

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 12/29/2025
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600</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 ensure residents had the right to be free from abuse for 1 of 5 residents (Resident #1) reviewed for abuse, neglect, and exploitation. The facility failed to protect Resident #1's right to be free from physical abuse when Resident #2 hit Resident #1 on the right arm, twice, on 12/10/2025. This failure could place residents at risk for physical injury. The findings included: 1. Record review of Resident #1's face sheet, dated 12/10/2025, revealed a [AGE] year-old female with an original admission date of 02/14/2018, and a current admission date of 10/28/2025. Resident #1's diagnoses included Dementia (a condition which affects memory, thinking, and the ability to perform daily activities), Alzheimer's Disease (a progressive disorder which was the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes), and Cognitive Communication Deficit (difficulties in communication which arise from impaired cognitive processes, such as attention, memory, organization, and executive functioning). Record review of Resident #1's Quarterly MDS assessment, dated 10/21/2025, revealed a BIMS score of 02, which indicated severely impaired cognition. The Quarterly MDS assessment also revealed Resident #1 had Non-Traumatic Brain Dysfunction (brain injuries caused by internal factors rather than external trauma, such as lack of oxygen to the brain, which could lead to cognitive impairments, exposure to toxins, pressure from tumors, strokes), Alzheimer's Disease (a progressive disorder which was the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes), and Non-Alzheimer's Dementia (a condition which affects memory, thinking, and the ability to perform daily activities, not related to Alzheimer's Disease). The MDS also revealed Resident #1 had physical and verbal behavioral symptoms directed toward others 1-3 days per week but not daily. Record review of Resident #1's care plan, initiated 12/10/2025, revealed Resident #1 was hit by another resident. Interventions included Resident #1 was moved to safety, and a full body assessment was completed. Resident #1's care plan also revealed Resident #1 had an altercation with another resident on 04/30/2024 and 01/14/2025. Interventions included Resident #1 was removed from the situation, taken to relax, and labs were ordered. Record review of Resident #1's progress note, dated 12/10/2025, revealed LVN-B was at the nurses' station documenting when she heard a male resident yelling at someone. LVN-B got up and ran around the nurses' station and saw a male resident make contact twice with Resident #1 on her right arm, so she ran toward the residents. The residents were immediately separated, and a head-to-toe assessment was completed with no injuries, redness, or swelling noted. LVN-B then reported the incident to the Administrator, RP, the DON, and the doctor. Resident #1 did not show any signs of distress, and Resident #1 was unable to describe what had occurred. 2. Record review of Resident #2's face sheet, dated 12/10/2025, revealed a [AGE] year-old male with an original admission date of 06/13/2023, and a most recent admission date of 10/17/2025. Resident #2's diagnoses included Dementia, Schizoaffective Disorder (a mental health condition which was marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), Cognitive Communication Deficit, Anxiety (intense, excessive and persistent worry and fear about everyday situations), and Major Depressive Disorder (a persistent feeling of sadness and loss of interest). Record review of Resident #2's Quarterly MDS assessment, dated 10/29/2025, revealed a BIMS score of 00, which indicated severely impaired cognition. The Quarterly MDS assessment also revealed Resident #2 had Non-Traumatic Brain Dysfunction, Non-Alzheimer's Dementia, Schizophrenia (a serious mental health condition which affects how individuals think, feel, and behave), Anxiety, and Depression (a persistent feeling of sadness and loss of interest). The only documented behavior for Resident #2 on the Quarterly MDS assessment dated [DATE] was a behavior of wandering. Record review of Resident #2's care plan, initiated 03/20/2024 and revised on 12/10/2025, revealed Resident #2 had the potential to be physically aggressive related to Dementia and Depression. This care plan listed the following entries: 04/30/2024 - altercation with another resident and placed on one-to-one monitoring until psychological evaluation done; 08/17/2024 - hit another resident in the arm; 07/26/2025 - altercation with another resident; 09/29/2025 - altercation with another resident; 12/10/2025 - altercation with another resident. Interventions included Resident #2 placed on one-to-one monitoring on 12/10/2025; Administer medications as ordered; Analyze times of day, places, circumstances, triggers, and what de-escalated the behavior and document; Assess and anticipate Resident #2's needs, such as food, thirst, toileting needs, comfort level, body positioning, and</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 4 treatment and medication carts (main treatment cart) reviewed for labeling and storage. The facility failed to ensure the main treatment cart belonging to RN-A was locked and secured. This failure could place the residents at risk of gaining access to unlocked medical supplies and medications which were not prescribed to them and could cause them harm. The findings included: Observation on 12/29/2025 at 8:19 AM revealed an unlocked treatment cart belonging to RN-A parked in the A Hall with no nurses or other staff around it. RN-A was in a room with a resident. There were residents noted to be ambulating in and down the halls. The main treatment cart lock was popped out, and all drawers were able to be opened and accessed. The main treatment cart was full of treatment supplies and treatment medications, to include scissors, needles, multiple containers of liquids, as well as a medication cup filled with a thick, white substance with a wooden spoon in it. Attempted to interview RN-A multiple times on 12/29/2025. She was performing treatments on residents at time the unlocked treatment cart was identified. RN-A left work early, as it was not her normal day or hours to work. Attempted to call RN-A multiple times on 12/29/2025 (called at 12:55 PM, texted at 12:56 PM, called at 5:01 PM) with no returned call or text from RN-A. In an interview on 12/29/2025 at 10:22 AM, the DON stated it was RN-A who worked on the main treatment cart today and did the resident treatments, and it was RN-A who left the main treatment cart unlocked. The DON stated all treatment carts and medication carts were to be locked for Resident safety if the nurse's step away from them. She stated if the carts were left unlocked residents could have gotten a hold of medications or supplies which could have caused them harm. She stated the last in-service for the nurses regarding medication carts was in November of 2024, so she went ahead and started an in-service today. In an interview on 12/29/2025 at 1:11 PM, the Administrator stated treatment and medication carts were supposed to be locked when not in use, and the nurses were responsible for their own medication and treatment carts. The cart was the responsibility of the nurse that was in control of it for that shift. He stated this was done for the residents' safety so they did not have access to medications or supplies which could harm them. The Administrator stated the DON had already started an in-service regarding this. Record review of the facility's Medication Storage Policy, dated 06/24/2025, revealed 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. 9. Unlocked medication carts are not left unattended.</p>		