STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675614	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballinger Healthcare and Rehabilitation Center	2001 6th St Ballinger, TX 76821

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services provided by the facility, as outlined by the comprehensive care plan, met professional standards of quality for one (Resident #27) of one resident observed for g-tube feedings.The facility failed to ensure the ADON administered medication and water to Resident #27 via her gastrostomy tube (g-tube) by following facility policy.The Facility failed to ensure the ADON performed hand hygiene and changed gloves while administering medication via g-tube.The facility failed to ensure the ADON cleaned the plunger after it came off established clean field area before using it again.These failures could place residents at risk for fluid overload, weight loss, aspiration pneumonia, abdominal discomfort, and risk for spread of infection.Findings included:Review of Resident #27 face sheet dated 02/19/26 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of gastronomy status (indicates that an individual has a surgically placed gastronomy tube (g-tube) providing direct access to the stomach for nutrition, hydration or medication), cerebral palsy (a group of conditions that affect movement and posture caused by brain damage before birth), anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about everyday issues affecting daily functioning and quality of life), intellectual disability, convulsion (a sudden, involuntary contractions of muscle causing uncontrollable shaking, which can affect part or all of the body), and dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities).Record review of Resident # 27's quarterly MDS dated [DATE], reflected a BIMS score 03 which indicated cognition was severely impaired. The MDS indicated that Resident #27 required total dependent on two or more staff for bed mobility, transfers, locomotion, eating, toilet use, and personal hygiene. The MDS indicated she was always incontinent with bowel and bladder.Review of Resident # 27's care plan dated 12/16/25, reflected the resident had a surgical site to abdomen related to peg-tube placement. The goal was for the surgical site to remain free from signs and symptoms of infection with treatment as ordered over the next 90 days.Review of Resident #27's Physician's Orders dated 2/01/26 through 02/28/26, reflected the following orders: Enteral feed order related to dysphagia. Start continuous enteral feeding. Formula: brand name 1.4. Rate: 45ml/hr. x 20 hours. Free water at 25ml/hr x20 hours. Start at 7:00a.m and end next day at 3: 00p.mObservations of medication administration via g-tube on Resident #27 on 02/18/26 at 11:47a.m., the ADON was observed putting on gloves without performing hand hygiene before starting care During the medication pass for Resident #27, The ADON separated the medications into different cups and crushed them. The ADON attached 60 cc of g-tube syringe. She checked for placement and instilled 60cc water before administering the medication. She was using over 30 cc of water for each medication administered which could cause fluid overload. This was against the facility's policy as reflected on the enteral tube medication administration policy. Resident #27 started coughing which caused the medication to spill out (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the syringe and spattered around the resident. The ADON tried to contain the spatter by using the plunger to cover the syringe. She placed the plunger on the unclean part of the bedside table away from the established clean field. The ADON did not clean the plunger before using it to stop the splatter. Additionally, her gloves were visible soiled with spattered medications. She did not wash hands, change gloves or perform hand hygiene. Meanwhile, the ADON did not completely dissolve the medication for Dilantin oral chewable 50 mg and omeprazole magnesium. There was a great quantity of these medications left on the cups. The ADON threw these medications in the trash can. Consequently, Resident#27 did not get all her medications as ordered.Record review of Resident #27's Physician Orders dated 02/01/26 through 02/28/26 reflected the following:Omeprazole Magnesium Oral Packet 40 mg. Give 1 tablet via p-tube two times a day.Dilantin Oral Tablet Chewable 50 MG. Give three tablets via peg-tube once a day.Famotidine Oral Tablet 20 MG. Give tablet via peg-tube two times a daySucralfate Oral Suspension 1 GM/10ML-10 ml via peg-tube four times a dayMetoclopramide Oral Solution 5 MG/5M. Give 10 ml via peg -tube four times a dayAcetaminophen Oral 15 ml. Give 15 ml via peg tube three times a dayFerrous Sulfate oral solution. Give 7.5 ml via g-tube one time a dayMiralax oral Powder 17 gm/scoop-Give I scoop via g-tube once a dayMultivitamins with minerals. Give 15 ml via g-tube one time a day.In an interview with the ADON on 02/19/26 at 3:36p.m., she stated she had been employed by the facility for about three weeks. She stated she received infection control training during her orientation. The ADON stated cross contamination was not washing hands or changing gloves. She stated she should have washed her hands and changed gloves while providing care. She said she was nervous. The ADON explained she was not aware she used excess water while administering medication to Resident #27 via g-tube. The ADON stated she did not receive training from the facility regarding medication administration via g-tube.During an interview with RNC on 02/19/26 at 4:12p.m, he stated he was aware of the concerns raised about infection control and medication administration via g-tube. He stated the staff was expected to wash hands before and after providing care to residents. RNC said staff were supposed to follow the facility procedure in medication administration through g-tube including checking placement and ensuring all medication was given to the resident. The RNC stated he could not locate training/in-services on g-tube medication administration by the facility. He stated that the staff receive annual training on infection control with checks with return demonstrations.Record review of the facility infection control policy updated 03/2024 reflected the following: Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: When coming on duty. When hands are visibly soiled (hand washing with soap and water); Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). Before and after performing any invasive procedure (e.g., fingerstick blood sampling). Before and after entering isolation precaution settings. Before and after eating or handling food (hand washing with soap and water). Before and after assisting a resident with meals. Before and after assisting a resident with personal care (e.g., oral care, bathing).Record review of the facility enteral tube medication administration policy undated reflected the following:Policy:Safely and accurately administer oral medications through an enteral tube.MedicationFeeding (50cc) syringe75-100 ml water 4) Clamp5. Stethoscope6. Drinking cupProcedure:1. Wash hands2. Identify resident before administering medicatione Check arm band or photograph ask resident to state their name or check with other staff members ifnecessary.Explain procedure and purpose of medication to resident. Residents have the right to be informed of all medications he/she receives. Provide privacyIf the resident is in bed, elevate the head of bed to 30-45-degreeangle.deletedVerify tube placement Unclamp tube and use either of the following procedures:(C) Insert (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a small amount of air into the tube with the syringe and listen to stomach with stethoscopefor gurgling sounds(C) Aspirate stomach contents with syringe Never administer medications through a [NAME]-[NAME] tube. Use a Dubhoff or Kangaroo tube.e Re-clamp tube to maintain a closed system. Check that the breathing tube is not clamped.Read medication label three times before administering, checking with MAR. If the label is incorrect, the nurse is responsible for applying a direction change sticker to the medicationlabel. Empty capsule contents into 10 to 15 ml of water or other appropriate liquid. Administer each medication separately, flushing tube with 5-15 ml of water after each dose. Medications are never added directly to the feeding solution.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice for 2 (Resident #2 and #36) of 4 residents observed for oxygen management. The facility failed to ensure Resident #2 and Resident #36 had an oxygen signs posted outside their room. This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and at risk of harm and exposure to a fire hazard if staff and visitors are not aware of oxygen present.Findings included: Record review of Resident #2's admission record dated 02/19/2026, revealed she was admitted to the facility on [DATE] with diagnoses of dementia and heart failure. The admission record indicated She was [AGE] years old. Record review of the current care plan for Resident #2, last reviewed/revised: dated 09/10/2025, revealed in part indicated: The resident has Oxygen Therapy related to SOB due to CHF. Provide reassurance and allay anxiety: Have an agreed-on method for the resident to call for assistance (e.g., call light, bell). Stay with the resident during episodes of respiratory distress. Record review of Resident #2's MDS assessment dated [DATE], revealed in part: Section O - Special Treatments, Procedures, and Programs. Respiratory Treatments - Oxygen therapy. Record review of Resident #2's order summary report dated 02/18/2026, revealed in part: Oxygen LPM: 2-5 liters via nasal cannula as needed for Shortness of Breath. Start date: 09/01/2025. Observation on 02/18/2026 at 10:28 AM, Resident #2 was observed in bed resting and was observed with oxygen on via nasal cannula on which was connected to the concentrator at . The concentrator was on and set at 2 liters per minute. There was no oxygen sign seen outside of the room. Record review of Resident #36's admission record dated 02/19/2026, revealed she was admitted to the facility on [DATE], with a diagnosis of chronic respiratory failure with hypoxia (low blood oxygen). The admission record indicated She was [AGE] years old. Record review of the current care plan for Resident #36, last reviewed/revised: dated 01/19/2026, revealed in part: The resident has Oxygen Therapy related to Chronic Respiratory Failure. Monitor for signs/symptoms of respiratory distress and report to MD PRN: Record review of Resident #36's MDS assessment dated [DATE] revealed in part: Section O - Special Treatments, Procedures, and Programs. Respiratory Treatments - Oxygen therapy. Record review of Resident #36's order summary report dated 02/18/2026 revealed in part: Oxygen LPM: 2 Via: nasal cannula every shift. Start date: 01/19/2026. Observation on 02/18/2026 at 10:22 AM, Resident #36 was in bed resting and had their oxygen on. She was observed with her nasal cannula on which was connected to the oxygen concentrator at 2 liters per minute. The concentrator was on and set at 2 liters per minute. There was no oxygen sign seen outside of the room. During an interview on 02/19/2025 at 2:34 PM, the ADON said it was expected for the resident rooms to have an oxygen signs posted outside the room to indicate there was oxygen being used in that room. The ADON said a possible negative outcome would be that someone could light a cigarette in that room, and also an electronic devices could lead to a fire. During an interview on 02/19/2026 at 2:52 PM, with the Administrator, he said it was expected for an oxygen signs in use to be posted outside the resident's residents rooms where oxygen was being used. The Administrator said this was expected for safety reasons such as no smoking allowed in that room. Record review of the facility policy titled 2.0 Nasal Cannula dated June 1, 2006, revealed in part: Oxygen therapy via nasal cannula is administered as ordered by a physician. Explain safety rules. Post No smoking - Oxygen in use sign on the patient's door if appropriate.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis. The facility failed to ensure they employed had a full time or interim DON from 12/27/2025 through present (02/19/2026). This failure could place all residents at risk of not receiving necessary care and services. Findings included: During an interview on 02/19/2026 at 2:55 PM, the Administrator said the previous DON's last day at the facility was 12/27/2025. The Administrator said the interim DON was the RNC whom would oversee the facility and was readily available by phone as needed. The Administrator acknowledged stated the RNC did not qualify to be the interim DON due to the RNC not being in the facility 8 hours a day. The Administrator said they had interviewed some possible candidates for the DON position. The Administrator said he did not believe the residents had had had any negative outcomes due to no current DON. as He said the RNC had been overseeing the facility plus and they had nursing staff available. Interview on 02/19/2026 at 3:00 PM, the Administrator said they the facility did not have a policy for DON requirements and went based on the state regulations for guidance.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented for 1 of 12 residents (Resident #2) reviewed, in that: The facility failed to ensure Resident #2's eTAR for the month of January 2026 were completed by the nursing staff and not left blank. This failure could place residents at risk of not receiving proper care and having their personal needs met.The findings included: Record review of Resident #2's admission record dated 02/19/2026, revealed she was admitted on [DATE] with diagnoses of dementia and heart failure. The admission record indicated she was [AGE] years old. Record review of care plan for Resident #2dated 09/10/2025, revealed The resident has Oxygen Therapy related to SOB due to CHF. Provide reassurance and allay anxiety: Have an agreed-on method for the resident to call for assistance (e.g., call light, bell). Stay with the resident during episodes of respiratory distress. Record review of Resident #2's MDS assessment dated [DATE], revealed Section O - Special Treatments, Procedures, and Programs. Respiratory Treatments - Oxygen therapy. Record review of Resident #2's eTAR for the month of January 2026 revealed Oxygen LPM: 2-5 liters via nasal cannula as needed for Shortness of Breath. The document did not indicate documentation for oxygen, pulse and rate, and time completed. During an interview on 02/19/2026 at 2:36 PM, the ADON said nurses should have documented Resident #2's oxygen status on the eTAR and not just on the vital signs section. The ADON said if e nurses did not document on the residents' eTAR they would not know if the resident was using the oxygen more regularly or if the resident needed it more than just as needed. During an Interview on 02/19/2026 at 3:12 PM, the Administrator said it was expected for nursing staff to document the residents' treatments on their corresponding eTAR. The Administrator said the documentation was located on the resident's electronic chart under vital signs but not on the eTAR. The Administrator said if the treatment was not documented, then they would not be able to determine if the treatment was done. Record review of the facility's undated policy titled Documentation revealed in part: Documentation is the recording of all information both objective and subjective in the clinical record of an individual and or soft resident file. Goal - the facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.

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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** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #9) of 3 residents reviewed for infection control. The facility failed to ensure LVN A used recommended PPE for Resident #9 who was on EBP precautions when changing her urinary catheter. This failure could place residents at risk of cross contamination and the spread of infection. Finding included: Record review of Resident #9's admission record dated 02/17/2026, indicated she was admitted [DATE], diagnosis included uninhibited neuropathic bladder (Usually due to damage to the brain from a stroke or brain tumor. This can cause reduced sensation of bladder fullness, low-capacity bladder, and urinary incontinence. The admission record indicated she was [AGE] years old. Record review of Resident #9's care plan dated 01/28/2026, revealed Resident is on enhanced barrierprecautions related to the presence of colostomy and foley catheter. There will not be any transmission of infection from or to the resident. Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, catheter care, or other high-contact activity. Date Initiated: 01/11/2026 Record review of Resident #9's MDS assessment dated [DATE] indicated Section H - Bladder and Bowel. Check all that apply: Indwelling catheter. Record review of Resident #9's order summary report dated 02/17/2026, indicated Foley Catheter: 18 French (size of catheter) with 10 bulb - change for occlusion, leaking, closed system was compromised as needed. Start date 01/28/2026. During an observation on 02/17/2026 at 10:55 AM, LVN A changing Resident #9's urinary catheter. LVN A entered the resident's room and washed her hands and then put on a pair of clean gloves. LVN A then proceeded to remove Resident #9's urinary catheter. LVN A used gloves but did not wear a gown during the resident care. There was a 3-drawer plastic dresser in the room that contained gloves and gowns observed. There was a posting posted outside Resident #9's room, the posting indicated Multi drug-Resistant Organism (MDROs) are a threat to our residents. Enhanced Barrier Precautions (EBP) steps, perform hand hygiene, wear gown, wear gloves, dispose of gown and gloves in room. Use EBP during high-contact care activities for residents with: Indwelling medical devices e.g. urinary catheter. During an interview on 02/19/2026 at 1:58 AM, LVN A said she was supposed to use a gown when she changed Resident #9's urinary catheter. The LVN said that she had a lot going on that day and was distracted so she forgot to put a gown on. LVN A said she had been trained on when and how to use EBP. LVN A said not wearing a gown could lead to an infection or cross contamination. During an interview on 02/19/2025 at 2:24 PM, the ADON said the expectation was for nursing staff to use PPE when assisting Resident #9 with her urinary catheter. The ADON said LVN A should have known to use PPE . The ADON said if nurses did not wear PPE as indicated then they could spread infections to and from that resident. During an interview on 02/19/2026 at 3:05 PM, the Administrator said it was expected for nursing staff to use EBP when care was provided to a resident that was on EBP precautions. The Administrator said that if the correct EBP was not worn it could lead to cross contamination. Record review of the facility undated policy titled Enhanced Barrier Precautions revealed Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: Wounds and or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Indwelling medical device example include urinary catheters.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observation, interview, and record review the facility failed to ensure each room was designed or equipped to assure full visual privacy for 3 (Rooms 5, 18 and 21) of 30 dual occupancy rooms reviewed for privacy in the facility. The facility failed to ensure that dual occupancy rooms were provided with ceiling suspended curtains, which extended around the bed, to provide total visual privacy. This failure could lead to a lack of privacy for residents, allow residents' private medical treatment to be observed by roommates or others, and lead to a decline in psychosocial well-being. Findings included: During an observation on 02/17/2026 at 2:35 PM, resident rooms 5, 18 and 21 on halls A and B revealed that each room had dual occupancy with an A and B bed in each. The rooms had a single ceiling to floor curtain that divided the center of the room but stopped approximately 12 inches from the wall. Both A and B beds had a side curtain each but they each had a gap of 18 inches and 30 inches and were unable to allow for beds to have total visual privacy. Interview on 02/19/2026 at 3:02 PM, the Administrator said if the resident room did not have a full visual privacy curtain, then it would not provide privacy when a resident requested it. The Administrator said they were already in the process of correcting the curtains. Interview on 02/19/2026 at 3:04 PM the Administrator said they did not have a policy regarding privacy curtains.