of all residents. She stated there were some residents that may not be able to yell out or get help. She also stated every staff member who walked into a resident's room was responsible for ensuring the call lights were within reach. The Administrator also stated if the call light was not in reach a resident may fall out of bed or a chair when the resident attempted to reach for the call light. She also stated there was a potential a resident may have an injury such as a broken bone. In an interview on 05/09/2024 at 12:05 PM with the Administrator. The policy on call lights was requested, but it was not provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49556 Based on interview and record review the facility failed to provide a private space for residents' monthly resident council meetings and the confidential resident group meeting during survey for five of five confidential residents reviewed for resident council. The facility did not provide a private space for resident council meetings. The failure could place residents, who attended resident council meetings, at risk of not being able to exercise their rights of being able to voice their grievances in a private space without uninvited staff being present. Findings Included: Interview on 05/07/2024 10:10 AM, the Administrator stated the residents would be in the dining area that it was located next to the nurses' station which was an open room with no doors for privacy. After speaking with the administrator, the meeting was then moved to the Activity Directors office. A confidential resident group meeting held in the Activity Director's office on -05/08/224 at 10:30 AM with 5 residents. The residents in attendance of the resident group meeting stated they normally meet in the dining room that has no doors. The residents stated they do not meet regularly. Residents in the meeting stated they don't feel comfortable saying too much without a door to close off the room. The residents said they would like to be able to meet in private. In an interview on 5/7/2024 at 1:00pm the Activity Director stated she had just started yesterday and was asked her where the residents normally meet. She said they should be meeting in a room with a door like the activity room so that the residents can have privacy. She told me when she has resident council meetings, she will hold the meetings in the activity office. Asked Administrator verbally on 5/7/2024 at 1:30 PM for Resident Council minutes and they were unable to provide. On 05/07/2024 and 05/08/2024 asked the administrator a copy of the Resident Council Policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 32452 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan 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. for one resident (Resident #18) of eight reviewed for indwelling urinary catheters care plans, in that: The facility failed to ensure Resident #18's Comprehensive Care Plan reflected his use of an indwelling urinary catheter. These failures could place residents with indwelling urinary catheters at risk for urinary tract infections, change of condition and risk for not having their individually assessed needs met which could result in a diminished quality of care and staff being unaware of needed interventions. Findings included: Review of Resident #18's face sheet dated 05/08/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Cerebrovascular disease (conditions that impact the blood vessels in your brain.), bipolar disorder (A serious mental illness characterized by extreme mood swings. They can include extreme excitement episodes or extreme depressive feelings.) and benign prostatic hyperplasia (A condition in which the flow of urine is blocked due to the enlargement of prostate gland. The symptoms include increased frequency of urination at night and difficulty in urinating.). Review of Resident #18's quarterly MDS assessment dated [DATE] reflected Resident #18 was assessed to not have a BIMS score conducted indicating severe cognitive impairment. Resident #18 was assessed to not have behaviors during the assessment period. Further review reflected Resident #18 was assessed to have an indwelling urinary catheter. Review of Resident #18's consolidated physician orders reflected an order dated 03/27/2024 for urinary catheter 16 F (French catheter scale is commonly used to measure the outside diameter of needles and catheters 1 French is equivalent to 0.33 mm of diameter) to gravity drainage. Review of Resident #18's comprehensive care plan reflected a focus area dated 05/11/2023 Resident #18 has bladder incontinence. Resident #18's care plan did not reflect his indwelling urinary catheter. Observation and interview on 05/07/2024 at 10:04 AM, revealed Resident #18 in bed with his indwelling urinary catheter drainage bag on the floor flat 2 to 3 feet away from his bed. Resident #18 was not interviewable and only smiled and waved at surveyor during interview attempts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/08/2024 at 2:45 PM. the DON stated the facility did not have a person doing the care plans that her and the ADON were doing them. She stated Resident #18's care plan did not address his catheter and the care plan should not say bladder incontinence since he has a catheter. She stated they must have just missed it. She further stated the failure could lead to infections. Review of the facility's policy Comprehensive care planning (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 medial, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment .The services provided or arranged by the facility, as outlined by the comprehensive care plan, will meet professional standards of quality. Professional standards of quality means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes may also be found in clinical literature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32452

Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for 5 of 10 residents (Resident #3, Resident #4, Resident #20, Resident #46, and Resident #61) reviewed for ADL's.

A) The facility failed to ensure assistance was provided for repositioning and incontinent care every 2 hours for Resident #4, and Resident #20.

B) The facility failed to ensure Resident #3, Resident # 46 and Resident #61's nails were cleaned.

These failures placed residents at risk for a decline in health, skin breakdown, loss of self-esteem, and a diminished quality of life and could result in health-related issues from lack of hygiene.

Findings Included:

A) Review of Resident #4's face sheet dated 05/07/2024 reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with the following diagnoses Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Acute Kidney Failure (A condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few days. Symptoms include legs swelling and fatigue.), Hemiplegia (Hemiplegia is a symptom that involves one-sided paralysis) and Diabetes Mellitus Type II (A condition results from insufficient production of insulin, causing high blood sugar).

Review of Resident #4's Quarterly MDS assessment dated [DATE] reflected Resident #4 was assessed to not have a BIMS score conducted indicating severe cognitive impairment. Resident #4 was assessed to have functional limitations in range of motion for both upper and lower extremities. Resident #4 was assessed to be dependent on staff for all ADLs and was assessed to be incontinent of bowel and bladder.

Review of Resident #4's comprehensive care plan reflected a focus area dated 02/23/2021 Resident #4 is incontinent of bowel and bladder. Interventions included incontinent care at least every 2 hours and apply moisture barrier after each episode .

Observations of Resident #4 on 05/07/2024 hourly from 8:00 AM till 3:35 PM revealed Resident #4 was in her room in her Geri chair (specialized recliners that are upholstered in non-permeable, easily sanitized vinyl) in the same position sitting upright on her coccyx.

In an interview on 05/07/2024 at 3:20 PM, CNA E stated she had not done incontinent care for Resident #4 since she had gotten her up around 8:00 AM or 8:30 AM due to needing help to transfer them. When asked if she had asked for help CNA E stated she did not. When asked why she shrugged her shoulders.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/07/2024 at 3:40 PM, revealed CNA F and CNA E in Resident #4's room to put her to bed. The CNAs using the Hoyer lift placed her in bed. Resident #4 was observed to have saturated pants with a strong urine odor. The CNAs removed her pants to reveal a saturated brief with a foul odor. Peri care was provided to Resident #4. The CNAs turned Resident #4 on her side to reveal no redness or skin breakdown. Review of Resident #20's face sheet dated 05/07/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses Multiple sclerosis (A disease that affects central nervous system. The immune system attacks the myelin, the protective layer around nerve fibers and causes Inflammation and lesions. This makes it difficult for the brain to send signals to rest of the body.), and hemiplegia and hemiparesis (Hemiplegia is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body). Review of Resident #20's Quarterly MDS dated [DATE] reflected she was assessed to have a BIMS score of 7 indicating severe cognitive impairment. Resident #20 was assessed to be dependent on staff for ADLs. Resident #20 was assessed to have impairment in ROM on one side for her upper extremities and both sides for her lower extremities. Resident #20 was further assessed to be incontinent of bowl and bladder. Review of Resident #20's comprehensive care plan reflected a focus area dated 10/14/2021 and revised on 07/26/2023 Resident #20 has hemiplegia/ hemiparesis. Interventions included reposition at least every 2 hours. Further review reflected a focus area dated 10/14/2021 and revised on 07/26/2023 Resident #20 is incontinent of bowl and bladder. Interventions did not include incontinent care every 2 hours. In an interview on 05/07/2024 at 3:20 PM, CNA E stated she had not done incontinent care for Resident #20 since she had gotten her up around 8:00 AM or 8:30 AM due to needing help to transfer them. When asked if she had asked for help CNA E stated she did not. When asked why she shrugged her shoulders. Observation on 05/07/2024 at 3:45 PM, revealed CNA F and CNA E in Resident #20's room to put her to bed. The CNA's using the Hoyer lift placed her in bed. Resident #4 was observed to have saturated pants with a strong urine odor. The CNA's removed her pant to reveal a saturated brief with a foul odor. Peri care was provided to Resident #20. The CNA's turned Resident #20 on her side to reveal no redness or skin breakdown. In an interview on 05/08/2024 at 2:13 PM, the DON stated she expected staff to check on residents every two hours and do position changes and incontinent care if needed. She stated CNA E should have asked for help and did not know why she did not. The DON stated she expected the nursing staff to make rounds as well to ensure the CNAs are doing their jobs. She stated failure to do so could cause skin breakdown. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility' policy Perineal care dated 04/27/2022 reflected An incontinent resident of urine and/or bowl should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible . Skin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown. Moisture may make the skin more susceptible to damage from friction and shear during repositioning. One form of early skin breakdown is maceration or the softening of tissue by soaking. Macerated skin has a white appearance and a very soft, sometimes soggy texture. The persistent exposure of perineal skin to urine and/or feces can irritate the epidermis and can cause severe dermatitis, skin erosion and/or ulcerations. Skin erosion is the loss of some or all of the epidermis (comparable to a deep chemical peel), leaving a slightly depressed area of skin. Because frequent washing with soap and water can dry the skin, the use of a perineal rinse may be indicated. This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition . B) Record review of Resident # 3's Face Sheet dated, 05/08/2024, reflected an [AGE] year-old admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of hemiplegia, unspecified affecting right nondominant side (the loss of muscle function on the right side of the body due to tissue damage to the brain or spinal cord), lack of coordination (uncoordinated movement is due to a muscle control problem that causes an inability to coordinate movements), and muscle weakness (when full effort does not produce a normal muscle contraction or movement). Record review of Resident #3's annual MDS Assessment, dated, 01/22/2024, reflected resident had a BIMS score of 10 which indicated the resident's cognition was moderately impaired. Resident #3 did not refuse care. He required assistance with ADLs from staff such as personal hygiene, dressing, toileting, showers/ bathing, and transfers. Record review of Resident #3's Comprehensive Care Plan, dated 04/03/2024, reflected Resident #3 had an ADL self-care performance deficit related to limited range of motion. Intervention: Resident #3 required extensive assistance of one staff with personal hygiene. Observation on 05/06/2024 at 7:17 AM, Resident # 3 was lying in bed. There was a thick black substance underneath all fingernails on his left hand and underneath the nails on his middle finger and fore finger on his right hand. Interview on 05/06/2024 at 7:20 AM Resident #3 stated he asked someone to clean his nails few days ago and the person stated they would come back and clean his nails. He stated no one had offered to clean them and he had not asked anyone else. He stated he did not recall the person's name or what date he requested his nails to be cleaned. Observation and interview on 05/08/2024 at 10:50 AM, Resident #3 had blackish substance underneath all of his nails on his right hand. Resident #3 stated he asked someone to clean his nails a few days ago and the person said they would come back and clean his nails. He stated no one had cleaned his nails after he asked someone to do it for him. Resident #3 stated he did not know the person's name. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #46's Face Sheet dated, 05/08/2024, reflected a [AGE] year-old female admitted to the facility on [DATE] with a diagnoses of lymphedema, not elsewhere classified (swelling in the body's tissues), major depressive disorder, single episode, unspecified (is used when the symptoms of depression cause significant distress or impairment in social, occupational, or other important areas of functioning but do not meet the full criteria for any of the depressive disorder diagnoses - Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your normal daily activity), and unspecified dementia, and unspecified severity, with psychotic disturbance (a mild cognitive impairment has yet to be diagnosed with behaviors). Record review of Resident #46's Quarterly MDS Assessment, dated on 04/13/2024 reflected Resident #46 had a BIMS score of 10 which indicated the resident's cognition was moderately impaired. Resident #46 did not reject care. She was also assessed to require assistance from staff with ADLs such as: personal hygiene, dressing, bathing, toileting, chair to bed/ bed to chair transfers, toilet transfers, and shower transfers. Record review of Resident #46's Comprehensive Care Plan, dated 04/20/2024, reflected Resident #46 was at risk for falls. She had an ADL self-care performance deficit. Intervention: Hygiene resident is able to rinse and spit, brush teeth and partials (does not mention other hygiene in the care plan). Observation on 05/06/2024 at 9:02 AM, Resident # 46 was in her room sitting in the recliner. There was a black hard substance underneath her ring finger, and middle fingernails on her left hand. She also had blackish substance underneath her middle finger, ring finger and fore fingernails on her right hand. Observation on 05/08/2024 at 10:21 AM, Resident #46 was lying in bed. There was black hard substance underneath her ring finger, and middle fingernails on her left hand. She also had blackish substance underneath her middle finger, ring finger and forefinger nails on her right hand. Record review of Resident # 61's Face Sheet dated, 05/08/2024, reflected a 60- year-old female admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses of mandibulofacial dysostosis (a rare syndrome characterized by underdeveloped factional bones and a very small lower jaw and chin), unspecified visual loss (vision that cannot be corrected with glasses or contact lenses), and deaf nonspeaking, not elsewhere classified (unable to hear or speak). Record review of Resident #61's Quarterly MDS Assessment, dated 04/14/2024 reflected Resident #61 rarely/never understood others. Her cognitive assessment was completed by staff. She was assessed to have poor short-and long-term memory recall and her decision-making ability was severely impaired. Resident #61 did not have any behavior problems such as rejection of care. Resident # 61 required assistance with ADLs such as: personal hygiene, dressing, eating, toileting, and showers. Record review of Resident #61's Comprehensive Care Plan, revised on 05/06/2024, reflected Resident #61 had impaired visual function. She was legally blind in both eyes. Resident #61 had communication problem related to being deaf and non-verbal. Intervention: anticipate and meet needs. Resident #61 also had an ADL self-care performance deficit. Intervention: Resident #61 required extensive assistance with personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/06/2024 at 9:19 AM, revealed Resident # 61 was standing in the hallway. She held her hands in front of her. Resident #63 had blackish substance underneath her middle finger, ring finger and forefinger nails on her right hand. Resident was not interviewable. In an interview on 05/08/2024 at 9:15 AM, LVN C stated the nurses and CNAs were responsible for nail care. She stated the nurses were responsible to clean all resident's nails with a diagnosis of diabetes. LVN C stated it was the CNA's responsibility to clean all other residents' nails. She stated the nurses' made rounds and checked residents, with diabetic nails. She also stated the CNAs usually did nail care when residents received a shower or as needed. She stated the blackish/ brownish substance possibility may had feces or any type of bacteria underneath the resident's nails. LVN C stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea or vomiting. She also stated a resident may become dehydrated. She also stated she had been in- serviced on nail care and infection control. She stated she was not aware of Resident #3, Resident #61 or Resident #46 refusing nail care. In an interview on 05/08/2024 at 08:53 AM, the ADON stated it was the nurses (LVN or RN's) responsibility to clean residents with a diagnosis of diabetes. She stated CNAs were expected to give nail care to other residents during showers or as needed. She stated if a resident had blackish substance underneath the nails and the resident ingested the substance there was a possibility the resident may become ill such as: vomiting or diarrhea. The ADON stated if staff saw a blackish substance underneath a resident's nails, she expected the nails to be cleaned immediately. She stated only nurses were assigned to clean resident's nails with a diagnosis of diabetes. In an interview on 05/08/2024 at 9:05 AM, LVN C stated the nurses and CNAs were responsible for nail care. She stated the nurses were responsible to clean all resident's nails with a diagnosis of diabetes. LVN C stated it was the CNA's responsibility to clean all other residents' nails. She stated the nurses' made rounds and checked residents, with diabetic nails. She also stated the CNAs usually did nail care when residents received a shower or as needed. She stated the blackish/ brownish substance possibility may had feces or any type of bacteria underneath the resident's nails. LVN C stated if a resident swallowed the bacteria there was a possibility a resident may become extremely ill with stomach issues such as diarrhea or vomiting. She also stated a resident may become dehydrated. She also stated she had been in- serviced on nail care and infection control. She stated she was not aware of Resident #3, Resident #61 or Resident #46 refusing nail care. In an interview on 05/08/2024 at 9:15 AM, CNA J stated CNAs were responsible for nail care unless a resident was a diabetic. She stated the CNAs usually cleaned nails during showers or when needed. CNA J stated the nursing staff was expected to clean and trim residents' nails immediately if there was a blackish substance underneath the residents' nails and/ or if their nails. CNA J stated the blackish substance may be bacteria from feces underneath the residents' nails. She stated if a resident swallowed the blackish substance there was a possibility a resident may become ill with stomach issues or any type of intestinal issues. She stated there was a possibility a Resident may need to be assessed at the emergency room if they became severely ill. CNA J stated she gave care to Resident # 3, Resident #46 and Resident #61 and she was not aware of any refusal of nail care from any of these residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/09/2024 at 9:30 AM, the Administrator stated the CNAs was responsible for nail care during the residents' showers and as needed except for residents with diagnosis of diabetes. She stated the nurses performed all fingernail care for the diabetic residents. The Administrator also stated if a resident swallowed any type of blackish substance and it was determined to be bacteria, there was a potential a resident may become ill with a stomach infection. She also stated the resident may have symptoms of diarrhea and possible dehydration. Record review of the facility's policy on Nail Care, dated 2003, reflected Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. Nail care will be performed regularly and safely. The resident will free from abnormal nail conditions. The resident will be free from infection. 40884

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 40884 Based on observations, interviews, and record review the facility failed to provide, based on comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choices of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, encouraging interaction in the community for 4 of 8 residents (Resident #4, Resident #20, Resident #21, and Resident # 61) reviewed for activities. Residents #4, #20, #21, and Resident #61 were not receiving one-on-one activities or involved in group activities during the months of February, March, April, and May of 2024. This failure could place residents at risk for a decline in social, mental, psychosocial well-being, and a diminished quality of life. Findings included: 1. Record review of Resident #4's face sheet, dated 05/07/2024, revealed Resident #4 was an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses unspecified dementia (the loss of cognitive functioning, thinking, remembering and reasoning to such an extent that it interferes with a person's daily life and activities), hemiplegia, unspecified affecting right dominant side (unable to move certain parts of the body, on the right side of the body due to tissue damage to the brain or spinal cord), cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain), and aphasia (a disorder that affects how you communicate). Record review of Resident #4's Annual MDS Assessment), dated 06/23/2023, reflected Resident #4 was assessed to rarely understand others or rarely make self-understood. The staff completed the cognitive assessment on Resident #4. She had poor short- and long-term memory recall. Resident #4's decision-making ability was severely impaired. Resident #4's activity preference was assessed by the staff. Her activity interests were the following: receive showers, listen to music, and had family involved in care discussions. Record review of Resident #4's Quarterly MDS Assessment, dated 02/24/2024, reflected Resident #4 rarely makes self-understood or understands others. The staff assessed her cognition. She had poor short- and long-term memory recall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Comprehensive Care Plan revised on, 04/08/2024, reflected Resident #4 had hemiplegia (paralysis on one side of the body)/ hemiparesis (weakness that affects one side of your body). She had impaired hearing and vision. Resident #4 also had a communication problem related to aphasia. She had impaired cognitive function related to dementia. Intervention: Provide a program of activities to accommodate resident's abilities. Resident #4 needed one-on-one in room activities, socialization, and sensory stimulation. (This problem was created on 04/06/2022) Intervention: The activity director will provide Resident #4 with one-on-one visits with sensory stimulation (music, and hand massages) at least two times per week. (intervention was created on 04/06/2022). Record Review of Resident #4's Activity Documentation in the electronic medical record reflected Resident #4 did not receive one-on-one activities or attend group activities during the months of February, March, April, and May of 2024. Observation on 05/06/2024 at 7:40 AM Resident #4 was sitting in her Geri-chair in her room and the television was on in the room. Observation on 05/07/2024 at 9:43 A M Resident #4 was sitting in her Geri-chair in her room. There was not any stimulation in the room. Observation on 05/07/2024 at 12:45 PM Resident #4 was sitting in her Geri-chair in her room. The TV was on in the room. Record review of Resident # 20's face sheet dated, 05/08/2024, reflected, Resident #20 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses multiple sclerosis (a chronic, typically progressive disease involving damage to the sheaths- membrane covering a muscle- of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impaired speech, blurred vision, severe fatigue and impairment of muscular coordination), unspecified dementia, unspecified severity, with agitation (the loss of cognitive functioning, thinking, remembering and reasoning to such an extent that it interferes with a person's daily life and activities with behaviors), major depressive disorder, recurrent, unspecified (symptoms align with depressive disorder and result in a significant distress or impairment in daily life- a mood disorder that causes a persistent feeling of sadness and lost of interest and can interfere with your normal day-to-day activities, and sometimes feel as if life wasn't worth living), anxiety disorder due to known physiological condition (frequent moments of worry or fear, symptoms rapid heartbeat, dizziness or feel weak), and attention and concentration deficit (forgetfulness, problems staying on task, easily distracted, easily bored, easily confused and difficulty following instructions). Record review of Resident # 20's Annual MDS Assessment, dated 08/19/2023 reflected Resident #20 had unclear speech. She had a BIMS score of five, which indicated the residents' cognition was severely impaired. Resident #20 was assessed of feeling depressed. She was not capable of finishing the activity preferences. The staff assessed Resident #20's activity interests were the following: listening to music, doing things in groups of people, spending time outdoors, and participating in religious activities or practices. Record review of Resident # 20's Quarterly MDS Assessment, dated 05/03/2024, reflected Resident #20 had a BIMS score of seven, which indicated the residents' cognition was severely impaired. Resident #20 was assessed to have been diagnosed with depression and anxiety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Record review of Resident #20's Comprehensive Care Plan, reviewed on 05/06/2024, reflected Resident #20 had impaired cognitive function and dementia. Intervention: engage Resident #20 in simple, structured activities and avoid over demanding tasks. (Problem and Intervention initiated on 10/14/2021). Resident #20 had communication problem related to multiple sclerosis. She had major depressive disorder. Resident #20 had psychosocial well-being problem potential related to illness/disease. Intervention: observe and document residents' feelings related to isolation, unhappiness, and/ or anger. Resident #20 needed in room activities, socialization, and sensory stimulation. Intervention: the activity director will provide the resident with one-on-one visits with sensory stimulation (music and talking about things she can see outside her window) at least two times per week. (Problem and Intervention was initiated on 04/21/2022). Resident #20 had depression. Intervention: observe any signs or symptoms of sadness, hopelessness, tearfulness, negative statements, or anxiety.

Record Review of Resident #20's Activity Documentation in the electronic medical record reflected Resident #20 did not receive one-on-one activities or attend group activities during the months of February, March, April, and May of 2024.

Observation on 05/07/2024 at 7:50 AM Resident #20 was in her room sitting in her chair. The television was on in the room.

Observation on 05/07/2024 at 9:45 AM Resident #20 was in her room sitting in a chair. There was not any stimulation in the room.

Observation on 05/07/2024 at 12:45 PM Resident #20 was in her room and the television was on in the room.

Record review of Resident # 21's Face Sheet, dated, 05/08/2024, reflected an [AGE] year old female admitted to the facility on [DATE] with the following diagnoses depression (a constant feeling of sadness and loss of interest, which stops you from doing your normal activities), anxiety disorder (frequent moments of worry or fear, symptoms rapid heartbeat, dizziness or feel weak), unspecified dementia, unspecified severity (the loss of cognitive functioning, thinking, remembering and reasoning to such an extent that it interferes with a person's daily life and activities), and senile degeneration of the brain, not elsewhere classified (decrease in the ability to think, concentrate, or remember).

Record review of Resident #21's Annual MDS Assessment, dated 10/07/2023, reflected Resident #21 had unclear speech and minimal difficulty with hearing (difficulty in some environments). Resident #21 rarely/ never understood when others were speaking to her. She had difficulty communicating some words or finishing her thoughts but was able to if given time. Resident #21 had a BIMS score of two which indicated her cognitive status was severely impaired. Her activity preferences were the following: listen to music, doing things with groups of people, spending time outdoors, and participating in religious activities or practices.

Record review of Resident #21's Quarterly MDS Assessment, dated 03/16/2024, reflected Resident #21 sometimes made self-understood (ability was limited to making concrete requests) and rarely/ never understand others. Resident was not capable of completing cognitive section of the MDS. She was assessed to have poor short- and long-term memory recall. Resident #21 was assessed to have the following diagnoses: depression, anxiety, and dementia.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's Comprehensive Care Plan, reviewed on 04/20/2024 reflected Resident #21 had a communication problem related to dementia. Intervention: Anticipate and meet needs. Provide a program of activities that accommodates the resident's communication abilities. Resident #21 had a potential to demonstrate physical behaviors. Intervention: Give Resident #21 as many choices as possible about her activities. She had a hearing deficit. Intervention: Speak in a clear voice and face her when speaking. Resident #21 needed in-room activities, socialization, and sensory stimulation. Intervention: The activity director will provide resident with one-on-one visits with sensory stimulation at least 2 times per week. (This intervention was initiated on 10/12/2022). Record Review of Resident #21's Activity Documentation in the electronic medical record reflected Resident #21 did not attend group activities or receive one-on-one activities during the months of February, March, April, and May of 2024. Observation on 05/06/2024 at 7:10 AM revealed Resident #21 was in her room sitting in her Geri- chair. The television was on in the room. Record review of Resident # 61's Face Sheet dated, 05/08/2024, reflected a 60- year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of unspecified visual loss (vision that cannot be corrected with glasses or contact lenses), anemia (low levels of healthy red blood cells to carry oxygen throughout your body. Symptoms include fatigue, weakness, and feeling short of breath), and deaf nonspeaking, not elsewhere classified (unable to hear or speak). Record review of Resident #61's Admission MDS Assessment, dated 07/15/2023, reflected Resident #61's hearing was highly impaired, and she did not speak. She rarely/ never made self-understood or understand others. Her vision was assessed to be severely impaired. Resident #61 was not able to complete the cognitive section of the MDS. Staff assessed resident to be severely impaired with daily decision-making ability. She had poor short- and long-term memory recall. Resident #61 was assessed to enjoy caring for her personal belongings and choosing clothes to wear. Record review of Resident #61's Quarterly MDS Assessment, dated 04/14/2024 reflected Resident #61 rarely/never was understood others. Staff completed her cognitive assessment. She was assessed to have poor short-and long-term memory recall and her decision-making ability was severely impaired. Resident #61 was assessed to have diagnoses of deaf, nonspeaking, and unspecified visual loss. Record review of Resident #61's Comprehensive Care Plan, revised on 05/06/2024, reflected Resident #61 had impaired visual function. She was legally blind in both eyes. Intervention: do not rearrange any furniture. Resident #61 had communication problem related to being deaf and non-verbal. Intervention: anticipate and meet needs. Resident #61 had hearing deficit to both ears. Intervention: observe for hearing ability and report any changes to the physician. Resident #61 had no activity involvement with a group. She will be provided with in room activities of choice three times per week. Intervention: Use tactile sensory such as zipper, button tools, and use puzzles for vision impaired. (The activity problem and interventions were initiated on 10/24/2023). Observation on 05/06/2024 at 9:19 AM revealed Resident # 61 was standing in the hallway with a plate in her hand and she held it up and was releasing it from her hand to fall on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/06/2024 at 9:24 AM revealed Resident #61 was assisted to her room by CNA P. When in her room, CNA P gave her a tactile activity item and Resident #61 immediately threw it on the floor. Interview on 05/06/2024 at 9:26 AM CNA P stated Resident #61 did not enjoy the cloth with items attached to it. She stated when Resident #61 was given that activity item she always threw it on the floor. Resident #61 enjoyed holding hands sometimes and would smell things sometimes. She stated she did not observe activity staff doing an activity with Resident #61 in her room or in a group activity. Observation on 05/06/2024 at 2:05 PM Resident #61 was pacing in her room and entered the hallway. She stood in hallway less than 3 minutes and walked into her room. She would sit in her chair less than 3 minutes and begin to pace again. The only activity item that was in her room was a piece of cloth with different tactile items attached to it. Observation on 05/07/2023 at 9:15 AM Resident #61 was standing in her room. CNA P was in her room and attempted to give her the cloth with activity items on the cloth. When CNA P gave it to her, Resident #61 would immediately throw it on the floor. Observation on 05/07/2024 at 10:50 AM Resident #61 was standing in the hall pacing sideways and then she would stand and move her head constantly. CNA P intervened and assisted Resident #61 to her room, and she assisted her to her chair. The resident sat for a few minutes and began to pace in her room. In an interview on 05/07/2024 at 10:53 PM CNA P stated Resident #61 was difficult to re-direct at times. She stated the activity staff did not give them any other activity items to attempt with Resident #61. She stated the staff does not know what she can or can not do therefore, the activity staff did not attempt to do anything with Resident #61. Observation on 05/08/2024 at 9:30 AM Resident #61 was in her room and would stand up from her recliner and then immediately sit on her recliner. She continued to do this for approximately 5 minutes. She began to pace in her room and would stand at the door leading to the hallway and stand for a few minutes before returning to her recliner. In an interview on 05/08/2024 at 10:54 AM CNA F stated she had given care to Resident #4, Resident #21, and Resident #20. She stated she did not remember how many days of the week or months she had given care to these residents. CNA F also stated she had not observed the Activity Director or any staff in Resident #4, Resident #21 or Resident #20's room doing any type of activities with them. She stated she had not observed these residents attending any group activities. CNA F stated all three residents needed some type of activities . She stated it was possible for a resident become lonely and their memory may decline. In an interview on 05/8/2024 at 2:50 PM LVN B stated she had not observed any in room activities with Resident # 4, Resident #20 or Resident #21. She stated they could benefit from having activities or some type of stimulation other than the television. She also stated these residents needed someone to talk to them or play some calm/relaxing music. LVN B stated she had not witnessed Resident #20, Resident #21, or Resident #4 attending any group activities . LVN B stated residents without any stimulation or involved in activities may become depressed or withdrawn. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/09/2024 at 9:15 AM LVN C stated she had not witnessed activity staff go into Resident #61's room and do any type of one-on-one activity. She stated to her knowledge Resident #61 did not receive any type of activity in her room or in a group setting by the activity staff. LVN C stated it was difficult to interview with Resident #61 due to her being blind and deaf. She stated sometimes she allows people to hold her hand and sit with her. She stated she did not know about activities with Resident #4, Resident #20, or Resident #21. LVN C stated all residents needed activities in their room or in a group setting. She stated if a resident did not receive any type of activities, they may become lonely or feel no one cared about them. Interview and record review on 05/09/2024 at 9:30 AM the Administrator stated she expected all the residents not leaving their rooms or attending group activities to receive some type of activity of their past or present interest in their room by the activity director. She stated she knew some of the residents' received visits in their room. The administrator stated they were unable to locate the in-room list in the activity office. The administrator stated if a resident did not leave their room and did not receive one-on-one visits there was a potential a resident may feel lonely, have a decrease in their cognitive status, develop depression, or if they had a diagnosis of depression their depression may lead to a major depressive disorder. The administrator stated she was the activity director's supervisor. She stated the activity director had not been in the facility during the survey from 05/06/2024 through 05/09/2024. She reviewed the electronic medical records of the residents identified of needing one-on-one activities (Resident #4, Resident #20, Resident #21, and Resident # 61). The administrator stated after reviewing the electronic medical records there was no documentation of these residents receiving one-on-one activities or attending any group activities for the months of February, March, April, and May of 2024 . Interview on 05/09/2024 at 10:05 AM CNA Q stated Resident #61 would sit still and was more relaxed when someone would sit with her. She stated this did not happen all the time, but it helped more than giving her the cloth activity item. CNA Q stated she was not aware of activity staff doing any activities with Resident #61 or attempting to try different activities with Resident #61. She also stated she had not observed activity staff do activities with Resident #61 in her room or attempt to do activity with her in a group setting . She stated if a resident did not receive any type of sensory stimulation in room or out of room with activity staff the resident may become depressed or lonely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0686

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32452

Based on observation, interview, and record review the facility failed to ensure residents receive care consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and once developed, failed to ensure necessary treatment and services to promote healing for one (Resident #21) of six residents reviewed for pressure ulcers.

The facility failed to ensure Resident #21 who was at risk for skin breakdown was turned every two hours and provided incontinent care. on 05/07/2024, Resident #21 was left in the same position in her Geri-chair (specialized recliners that are upholstered in non-permeable, easily sanitized vinyl.) for 6 and a half hours from 8:00 AM till 2:30 PM. Once Resident #21 was placed in bed she was observed to have two DTIs (A pressure-related injury to subcutaneous tissues under intact skin.) to her coccyx that were previously unidentified by the facility.

An immediate Jeopardy (IJ) situation was identified on 05/07/2024 at 5:10 PM. While the IJ was removed on 05/09/2024 at 3:12 PM, the facility remained out of compliance at a scope of isolated with no further actual harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

These failures placed the residents at risk for developing worsening pressure ulcers, Cellulitis (skin infection), Osteomyelitis (infection of the bone), Sepsis (infection of the blood), severe pain or death.

Findings Include:

Review of Resident #21's face sheet dated 05/07/2023 reflected a [AGE] year-old female admitted to the facility on [DATE] with the following diagnoses Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Hypertension (High pressure in the arteries (vessels that carry blood from the heart to the rest of the body). Symptoms varies from person to person and generally include unexplained fatigue and headache.) and chronic lymphocytic leukemia (is a type of cancer in which the bone marrow makes too many lymphocytes (a type of white blood cell).

Review of Resident #21's quarterly MDS dated [DATE] reflected Resident #21 was assessed to have a BIMS assessment was not conducted indicating Resident #21 had severe cognitive impairment. Resident #21 was assessed to be dependent on staff for all areas of ADL care and was assessed to be incontinent of bowel and bladder.

Review of Resident #21's comprehensive care plan reflected:

-problem dated 09/26/2022 Resident #21 is incontinent of bowel and bladder. Interventions included .Check resident every two hours and assist with toileting as needed. Provide peri care after each incontinent episode and report any skin change to nurse immediately.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-problem dated 11/22/2023 and revised 04/19/2024 Resident #21 has actual impairment to skin integrity related to fragile skin, prone to easily bruising with pressure due to chronic lymphocytic leukemia. Interventions included .Keep skin clean and dry .reposition resident to prevent pressure for body parts . further review of Resident #21's care plan reflected no plan of care for pressure ulcers. Review of Resident #21's consolidated physician orders dated 05/07/2024 no orders for pressure ulcer wound care. Further review reflected an order dated 09/27/2022 pad all boney prominences with pillows to prevent breakdown. Review of Resident #21's weekly skin assessment dated [DATE] and locked on 05/06/2024 reflected no MASD or pressure ulcers were identified. Observation and interview on 05/07/2024 at 8:00 AM, revealed Resident #21 in her Geri chair in her room. Resident #21 was not interviewable. Observation on 05/07/2024 at 9:43 AM, revealed Resident #21 in her Geri chair in the same position in her room. Observation on 05/07/2024 at 12:00 PM, revealed CNA E passing out meal trays on Resident #21's hall. CNA E arrived at Resident #21's room at 12:25 PM and started feeding Resident #21. CNA E did not reposition Resident #21. Observation on 05/07/2024 at 12:45 PM, revealed Resident #21 up in her Geri chair in the same position. Observation on 05/07/2024 at 1:45 PM, revealed Resident #21 up in her Geri chair in the same position. In an interview on 05/07/2024 at 1:54 PM, CNA E stated she had not done incontinent care or repositioned Resident #21 since she got her up at around 8:00 AM. She stated she was fixing to go get help since she was on the hall by herself, and she needed help to put her to bed. Observation on 05/07/2024 at 2:30 PM, revealed CNA E and CNA F in Resident #1's room to put her in bed via the Hoyer lift. Observation of Resident #21's brief revealed it was saturated with urine and had a strong odor. CNA E turned Resident #21 to her right side to reveal a DTI approximately 0.1cm x 0.1cm to her right ischial tuberosity surrounded by a blanchable area of redness approximately 3 cm long and a 0.2 cm x 0.2 cm DTI to her lower coccyx area. In an interview on 05/07/2024 at 3:00 PM, the ADON state Resident #21 did not currently have skin breakdown so any areas on her would be new. After observing the areas to Resident #21's coccyx area she stated Resident #21 did have breakdown areas on her boney prominences. In an interview on 05/07/2024 at 3:15 PM, the DON stated she looked at Resident #21 yesterday and her skin was clear. When asked if the area could have resulted from her being up in her chair for an extended period of time she stated, I did not know she was up all day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/07/2024 at 3:20 PM, Resident #21's Hospice Nurse stated Resident #21 was at risk for breakdown and her skin was very delicate. She stated Resident #21's coccyx area was clear on her last visit a few days ago. Observation and interview on 05/08/2024 at 10:38 AM, revealed Resident #21 in room being prepped for wound care with the Wound care physician. Observation of Resident #21's coccyx area DTIs revealed both had declined and were darker in color from 05/07/2024. Resident #21's wound care physician stated both areas on Resident #21's coccyx were DTIs. He stated the areas could definitely be caused by not being turned and being on the same bony prominences for an extended period of time. Review of Resident #21's Physician wound evaluation and management summary dated 05/08/2024 reflected Resident #21 was assessed to have an unstageable DTI to the distal sacrum measuring 0.1cm x 0. 1cm and undetermined depth. Further review reflected an unstageable DTI to the sacrum measuring 0.3cm x 0.3cm and undetermined depth. In an interview on 05/08/2024 at 2:13 PM, the DON stated she expected the CNAs to check on the residents every 2 hours and do position changes. She stated CNA E could have asked anyone to help her and she did not. The DON stated CNA E did not give her an explanation of why she did not change Resident #21. The DON stated she expected the nurses as well to make rounds every two hours to ensure the CNAs are doing their jobs and to make sure the residents are taken care of to prevent skin breakdown. Review of the facility policy pressure injury prevention, assessment and treatment dated 08/12/2016 reflected 1.Nursing personnel will continually aim to maintain the skin integrity, tone, turgor, and circulation to prevent breakdown, injury, and infection. 2. Early prevention and/or treatment is essential upon initial nursing assessment of the condition of the skin on admission and whenever a change in skin status occurs. The nurse will determine if prevention and/or treatment of pressure sore(s) is indicated and notify the Treatment Nurse/designee of any potential problems . 4. Causes of Pressure Injuries: Unrelieved pressure over a bony prominence resulting in ischemia at the area of pressure. 1.Prevention: The nurse can assist in the prevention of pressure injuries by performing the following nursing interventions: NOTE: Add any interventions to care plan. 1. Determine resident's skin tolerance to pressure and develop a turning schedule; residents should be turned every two (2) hours or more often if necessary and notify the Treatment Nurse/designee of any potential problems. 2. Do the blanching test by pressing the finger into a reddened area, a normal blood supply to the reddened area is seen when the area blanches white and then turns pink again. If the area remains red, a pressure sore is impending due to impaired circulation, keep resident off the area for 24 hours and then repeat the test. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility' policy Perineal care dated 04/27/2022 reflected An incontinent resident of urine and/or bowl should be identified, assessed, and provided appropriate treatment and services to restore as much normal bladder/bowel function as possible . Skin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown. Moisture may make the skin more susceptible to damage from friction and shear during repositioning. One form of early skin breakdown is maceration or the softening of tissue by soaking. Macerated skin has a white appearance and a very soft, sometimes soggy texture. The persistent exposure of perineal skin to urine and/or feces can irritate the epidermis and can cause severe dermatitis, skin erosion and/or ulcerations. Skin erosion is the loss of some or all of the epidermis (comparable to a deep chemical peel), leaving a slightly depressed area of skin. Because frequent washing with soap and water can dry the skin, the use of a perineal rinse may be indicated. This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition . The Administrator was notified on 05/07/2024 at 5:10 PM, that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 05/09/2024 at 11:40 AM: Date: 5/7/2024 On 5/6/2024 an annual survey was initiated at the facility. 5/7/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an Immediate jeopardy to resident health and safety. Plan of Removal for F686 Approximately 48 residents who are incontinent and/or require assistance with turning and repositioning could be affected by this deficient practice. Problem: Failure to prevent pressure injury Root cause analysis was conducted. CNA E failed to change the resident's brief timely. CNA E failed to reposition the resident at minimum of every two hours while in the Geri chair. This caused pressure injuries. The Administrator, DON, and ADON will review the schedule daily to include weekends. This review will include that 2 staff members will be present at all times on station #1 to assist with ADLs. The call-in process is that they call the DON's cell phone when calling in. DON is responsible for initiating finding additional coverage. The DON will utilize the PRN call list, shift bonuses, staff from nearby sister facilities, or agency staffing if needed. Interventions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Weekly ulcer assessments for Residents #21 were completed to include measurements by DON, ADON, and Tx Nurse on 5/7/24. Two new pressure wounds were identified, measured, and treated according to physician orders. The MD was notified on 5/7/24 of Resident #21 new pressure wounds by the Tx Nurse. Orders were received for treatment and implemented on 5/7/24. Wound care treatments for Residents #21 were completed as ordered by the Tx Nurse on 5/7/24. 100% skin rounds were initiated 5/7/24 by DON, ADON, Treatment Nurse. No additional pressure wounds were identified. Administrator, DON, ADON, and Tx Nurse were in-serviced 1:1 by the Regional Compliance Nurse on 5/7/24 on the following topics. Completed 5/7/24. Pressure Injury Prevention Policy- to include incontinent care and repositioning at a minimum of every two hours while in bed or chair. Abuse and Neglect- failure to provide incontinent care or reposition a resident every two hours could result in skin breakdown which is neglect. Incontinent care- all residents should be checked and changed for incontinence at a minimum of every 2hrs while in bed or chair. The in-servicing includes requesting assistance for ADLs when needed. If staff can't locate assistance, notify the DON immediately. CNA E was in-serviced 1:1 by the DON on 5/7/24 for the following topics. Completed on 5/7/24. Pressure Injury Prevention Policy- to include incontinent care and repositioning at a minimum of every two hours while in bed or chair. Abuse and Neglect- failure to provide incontinent care or reposition a resident every two hours could result in skin breakdown which is neglect. Incontinent care- all residents should be checked and changed for incontinence at a minimum of every 2hrs while in bed or chair. The hall is adequately staffed with 1 nurse, 1 med aide, and 2 CNAs. The in-servicing includes requesting assistance for ADLs when needed. If staff can't locate assistance, notify the DON immediately. In-services: The following in-services were initiated by Regional Compliance Nurse, DON on 5/7/24 for all clinical staff. Any clinical staff not present or in-serviced on 5/7/24 will not be allowed to assume their duties until in-serviced. All new hires will be in-serviced during orientation. All agency staff or staff on leave will in serviced prior to assuming their next assignment. Pressure Injury Policy- to include incontinent care and repositioning at a minimum of every two hours while in bed or chair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER: Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Abuse and Neglect- failure to provide incontinent care or reposition a resident every two hours while in bed or chair could result in skin breakdown which is neglect. Incontinent care- all residents should be checked and changed for incontinence at a minimum of every 2hrs while in bed or chair. The in-servicing includes requesting assistance for ADLs when needed. If staff can't locate assistance, notify the DON immediately. The Administrator, DON, and ADON/designee will be responsible for ensuring that residents are checked for incontinence, brief changed, turned, and repositioned while in bed or Geri chair. Monitoring will occur during rounds daily for 10-15 randomly selected residents 7 days per week across all shifts including weekends. Monitoring will be documented on a form will continue for a minimum of 6 weeks. The Medical Director was notified of the immediate jeopardy situation on 5/7/24 by the administrator. An ADHOC QAPI meeting was held with the Administrator, DON, ADON, Tx Nurse and Medical Director to discuss the immediate jeopardy and plan of removal. Completed 5/7/24. The Survey Team monitored the POR on 05/08/2024 through 05/09/2024 as followed: Review of the facility's weekly wound assessment for Resident #21 reflected it was complete and conducted by the wound care physician on 05/08/2024. Review of Resident #21's nursing progress notes and weekly wound assessment dated [DATE] reflected Resident #21's physician was notified, and orders received for treatment and consult with wound care physician. Observation on 05/08/2024 at 10:38 AM, revealed wound care treatment conducted by the ADON and wound care physician. Review of the facility's skin round documentation initiated on 05/07/2024 reflected skin assessments conducted on all residents without new pressure ulcers being identified. Review of the one-on-one in-services for the Administrator, DON, ADON and Treatment Nurse dated 05/08/2024 reflected it was conducted by the RNC and covered the following areas: Pressure Injury Prevention Policy- to include incontinent care and repositioning at a minimum of every two hours while in bed or chair. Abuse and Neglect- failure to provide incontinent care or reposition a resident every two hours could result in skin breakdown which is neglect. Incontinent care- all residents should be checked and changed for incontinence at a minimum of every 2hrs while in bed or chair. The in-servicing included requesting assistance for ADLs when needed. If staff can't locate assistance, notify the DON immediately. In an interview on 05/08/2024 at 9:29 AM, the DON stated she was in-serviced by the RNC regarding pressure ulcer prevention, ADL care and monitoring staff to ensure care is provided. In an interview on 05/08/2024 at 9:45 AM the Administrator stated the RNC performed the one on one inservices for her and the DON and ADON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0686

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Review the one-on-one in-service for CNA E dated 05/08/2024 reflected it was conducted and covered the following topics: Pressure Injury Prevention Policy- to include incontinent care and repositioning at a minimum of every two hours while in bed or chair. Abuse and Neglect- failure to provide incontinent care or reposition a resident every two hours could result in skin breakdown which is neglect. Incontinent care- all residents should be checked and changed for incontinence at a minimum of every 2hrs while in bed or chair. The hall is adequately staffed with 1 nurse, 1 med aide, and 2 CNAs. The in-servicing includes requesting assistance for ADLs when needed. If staff can't locate assistance, notify the DON immediately.

Attempts to interview CNA E on 05/09/2024 were unsuccessful.

Review of the facility conducted in-services for Pressure Injury Policy- to include incontinent care and repositioning at a minimum of every two hours while in bed or chair was signed by 9 out of 10 CNAs and MAs and all 29 nurses dated 05/08/2024 and 05/09/2024.

Review of the facility conducted in-services for Abuse and Neglect- failure to provide incontinent care or reposition a resident every two hours while in bed or chair could result in skin breakdown which is neglect was signed by 9 out of 10 CNAs and MAs and all 29 nurses dated 05/08/2024 and 05/09/2024.

Review of the facility conducted in-services for Incontinent care- all residents should be checked and changed for incontinence at a minimum of every 2hrs while in bed or chair. The in-servicing includes requesting assistance for ADLs when needed. If staff can't locate assistance, notify the DON immediately was signed by 9 out of 10 CNAs and MAs and all 29 nurses dated 05/08/2024 and 05/09/2024.

In an interview on 05/09/2024 at 9:18 AM, CNA H stated she had been trained on rounds. She stated that the training covered doing rounds every two hours, changing the resident, and getting them off their bottoms. She stated residents on the secure unit were changed every hour to every hour and a half. She stated that when a resident had a change in skin condition that it should be reported to the nurse. She stated she was trained on pressure injury prevention. She stated the training covered making sure the resident was not on their bottom for an extended period and to keep them dry. She felt like the facility had enough staff and that the staff could do all their tasks and showers.

In an interview on 05/09/2024 at 9:23 AM, the ADON stated she had been trained on doing rounds. She stated that the training covered turning the resident and changing the resident. She stated residents were checked every two hours. She stated that when changing a resident staff were to reposition the resident to ensure the resident was not on the same side they had been on. The ADON stated she had been trained on change in skin condition. She stated that she would take care of the resident. She said she would assess the skin, so she could get measurements. She said she would then call the wound doctor and the family about the change in skin. She stated she would get an order in place. She stated that she had been trained on pressure injury prevention. She stated the training covered making sure that the resident is turned or repositioned every two hours. She stated when the resident was in a chair staff are supposed to repositioned in the chair. She stated that she felt the facility had enough staff. She stated everyone worked together and the staff were able to get everything done. She said she felt she had enough time to do all tasks and rounds.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/09/2024 at 9:37 AM, CNA G stated he was trained on rounds. He stated the training covered making sure the rounds were done every two hours and repositioned when finished changed. He stated that if the resident had a change in skin condition, he would report it to the nurse. He stated he was trained on pressure injury prevention. He stated the pressure injury prevention training covered turning the resident every two hours, making sure the resident was of the injury and put a pillow under the resident and keeping them dry. He stated he did not think the facility had enough staff. He stated he was able to complete all tasks because the shift is 12 hours. He stated he will do a shower for 30 minutes and then check the residents. He stated that the nurses and CMAs were good about helping. In an interview on 05/09/2024 at 9:12 AM CNA I stated she has been in-serviced this morning on turning every 2 hours, abuse, and neglect, not feeding 2 patients at one time, and reporting skin issues. I asked if you see a change in skin condition what do you do? She stated she tells her charge nurse immediately. When asked her if she felt there is enough staff working on the floor. She said yes. There is always 2 people on the locked unit. She stated if someone calls in sick, they bring someone else in. In an interview on 05/09/2024 at 9:22 AM LVN C stated she had been in-serviced this morning on abuse and neglect, pressure injury, skin breakdown, turning residents every 2 hours, not to feed 2 patients at one time and reporting skin issues. I asked if you see a change in skin condition what do you do? She told me she does an assessment, reports to the DON, lets the doctor know, and then puts treatment into place. I asked her how often she checks on residents, and she told me every 2 hours and if resident is having diarrhea more often. I asked her if she felt there is enough staff. She said for the most part yes. There is a shortage everywhere. I asked her what happens when there is not enough staff on the floor. She said there are enough resources and people come help. In an interview on 05/09/2024 at 9:32 AM, CNA J stated she had in serviced on rounds, checking residents every 2 hours, abuse, and neglect, and who to report skin breakdown to. I asked her how often she checks on her residents she said every 2 hours. I asked her if she felt there was enough staff on the floor. She said yes. I asked her what happens when there is not enough staff. She said she does her job and does what she needs to do. In an interview on 05/09/2024 at 9:38 AM, CMA D stated she has been in serviced this morning on not feeding 2 people at once, completing rounds every 2 hours, abuse, and neglect. I asked her if she sees a change in skin condition what she does. She reported she goes to the charge nurse. I asked her who she reports skin changes to she said the charge nurse. I asked her how often rounds are she said every 2 hours. In an interview on 05/09/2024 at 9:42 AM, LVN B stated she has been in-serviced this morning on abuse and neglect, skin breakdown, incontinent care, cleaning glucometers. I asked her how often they check on residents. She said every 2 hours. I asked her if she felt there was enough staff she said yes. That they always call people in if someone does not come in. In an interview on 05/09/24 at 12:55 PM, LVN K worked 6P to 6 A on 5/8 to 5/9 She stated they were in serviced on a lot last night and she was half asleep and will try to remember 1. Incontinent care (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER: Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Using barrier cream 3. Foley catheter and using PPE when giving care to Foley Catheter 4. Abuse and Neglect 5. Reporting any new skin concerns 6. Pressure Ulcers She stated there was more, but she could not remember. In an interview on 05/09/2024 at 12:49 PM, CNA O stated she was in serviced on abuse neglect the rounds and PPE for open wound and foley. Reposition the resident every two hours with the rounds. Was in serviced on pressure injury precautions put a pillow under the resident. The resident has heel protectors on to prevent pressure. Stated she thinks there is enough. No task not able to complete has not been short in over a month. Yes, stated she can do all her rounds and shower she is the only aid for two halls. In an interview on 05/09/2024 at 12:58 PM, CNA P stated he had been in serviced on rounds, checking residents every 2 hours, abuse, and neglect. He said he checks on residents every 2 hours and felt there was enough staff on the floor. He said they will call and see if more people come in she stated there is not enough staff. On 05/09/2024 at 3:12 PM, the Administrator was notified the IJ was removed on 05/09/2024 at 3:12 PM, the facility remained at a level of actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32452

Based on observation, interview, and record review the facility failed to ensure a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for two of five residents (Resident #4 and Resident #20), reviewed with limited range of motion.

A) The facility failed to ensure Resident #4 had interventions in place for her bilateral hand contractures (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen and a decrease in ROM) to prevent further decline of the range of motion in her hands and failed to ensure her fingernails were trimmed.

B) The facility failed to ensure Resident #20 had interventions in place for her right-hand contracture to prevent further decline of the range of motion in her right hand.

This deficient practice placed residents with contractures at risk for decrease in mobility, range of motion, and contribute to worsening of contractures.

Findings Include:

A) Review of Resident #4's face sheet dated 05/07/2024 reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with the following diagnoses Dementia (A group of symptoms that affects memory, thinking and interferes with daily life.) , Acute Kidney Failure(A condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few days. Symptoms include legs swelling and fatigue.), Hemiplegia (Hemiplegia is a symptom that involves one-sided paralysis) and Diabetes Mellitus Type II (A condition results from insufficient production of insulin, causing high blood sugar).

Review of Resident #4's Quarterly MDS assessment dated [DATE] reflected Resident #4 was assessed to not have a BIMS score conducted indicating severe cognitive impairment. Resident #4 was assessed to have functional limitations in range of motion for both upper and lower extremities. Resident #4 was assessed to be dependent on staff for all ADLs and was assessed to be incontinent of bowel and bladder.

Review of Resident #4's comprehensive care plan reflected a focus area dated 02/23/2024 Resident #4 has hemiplegia/hemiparesis. Interventions included apply right wrist cock-up splint with finger extenders after breakfast and take off before lunch .apply left padded palm guard on after breakfast and off before lunch . clean both hands with soap and water. Provide gentle stretch and ROM to bilateral hands one time day for contracture management .reposition at least every 2 hours and PRN. Further review of Resident #4's comprehensive care plan reflected a focus area dated 02/23/2021 Resident #4 is incontinent of bowel and bladder. Interventions included incontinent care at least every 2 hours and apply moisture barrier after each episode .

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's consolidated physician orders reflected orders to apply Left padded palm guard after breakfast and off before lunch, apply right wrist cock-up splint with finger extenders after breakfast and take off before lunch and to clean both hand with soap and water and provide gentle stretch and ROM to bilateral hand for contracture management. Observation on 05/07/2024 at 9:43 AM, revealed Resident #4 had contractures to both hands. Her fingers were bent toward her palm with her fingers pushing into the palm of her hand. Resident #4 had long finger nails. No splints or palm guards were observed. Observation on 05/07/2024 at 12:00 PM, revealed CNA E in Resident #4's room feeding her roommate Resident #20. Resident #4 bilateral hands remained without splints or palm guards. Observation on 05/07/2024 at 12:45 PM, revealed Resident #4 remained in room bilateral hands remained without splints or palm guards. In an interview on 05/07/2024 at 1:15 PM, CNA E stated Resident #4 should have wash cloths in her hands. She stated her fingers nails were very long and needed to be trimmed. She stated the facility did not have a shower aide, so she had to do the showers and work two halls and has not gotten around to doing Resident #4's fingernails or putting her hand rolls in because they were short staffed. She stated she was also responsible for showering Resident #4, and she stated did not get to it yesterday, but she did do it Friday. In an interview on 05/07/2024 at 1:25 PM LVN A stated Resident #4 should have hand rolls in her hands at all times and further stated that Resident #4 fingernails were long and needed to be trimmed she stated the CNA gets behind because she has to work both halls and do showers. Review of Resident #20's face sheet dated 05/07/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses Multiple sclerosis (A disease that affects central nervous system. The immune system attacks the myelin, the protective layer around nerve fibers and causes Inflammation and lesions. This makes it difficult for the brain to send signals to rest of the body.), and hemiplegia and hemiparesis (Hemiplegia is a symptom that involves one-sided paralysis. Hemiplegia affects either the right or left side of your body). Review of Resident #20's Quarterly MDS dated [DATE] reflected she was assessed to have a 7 BIMS score indicating severe cognitive impairment. Resident #20 was assessed to be dependent on staff for ADLs. Resident #20 was assessed to have impairment in ROM on one side for her upper extremities and both sides for her lower extremities. Review of Resident #20's comprehensive care plan reflected a focus area dated 10/14/2021 and revised on 07/26/2023 Resident #20 has hemiplegia/ hemiparesis. Interventions included reposition at least every 2 hours. Further review reflected a focus area dated 10/14/2021 and revised on 07/26/2023 Resident #20 is incontinent of bowl and bladder. Interventions did not include incontinent care every 2 hours. Resident #20's care plan did not include interventions for her contracted right hand or use of the therapy carrot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's consolidated physician orders reflected no orders for contracture devices. Further review reflected an order dated 04/27/2024 Pt to receive skilled OT services 3 X week X 60 days for therapeutic exercise, contracture management/education and therapeutic activities as tolerated. Observation and interview on 05/06/2024 at 7:15 AM, revealed Resident #20 up in Geri chair alert but not interviewable. Resident #20 was observed to have a contracture to her right hand and a therapy carrot was observed in her hand. Observation on 05/07/2024 at 9:43 AM, revealed Resident #20 in room up in Geri chair. No hand roll or device was in her right hand. Observation on 05/07/2024 at 12:45 PM, revealed Resident #20 in room up in Geri chair. No hand roll or device was in her right hand. Further observation revealed Resident #20's therapy carrot was noted on her night stand behind her. In an interview on 05/07/2024 at 1:15 PM, CNA E stated Resident #20 needed her therapy carrot in her hand, but she takes it out. CNA E then reached behind Resident #20 (who is unable to move on own) and retrieved the therapy carrot from her nightstand and placed it in her hand without resistance from Resident #20. In an interview on 05/08/2024 at 2:13 PM, the DON stated regarding residents with contractures, she expected staff to do range of motion and make sure their devices are in place and the nurses need to make rounds to check on residents because it could cause increased contracture, decreased ROM and pressure. Review of the Facilities policy Immobilization Devices, Splints/ Slings/ Collars/ Straps dated 2003 reflected immobilization devices are splints, slings, cervical collars, and clavicle straps that are applied to restrict movement, support, and preserve the integrity of an injured arm, shoulder or neck. Splints are rigid devices that can be used to treat a bone fracture, dislocation, or to prevent further damage of bones. All devices will be monitored on every two-hour schedule. Monitoring will be documented in the clinical record or flow sheet. Gradual discontinuation of the use of a device is preferred over abrupt cessation to allow for gradual muscle strengthening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review the facility failed to ensure residents who are incontinent of bladder receive appropriate treatment and services to prevent urinary tract infections for one of four residents reviewed for catheters. (Resident #18) The facility failed to ensure Resident #18 received care to prevent urinary tract infections when they stored his catheter bag on the floor and failed to ensure a catheter secure device was in place to prevent dislodgment. These failures could place residents with foley catheters at risk for urinary tract infections and change of condition. Findings included: Review of Resident #18's face sheet dated 05/08/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Cerebrovascular disease (conditions that impact the blood vessels in your brain.), bipolar disorder (A serious mental illness characterized by extreme mood swings. They can include extreme excitement episodes or extreme depressive feelings.) and benign prostatic hyperplasia (A condition in which the flow of urine is blocked due to the enlargement of prostate gland. The symptoms include increased frequency of urination at night and difficulty in urinating). Review of Resident #18's quarterly MDS assessment dated [DATE] reflected Resident #18 was assessed to not have a BIMS score conducted indicating severe cognitive impairment. Resident #18 was assessed to not have behaviors during the assessment period. Further review reflected Resident #18 was assessed to have an indwelling urinary catheter. Review of Resident #18's comprehensive care plan reflected a focus area dated 05/11/2023 Resident #18 has bladder incontinence. Resident #18's care plan reflected no plan of care of his indwelling urinary catheter. Further review of Resident #18's care plan reflected a focus area dated 04/08/2024 Resident #18 is non-complaint with catheter bag positioning and leaving privacy bag on. Interventions included Educated and remind resident on infection control, instructing him to keep it off the bedside table, nurses' station, etc.; Educated resident to keep catheter bag below his bladder and Remind resident to keep privacy bag on. Resident #18's care plan did not address him placing his urine collection bag on the floor, or staff interventions and monitoring to keep the collection bag off the floor, the use of a catheter secure device to prevent dislodgment or traumatic removal of his indwelling urinary catheter or monitoring for his behaviors of trying to hit staff with his urinary collection bag. Review of Resident #18's consolidated physician orders reflected an order dated 03/27/2024 for urinary catheter 16 F (French catheter scale is commonly used to measure the outside diameter of needles and catheters 1 French is equivalent to 0.33 mm of diameter) to gravity drainage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/06/2024 at 8:30 AM, revealed Resident #18 in room in bed. Resident #18's indwelling urinary catheter drainage bag was lying flat on the floor approximately 3 feet from his bed. Observation and interview on 05/07/2024 at 10:04 AM, revealed Resident #18 in bed with his indwelling urinary catheter drainage bag on the floor flat 2 to 3 feet away from his bed. Resident #18 was not interviewable and only smiled and waved at surveyor during interview attempts. In an interview on 05/08/2024 at 2:13 PM, the DON stated that urinary catheter drainage bags should not be on the floor because it could cause UTI's. She stated with Resident #18 it was a behavior, but the staff should be making rounds and checking on that to keep it off the floor. Observation on 05/08/2024 at 3:33 PM, revealed CNA F and CNA G in Resident #18's room to preform catheter care. Resident #18's urinary catheter drainage bag was on the floor in the middle of the room. CNA G picked up the bag and hung it on the bed frame. The CNAs pulled down Resident #18's pants to reveal he had no catheter secure device in place. Catheter care was done with out resistance or exhibited behaviors from Resident #18. In an interview on 05/08/2024 at 3:40 PM, CNA F stated Resident #18 did not use a catheter secure device because it got caught in his pants when they pulled his pants up and that he would miss with it. In an interview on 05/09/2024 at 9:29 AM, the DON stated she expected all residents with catheters to have catheter secure devices in place to prevent traumatic removal. Review of the facility's policy Catheter care dated 02/13/2007 reflected .4. When the resident is ambulatory the bag must be held lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. 5.Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site. 9.Review the residents' plan of care daily for changes. 10. Be sure the catheter tubing and drainage bag are kept off the floor The facility policy did not address using catheter secure devices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review the facility failed to ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being, for one of 12 residents (Resident #18) reviewed for residents with dementia and behaviors. The facility failed to develop and implement a comprehensive person-centered care plan to address Resident #18's continuous behaviors regarding his indwelling catheter. This failure could place residents at risk for their medical, physical, and psychological needs not being met and placed residents with indwelling catheters at risk of urinary tract infections and traumatic removal of the catheter leading pain and injury. Findings included: Review of Resident #18's face sheet dated 05/08/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses dementia (A group of symptoms that affects memory, thinking and interferes with daily life.), Cerebrovascular disease (conditions that impact the blood vessels in your brain.), bipolar disorder (A serious mental illness characterized by extreme mood swings. They can include extreme excitement episodes or extreme depressive feelings.) and benign prostatic hyperplasia (A condition in which the flow of urine is blocked due to the enlargement of prostate gland. The symptoms include increased frequency of urination at night and difficulty in urinating). Review of Resident #18's quarterly MDS assessment dated [DATE] reflected Resident #18 was assessed to not have a BIMS score conducted indicating severe cognitive impairment. Resident #18 was assessed to not have behaviors during the assessment period. Further review reflected Resident #18 was assessed to have an indwelling urinary catheter. Review of Resident #18's comprehensive care plan reflected a focus area dated 05/11/2023 Resident #18 has bladder incontinence. Resident #18's care plan reflected no plan of care of his indwelling urinary catheter. Further review of Resident #18's care plan reflected a focus area dated 04/08/2024 Resident #18 is non-complaint with catheter bag positioning and leaving privacy bag on. Interventions included Educated and remind resident on infection control, instructing him to keep it off the bedside table, nurses' station, etc.; Educated resident to keep catheter bag below his bladder and Remind resident to keep privacy bag on. Resident #18's care plan did not address him placing his urine collection bag on the floor, or staff interventions and monitoring to keep the collection bag off the floor, the use of a catheter secure device to prevent dislodgment or traumatic removal of his indwelling urinary catheter or monitoring for his behaviors of trying to hit staff with his urinary collection bag. Review of Resident #18's consolidated physician orders reflected an order dated 03/27/2024 for urinary catheter 16 F (French catheter scale is commonly used to measure the outside diameter of needles and catheters 1 French is equivalent to 0.33 mm of diameter) to gravity drainage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's nursing progress notes reflected an entry dated 05/04/2024 Resident approaching both nursing stations and placing his catheter collection bag on the counter after being asked numerous times not to. Very difficult to redirect- even swung like he was going to hit at this nurse . Further review reflected an entry dated 05/01/2024 Resident wandering up to nurses' station and placing his urine collection bag onto the nurses' station desk area. Attempted to re direct resident numerous times but continued to place the bag on the desktop. Observation on 05/06/2024 at 8:30 AM revealed Resident #18 in room in bed. Resident #18's indwelling urinary catheter drainage bag was lying flat on the floor approximately 3 feet from his bed. Observation and interview on 05/07/2024 at 10:04 AM, revealed Resident #18 in bed with his indwelling urinary catheter drainage bag on the floor flat 2 to 3 feet away from his bed. Resident #18 was not interviewable and only smiled and waved at surveyor during interview attempts. In an interview on 05/08/2024 at 2:13 PM, the DON stated that urinary catheter drainage bags should not be on the floor because it could cause UTI's. She stated with Resident #18 it was a behavior, but the staff should be making rounds and checking on that to keep it off the floor. The DON stated the nurses should be calling Resident #18's family and getting assist from them if his behaviors are not easily redirected. The DON stated Resident #18's care plan should address his use of the urinary catheter, his behaviors, and interventions to guide staff regarding his behaviors. In an interview on 05/08/2024 at 2:45 PM, the DON stated the facility did not have a person doing the care plans that her and the ADON were doing them. She stated Resident #18's care plan did not address his catheter and the care plan should not say bladder incontinence since he has a catheter. The DON stated his care plan should reflect his behaviors with his foley and interventions to address the behavior of placing the foley on floor and carrying it around which cause infection and lots of things. She stated they must have just missed it. In an interview on 05/08/2024 at 3:20 PM, LVN B stated Resident #18 did have behaviors related to this urinary catheter. LVN B was not sure what interventions were in place for them. She stated they tried a leg bag but because of his pants it made it difficult. She further stated he does put the bag on the floor, but staff should monitor and get it off the floor when they see it. When asked if they document his behavior and how often they monitor his drainage bag she stated she did not know. Observation on 05/08/2024 at 3:33 PM revealed CNA F and CNA G in Resident #18's room to preform catheter care. Resident #18's urinary catheter drainage bag was on the floor in the middle of the room. CNA G picked up the bag and hung it on the bed frame. The CNAs pulled down Resident #18's pants to reveal he had no catheter secure device in place. Catheter care was done without resistance or exhibited behaviors from Resident #18. In an interview on 05/08/2024 at 3:40 PM CNA F stated Resident #18 did not use a catheter secure device because it got caught in his pants when they pulled his pants up and that he would miss with it. In an interview on 05/09/2024 at 9:29 AM the DON stated she expected all residents with catheters to have catheter secure devices in place to prevent traumatic removal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy Catheter care dated 02/13/2007 reflected .4. When the resident is ambulatory the bag must be held lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. 5.Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site. 9.Review the residents' plan of care daily for changes. 10. Be sure the catheter tubing and drainage bag are kept off the floor The facility policy did not address using catheter secure devices. Review of the facility's undated policy Dementia and Behavioral Health reflected Behavior Human behavior is the response of an individual to a wide variety of factors. Behavior is generated through brain function, which is in turn influenced by input from the rest of the body. Specific behavioral responses depend on many factors, including personal experience and past learning, inborn tendencies and genetic traits, the environment and response to the actions and reactions of other people. A condition (such as dementia) that affects the brain and the body may affect behavior . The use of any approach must be based on a careful, detailed assessment of physical, psychological, and behavioral symptoms and underlying causes as well as potential situational or environmental reasons for the behaviors. Caregivers and practitioners are expected to understand or explain the rationale for interventions/approaches, to monitor the effectiveness of those interventions/approaches, and to provide ongoing assessment as to whether they are improving or stabilizing the resident's status or causing adverse consequences. Describing the details and possible consequences of resident behaviors helps to distinguish expressions such as restlessness or continual verbalization from potentially harmful actions such as kicking, biting, or striking out at others. This description alone does not suggest that a specific intervention is or is not indicated; however, it is important information that may assist the care team (including the resident and/or family or representative) in decision-making and in matching selected interventions to the individual needs of each resident. Identifying the frequency, intensity, duration, and impact of behaviors, as well as the location, surroundings or situation in which they occur may help staff and practitioners identify individualized interventions or approaches to prevent or address the behaviors. Individualized, person-centered interventions must be implemented to address behavioral expressions of distress in persons with dementia. In many situations, medications may not be necessary; staff/practitioners should not automatically assume that medications are an appropriate treatment without a systematic evaluation of the resident. Examples of techniques or environmental modifications that may prevent certain behavior related to dementia may include (but are not limited to) . Staff must make an ongoing effort to identify and document the new onset or worsening behavioral symptoms, including whether or not the behavior presents a significant risk for adverse consequences to the resident and/or others .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49097 Based on observations, interviews, and record review, the facility failed to prepare puree food by methods that conserve nutritive value, flavor, and appearance for 1 of 1 kitchen observed for puree preparation. The facility failed to follow the puree diet recipes. The puree diet meatloaf was mixed with water instead of thickener or a broth with nutrient value. This failure could affect residents on puree diet at risk of receiving inadequate diet that could affect their health. Findings included: Observation on 05/06/2024 at 12:08pm revealed [NAME] M pureed the meatloaf with water instead of the thickener on the counter. [NAME] M did not have any recipes out for the pureed food. Observation of [NAME] N pureeing food on 05/07/2024 at 10:41am did not have recipes out for the pureed food. An interview with [NAME] N on 05/07/2024 at 2:08pm revealed that [NAME] N had been trained on puree. She stated that when pureeing meat, broth or thickener was supposed to be used. She stated that when adding thickener or broth, a little at a time was added until the meat was at the proper texture. She stated she did not know the negative outcome of adding water to puree. She stated the cook was responsible for ensuring the puree was done correctly. [NAME] N stated the facility does have recipes for Puree and that she forgot to use the recipes. An interview with the FFS on 05/07/2024 at 2:23pm revealed when pureeing food, it was supposed to be mixed with broth, or a thickener. She stated she does not use the thickener much, instead she used the juices from the cooked food. The FFS stated that the facility does have recipes for puree. She also stated that she uses a measuring cup to ensure the right amount of thickener or broth was added. She said that the negative outcome of adding water to puree was that the food would not turn out right. She stated she did not know why the cooks did not use the recipes for puree. She also stated she did not know why [NAME] M used water when pureeing the meatloaf. An interview with the Administrator on 05/08/2024 at 10:34am revealed that staff were trained when they start working at the facility on puree by the dietary director. She stated the facility does have recipes for the cooks to follow. She stated that if staff were using the recipes, it would tell them how much thickener to use when doing puree. She stated that staff were never supposed to mix puree meat with water. She stated by using water it would take away the nutrient value and residents would not get the nutrition they need. She stated staff were supposed use broth when pureeing the meat An interview with Administrator on 05/08/2024 at 9:23am attempted several times to get the puree policy and did not receive it at exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with [NAME] M on 05/09/2024 at 8:37am revealed that the process for puree was to add gravy in the meat than add thickener if needed. She stated that she was trained to add thickener a little at a time until the food was at the right texture. She stated water was not supposed to be used when pureeing food. [NAME] M stated that when water was used it takes the nutrients out of the food. She stated she added water because she was trained by the previous manager to add the water to puree foods . Record Review of Recipes to Scale dated 05/09/2024 revealed that water should not be used as a liquid to puree food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49097 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for foods safety for 1 of 1 kitchen reviewed for food safety and sanitation. The facility failed to ensure food that was prepped was labeled and dated. The facility failed to maintain proper temperatures of food before putting on the steam table. This failure placed residents at risk of foodborne illness. Findings included: Observation of the kitchen on [DATE] at 6:52am revealed inside the walking cooler with milk, apple juice, and orange juice were not dated or labeled with the date they were prepped. In the freezer there were two bags of round pieces of dough that were not sealed or dated as to when it was opened. There were also sausage patties that were not sealed or dated in the freezer. In the dry food storage area, there was a container of flour that did not have a date as to when it was opened. Observation of [NAME] M on [DATE] at 12:08pm revealed the temperature of the pureed meatloaf was 120 degrees when put on the steam table. The temperature of the puree peas was 142 degrees when put on the steam table. Observation of [NAME] M on [DATE] at 12:10pm revealed [NAME] M put the food back in the oven to bring to correct temperature after surveyor started asking about temperatures. An interview with [NAME] N on [DATE] at 2:14pm revealed that items were to be labeled the day they were opened. She stated that anything that was opened or prepped should be labeled. [NAME] N stated that the aides and cooks were responsible for ensuring food was labeled and dated after opened or prepped. She stated that by not labeling and dating the items it could result in the residents getting sick. She stated that she did not know why the items in the cooler, freezer, and dry storage were not labeled and dated. An interview with Dietary Aide L on [DATE] at 2:17pm revealed that items should be labeled and dated after each use. She stated that any product that the staff open, or use should be labeled and dated with the date the food was opened or prepped. She stated that the risk of not labeling, and dating was that staff would not know when the food expired. She stated that residents would get sick if the staff used food that was expired due to not dating. She stated she did not know why the items that were in the cooler, freezer, and dry storage were not labeled and dated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the FFS on [DATE] at 2:21pm revealed that food items were to be labeled and dated when they come in and when the food was opened. She stated the risk of not labeling and dating food when it was opened or prepped could cause the residents to get sick. She also stated if the food was not labeled or dated the staff would not know how long it had been there. She stated the sticker could have fallen off the items in the cooler, freezer, and dry storage. She stated that the temperatures for meat on the steam table was 185 degrees. She stated for vegetables the temperature was 165 degrees. The FFS stated by food not being at the correct temperature it could cause harm to the residents. An interview with the Administrator on [DATE] at 10:23am revealed that food items were to be labeled and dated when the food comes in off the truck. She also stated that the food should be labeled and dated when opened and that the food should have two dates on them. She stated the risk of not labeling and dating food items would grow bacteria and cause the residents to get sick. She stated the dietary director was responsible for ensuring the food was labeled and dated. The Administrator also stated the items in the cooler, freezer, and dry storage should have been dated and the dietary director should have been checking daily to ensure the food was labeled and dated. The administrator stated the proper temperature for meat on the steam table is 140 and for vegetables was also 140. The Administrator stated the risk of food not being at correct temperature could create bacteria in the food and cause people to become ill. An interview with [NAME] M on [DATE] at 8:27am revealed that she had been trained on proper temperatures. She stated the temperature for meat when put on the steam table should be 165 degrees and vegetables should be 155 degrees. She stated the risk of the food not being at proper temperature could result in someone getting sick or the food being cold. She stated she did not know why she put the food on the steam table when they were not at the correct temperature. Record Review of the Food Safety Policy, not dated, revealed open food shall be labeled, dated, and stored properly. Record Review of Food Storage and Supplies Policy, not dated, revealed open packages of food are stored in closed containers with covers or in sealed bags and dated as to when opened. Record Review of Food Safety Policy dated ,d+[DATE] revealed Potentially hazardous food shall be maintained at: 41 degrees F or less, or 140 degrees F or above. Record Review of the 2022 FDA Food Code revealed TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the FOOD reach a temperature of at least 74oC (165oF).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32452 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases for two of four residents reviewed for infection control. (Residents #22 and #32) LVN A failed to sanitize the common glucometer, which is used during blood testing between resident blood sugar checks. This failure could lead to contamination of the nurse cart and potential resident exposure to blood-borne diseases. Findings Included: Review of Resident #22's face sheet dated 05/09/2024 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses Diabetes Mellitus Type II (A condition results from insufficient production of insulin, causing high blood sugar.) and Sepsis due to Methicillin Susceptible Staphylococcus Aureus (an infection caused by a type of bacteria commonly found on the skin). Review of Resident #22's Quarterly MDS assessment dated [DATE] reflected Resident #22 was assessed to have a BIMS score of 15 indicating he was cognitively intact. Resident #22 was assessed to have Diabetes Mellitus and further assessed to not receive insulin injections or have orders for insulin during the assessment period. Review of Resident #22's comprehensive care plan reflected a focus area dated 08/10/2023 Resident #22 had Diabetes Mellitus. Interventions included .Monitor for hyper/hypoglycemia (high or low blood sugar) . Review of Resident #22's consolidated physician orders reflected an order dated 01/09/2024 Accuchecks (blood sugar finger stick) three times daily for Diabetes Mellitus. Review of Resident #32's face sheet dated 05/09/2024 reflected a [AGE] year old male admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnosis Diabetes Mellitus Type II (A condition results from insufficient production of insulin, causing high blood sugar). Review of Resident #32's Quarterly MDS assessment dated [DATE] reflected Resident #32 was assessed to have a BIMS assessment was not conducted indicating severe cognitive impairment. Resident #32 was assessed to have Diabetes Mellitus and further assessed to not receive insulin injections or have orders for insulin during the assessment period. Review of Resident #32's comprehensive care plan reflected a focus area dated 12/15/2021 Resident #32 has Diabetes Mellitus and is on PO and SQ hypoglycemic medications. Review of Resident #32's consolidated physician orders dated 04/30/2024 Accuchecks (blood sugar finger stick) before meals and at bedtime related to Diabetes Mellitus. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/07/2024 at 11:00 AM revealed LVN A preparing to perform a finger stick blood sugar (FSBS) test on Resident #22. LVN A removed the glucometer from the cart and placed the glucometer on the cart without cleaning the cart. LVN A without cleaning the glucometer took a piece of wax paper out of the cart and took the glucometer and wax paper into Resident #22's room and without cleaning the over bed table she put down the wax paper and placed the glucometer on it. LVN A then performed the FSBS test on Resident #22. After the FSBS test LVN A took the glucometer and placed on her cart without cleaning it. LVN A then went to Resident #32's room. LVN A took the same glucometer into Resident #32's room with a piece of wax paper and placed in on his overbed table without cleaning it. LVN A then performed the FSBS test on Resident #32. LVN A then took the glucometer and placed it back on top of her medication cart. In an interview on 05/07/2024 at 11:06 AM LVN A stated she should have cleaned the glucometer between Resident #22 and Resident #32. She stated she forgot. She stated by not cleaning it could lead to the spread of infection in residents. In an interview on 05/08/2024 at 2:13 PM the DON stated she expected nurses to clean the glucometer between Residents to prevent the spread of infection. Review of the facility policy on Infection Control dated 03/2024 reflected The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection .Resident care equipment and articles . Invasive resident care equipment (i.e., scalpel, sharps) will be single use only. Tympanic thermometers will be used routinely unless otherwise specified. Tympanic thermometers will utilize the disposable covers to decrease the opportunity to spread infection. If rectal thermometers are specified for use, they will be cleaned immediately after use with an approved disinfectant. Any resident care equipment/article that is visibly contaminated with blood or body fluids will immediately be cleaned with an approved disinfectant.