

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675494	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Lone Star Ranch Rehabilitaion and Healthcare Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 316 General Cavazos Blvd Kingsville, TX 78363	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 2 (Resident #1 and Resident #2) of 2 residents reviewed for medical records.LVN A failed to document a verbal and physical altercation on 10/08/25 between Resident #1 and Resident #2 in a timely manner in Resident #1's progress notes.LVN A failed to document a verbal and physical altercation on 10/08/25 between Resident #1 and Resident #2 in a timely manner in Resident #2's progress notes.LVN B failed to document injury assessments on Resident #1 in a timely manner.RN C failed to document injury assessments on Resident #1 in a timely manner. These failures could put residents at risk of improper care based on inaccurate or incomplete documentation.Record review of Resident #1's admission record reflected a [AGE] year-old male admitted to the facility on [DATE]. His relevant diagnoses included unspecified dementia with agitation (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities with restless behaviors like pacing and rocking, as well as verbal or physical aggression like shouting or combativeness), mood disorder due to known physiological condition with depressive features (a mental health condition characterized by a disturbance in mood (like depression or mania) that is directly caused by a medical or physiological condition), and cognitive communication deficit (difficulty with communication).Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected a BIMS score of 4 which indicated severe cognitive impairment. Record review of Resident #1's progress notes reflected the following entries:Created date: 10/08/25 at 12:54 PM; Effective date: 10/08/25 at 12:50 PM by the MDS nurse, [PA-C] informed of incident with other resident and gave new order to increase Depakote 125mg PO TID. Order carried out and RP notified and agreed to medication increase. Floor nurse along with DON and Admin made aware of new order.Created date: 10/13/25 at 4:49 PM; Effective date: 10/08/25 at 4:46 PM by LVN A, CN was at nurses station and heard the resident in a verbal altercation with another resident in the hallway. CNA stated this resident was hit with a walker in the face by another resident passing him by. CNA separated both residents to de-escalate the situation. Resident stated, I don't know what happened, but he hit me. CN performed a head-to-toe assessment on the resident for any injuries. Resident had redness to the left eyebrow and under his left eye. Resident stated he had pain to the area. CN administered Tylenol to relieve the pain. RP, DON, ADMN and MD were notified.Created date: 10/15/25 at 4:05 PM; Effective date: 10/10/25 at 4:03 PM by LVN B, The resident with no noted injuries from altercation on 10/08/25, no bruising, nor redness noted to face nor upper body, the resident has no recollection of the incident.Created date: 10/16/25 at 5:24 AM; Effective date: 10/10/25 at 9:21 PM by RN C, No evidence of bruising or redness noted to face, or upper torso present from altercation on 10/08/25. No indication of pain. Continue plan of care.Created date: 10/15/25 at 4:07 PM; Effective date: 10/11/25 at 4:00 PM by LVN B, The resident with no noted bruising nor redness to face nor upper body from altercation on 10/08/25, no c/o of pain voiced denies pain when asked. The resident does not remember anything about the altercation.Created date: 10/16/25 at 5:25 AM; Effective date: 10/11/25 at 8:15 PM by RN C, No evidence of bruising or redness noted to face or upper torso present from altercation on 10/08/25. No indication of pain. Continue plan of care.Created date: 10/15/25 at 4:10 PM; Effective date: 10/12/25 at 1:07 PM by LVN B, The resident does not have any noted bruising nor redness to the face nor upper body from the altercation on 10/08/25, denies pain when asked, no c/o of pain voiced. the resident has no recollection of the altercation.Created date: 10/16/25 at 10:26 PM; Effective date: 10/12/25 at 10:30 PM by RN C, No evidence of bruising or redness noted to face or upper torso present from altercation on 10/08/25. No indication of pain. Continue plan of care.Record review of Resident #2's admission record reflected n [AGE] year-old male admitted to the facility on [DATE]. His relevant diagnoses included Alzheimer's disease with early onset (progressive brain disorder that slowly destroys memory and thinking skills) and unspecified dementia, unspecified severity, with other behavioral disturbance (loss of memory, language, problem solving and other thinking abilities which significantly impair a person's ability to perform daily activities with behavioral disturbances such as depression, agitation, and wandering).Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 4 which indicated severe cognitive impairment. Record review of Resident #2's progress notes reflected the following entry:Created date: 10/13/25 at 4:51 PM; Effective date: 10/08/25 at 4:50nm by LVN A. CN was at nurses station and heard the</p>		