STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675630	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gulf Shores Rehabilitation & Healthcare Center	1301 S Terrell St Falfurrias, TX 78355

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all alleged violations involving the reasonable suspicion of a crime were reported immediately to a law enforcement entity for its political subdivision, within two hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 (Resident #1) of 5 residents reviewed for abuse/neglect.The facility failed to report to the local law enforcement agency within the allotted time frame of 24 hours on 01/27/2025 around 8:53 AM when LVN A observed red/yellow discoloration on Resident #1's left breast and areola.This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse.The findings included:Record review of Resident #1 face sheet dated 07/07/2025 revealed Resident #1 was a [AGE] year-old- female who was initially admitted on [DATE]. Resident #1 was admitted with diagnoses of Alzheimer's disease (cognitive impairment) and dementia (cognitive impairment) and altered mental status. Record review of Resident #1's Comprehensive MDS dated [DATE] revealed Resident #1 had a long-term and short-term memory problem which meant severely cognitively impaired and was dependent on staff for ADLs.Record review of Resident #1's Care Plan date implemented 11/03/2024 and revision date on 03/02/2025 have actual impairment of my skin integrity r/t Diabetes, protein calorie malnutrition, B&B incontinence 1/27/2025 Discoloration to right chest down to breast. 1/27/25Resident noted tightly crossing arms over chest area, at risk for self-inflicted bruising. Goal: My area of discoloration to left chest and breast will be resolved by review date. I will maintain intact skin through the review date. Interventions: 1/18/25 Staff in-serviced by DOR on proper transfer techniques and handling residents. Resident sleeps with arms crossed in fetal position and is at risk for bruising. or changes and report to DS if abnormal. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocol for treatment of skin impairment. Incontinent care as needed. Apply barrier cream as needed. Keep skin clean and dry. Use lotion on dry skin. Monitor (specify meds/treatments) for potential side effects compromising skin integrity. Notify MD/NP/PA/RP of impairments of skin integrity. Pillow will be given to resident and placed over chest to minimize resident from applying pressure to chest area to prevent bruising. Skin checks weekly. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Record review of Resident #1's Skin Observation tool dated 01/27/2025 at 08:53AM revealed Area of red/yellow discoloration from left chest down to left breast and areola. Skin 100% intact 20cm X 7.5cm X 0cm. Record review of the facility's Provider Investigation Report regarding Resident #1 revealed incident date 01/27/2025, Facility Nurse performed a head-to-toe assessment and noted red and fading yellow discoloration to the left chest wall and left breast and areola skin intact 20 cm x 7.5 cm x 0. Resident in not apparent pain. No physiological or psychological distress noted. Resident within her normal baseline.During an interview on 07/07/2025 around 2:21PM, the Administrator stated the bruise on Resident #1 did not look suspicious, however on 01/27/2025 could not definitively rule out abuse as the investigation was ongoing. The Administrator stated once she attained all the details regarding Resident #1's left chest bruise, she concluded that the injury may have stemmed from possible gait belt usage. The administrator stated she the facility's protocol would be to initially treat the skin irregularity as abuse and would notify HHSC and local law enforcement immediately. The Administrator stated she did know recall why she did not notify the local law enforcement as it is one of her initial steps. The Administrator stated the reason she notifies the local law enforcement was due to being on her facility policy and procedures in accordance with state regulations. The Administrator gave no definitive answer when questioned what could happen if the local law enforcement is not notified of an allegation of abuse. The Administrator reiterated she may have forgotten to notify local law enforcement regarding Resident #1's bruise, and continued to state the bruise was not suspicious, however since Resident #1 was cognitively impaired she was unable to verbalize how the skin discoloration occurred. The Administrator stated she reports all allegations of abuse and neglect to the appropriate state agencies and local law enforcement, however for this incident she did not, but will for future incidents. Record review of the facility's gait belt transfer in-service dated 1/27/25 was reviewed.Record review of the facility's Abuse Prohibition Policy in-service dated 1/27/25 was reviewed.Record review of the facility's Abuse Prohibition Policy reviewed dated 6/2/25 revealed,Reporting/Response: 2. The facility will report all allegations and substantiated occurrences of abuse, neglect or misappropriation of resident property to the state agency and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents, for one of four residents (Resident #2) reviewed for accidents and supervision.The facility failed to ensure CNA A used a gait belt to transfer Resident #2 from the wheelchair to bed on 07/06/2025.This failure could place residents at risk for falls, injuries and a decline in health.Findings include:Record review of Resident #2's face sheet, dated 07/07/2025, revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 diagnoses included lack of coordination, muscle wasting and atrophy (breakdown of tissue), hemiplegia (paralysis of one side of body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, abnormalities of gait and mobility, and lack of coordination. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed Resident #2 had a BIMS score of 15, which meant Resident #2 was cognitively aware. Resident #2 needed substantial/maximal assistance for chair/bed-to-chair transfer. Resident #2 was coded to have neurological deficits of cerebrovascular accident, transient ischemic attack or stroke and hemiplegia or hemiparesis.Record review of Resident #2's care plan focus date initiated 10/10/2024 and revised on 01/25/2025, The resident has an ADL self-care performance deficit r/t Left hemiplegia (weakness to extremities) and hemiparesis (paralysis to one side of the body) TRANSFER: The resident requires Total assistance) by (X1) staff to move between surfaces. Encourage the resident to use bell to call for assistance.During an observation 07/06/2025 at 3:27PM CNA A entered Resident #2's room and assisted Resident #2 by pushing Resident #2's wheelchair to the right side of her bed. CNA A then locked the wheelchair brakes and proceeded to stand in front of Resident #2. Upon initial observation there was observable left sided deficit on Resident #2's left leg and right leg. CNA A then proceeded to assist Resident #2 to stand and observed CNA A use arm strength to transfer Resident #2 from wheelchair to bed. During Resident #2's transfer, Resident #2 pivoted to her bed and observed visible struggle while she staggered when pivoting from wheelchair to bed. Resident #2 was observed to have compromising balance as she was observed to be struggling while transferring to her bed. Resident #2 was successful in transferring to the bed. Throughout the transfer CNA A did not utilize a gait belt.During an interview on 07/06/2025 AT 3:40PM, CNA A stated she should have used a gait belt to assist Resident #2 to transfer onto her bed. CNA A stated she was unaware Resident #2 had a stroke or had left sided weakness, while Resident #2 struggled to transfer into the bed. CNA A was asked if she utilized a gait belt when transferring Resident #2, CNA A stated she did not use a gait belt due to not having a gait belt with her. CNA A stated she left her gait belt in a different hall but usually keeps it on her person. CNA A stated she did not use a gait belt because she had left the gait belt in her assigned hallway. CNA A stated she was supposed to use a gait belt for transfers but did not have access to it as it was in a destination that was not near Resident #2's room. CNA A stated by not using a gait belt Resident #2 could have fallen and was fortunate that she did not fall. CNA A stated going forward she would ensure to always keep a gait belt with her and would utilize the gait belt when she transferred any resident. CNA A stated she could not recall when she was last educated about resident transfers.During an interview on 07/07/2025 at 1:27PM the DON stated he was made aware of the observation by CNA A. The DON stated initially, the physical therapy department will conduct a transfer mobility in-service when needed. The DON stated CNA A should have used a gait belt when transferring Resident #2 from wheelchair to the bed, as not only a safety precaution but also to maintain Resident #2's wellbeing. The DON stated the therapy department would work with the CNAs on proper body mechanics when transferring a resident. The DON stated the nursing staff would notify the CNAs on what level of transfer assistance is warranted for each resident. The DON stated CNA A may have compromised Resident #2's well-being as Resident #2 may have fallen. The DON stated CNAs should use a gait belt with all mobile residents as a precautionary safety measure. The DON stated all CNAs were supposed to keep a gait belt on their persons. The DON gave no definitive answer when asked who was responsible for training staff on transferring precautions/procedures. The DON stated going forward he would conduct an impromptu in-service regarding gait belt transfers.Record review of the facility's CNA A's Restorative Nurse Aide Competency Checklist dated 4/18/2025 revealed CNA A was checked off on 2. Gait: b. Proper use of gait belt.Record review of the facility's Safe Patient Handling and Moving Protocol reviewed on 06/18/2025 documented General considerations: Utilize gait belt during all weight bearing transfer activity

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 disease and infection for one (Resident #2) of five residents reviewed for infection control, in that:CNA A, on 07/06/2025, did not remove her contaminated gloves nor performed hand hygiene after touching multiple surfaces prior to initiating Resident #2's perineal care. Additionally, CNA A failed to perform hand hygiene and gloves changes while performing incontinent care.These failures could place residents at risk for contamination and infection.The findings included:Record review of Resident #2's face sheet, dated 07/07/2025, revealed a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 diagnoses included lack of coordination, muscle wasting and atrophy (breakdown of tissue), hemiplegia (paralysis of one side of body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, abnormalities of gait and mobility, and lack of coordination.Record review of Resident #2's Quarterly MDS, dated [DATE], revealed Resident #2 had a BIMS score of 15, which meant Resident #2 was cognitively aware. Resident #2 needed substantial/maximal assistance for chair/bed-to-chair transfer and was dependent on staff for toileting hygiene, however, gave no specificity on how many staff members were required for transferring within the MDS document. Resident #2 was coded to have neurological deficits of cerebrovascular accident, transient ischemic attack or stroke and hemiplegia or hemiparesis.Record review of Resident #2's care plan focus date initiated 10/10/2024 and target date 09/21/2025, The resident has (bladder and bowel incontinence r/t CEREBRAL INFARCTION, UNSPECIFIED. Goal: The resident will remain free from skin breakdown due to incontinence and brief use through the review date. BRIEF USE: The resident uses disposable briefs. Change (Q 2hrs) and prn. Clean peri-area with each incontinence episode. Encourage fluids during the day to promote prompted voiding responses. INCONTINENT: Staff to perform incontinent care during daily care and as needed. Wash, rinse anddry perineum. Change clothing PRN after incontinence episodes. Monitor/document for s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.During an observation 07/06/2025 at 3:27PM while Resident #2 was in bed, CNA A applied clean gloves, lowered the head of bed using the bed remote, then closed Resident #2's curtain, unlatched Resident #2's brief, retrieved clean wipes, and began to clean perineal area with same contaminated gloves she used to touch the multiple surfaces. CNA A the proceeded to assist Resident #2 to turn to her left side, attained additional cleansing wipes and cleaned the visible bowel movement on Resident #2's buttock. CNA A then rolled the brief within itself and threw the contaminated brief and soiled gloves in the trash. CNA A then proceeded to apply clean gloves without any hand hygiene, and attained a clean brief and transfer sheet, and placed both items under Resident #2's buttocks, followed by turning Resident #2 onto her back, and latching the brief attachments to close the brief. CNA A did not perform any hand hygiene prior to, during, nor after incontinent care, nor did she perform any contaminated glove change when cleaning Resident #2's labial area to buttock area.During an interview on 07/06/2025 at 3:50PM CNA A stated she should have performed gloves removal followed by hand hygiene prior to unlatching Resident #2's brief straps. CNAA stated she should have removed contaminated gloves and performed hand hygiene after touching Resident #2's environment due to those surfaces having germs. CNA A stated she should have removed her contaminated gloves and performed hand hygiene after she cleaned Resident #2's perineal area, prior to turning Resident #2 onto her left side, followed by applying clean gloves and cleaning Resident #2's buttock area. CNA A stated Resident #2 could potentially become sick or become septic from the introduction of germs and could had led to an UTI. CNA A stated UTIs are very bad especially for the geriatric community. CNA A stated Resident #2's health could be affected by an infection by potentially compromising Resident #2's health by depleting Resident #2's strength or weight loss, and these situations could have severe/detrimental effects on Resident #2's well-being. CNA A stated she was not given a competency check off regarding perineal care or hand hygiene nor does she recall being in-serviced about hand hygiene or perineal care.During an interview on 07/07/2025 at 1:27PM with the DON, the DON stated the facility follows the CDC recommendations regarding hand hygiene. The DON stated by CNA A touching multiple surfaces followed by performance of perineal care, Resident #2