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	12/04/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews and record review, the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 8 residents (Resident #8) reviewed for physician notification. The facility failed to ensure RN A notified Resident #8's provider when RN A did not administer Resident #8's Tresiba as prescribed by the physician on 8 of 9 opportunities from 11/1/24 to 11/30/24. This failure could affect residents by placing them at risk of not receiving the therapeutic effects of medications, decline in health, and death. The findings included: Record review of Resident #8's admission record reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8's diagnoses included type 2 diabetes mellitus with hyperglycemia (persistently high blood sugar), type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage caused by persistently high blood sugar) and cognitive communication deficit. Record review of Resident #8's quarterly MDS dated [DATE] reflected a BIMS of 8 which indicated moderate cognitive impairment. Record review of Resident #8's order summary report reflected the following orders: Check blood sugar levels via accucheck one time a day related to type 2 diabetes mellitus with hyperglycemia ordered on 7/9/24. Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 units/ml (Insulin Degludec) Inject 62 units subcutaneously one time a day for diabetes ordered on 11/1/24. Record review of Resident #8's November 2024 MAR reflected the following: (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An order for Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 units/ml (Insulin Degludec) Inject 62 units subcutaneously one time a day for diabetes at 6:00am, ordered on 11/1/24 at 3:51pm. This medication was held by RN A on 11/3/24 (BS 108), 11/10/24 (BS 97), 11/11/24 (BS 84), 11/17/24 (BS 81), 11/18/24 (BS 101), 11/24/24 (BS 83), 11/25/24 (BS 91), and 11/28/24 (BS 106) which was 8 of 9 opportunities that RN A had to administer the medication. Attempts were made to contact RN A for interview on 12/3/24 at 3:33pm, 12/4/24 at 9:15am and 12:39pm by the state surveyor and on 12/04/24 at 09:43am, 12:36pm, and 12:37pm, by the DON with no success. In a telephone interview on 12/4/24 at 10:00am, LVN D stated Resident #4's Tresiba order stated to give 62 units every morning and there was not a hold parameter. LVN D stated the Tresiba was a pen, and the needles were changed every morning, though she did not recall an order to change it every morning. LVN D stated they were not able to automatically see the previous doses that were given or held in the MAR. LVN D stated if there was an order for insulin that did not have a hold parameter, but it was held anyway, it could cause the resident's sugar to go high and could result in complications such as kidney damage. LVN D stated if a medication was held, they would notify the physician right away and it was documented in the progress notes or in a communication to the physician. LVN D stated, If we did not notify the physician about holding medications, we could get into trouble. It could cause the resident to have hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). LVN D stated the last in-service on medication administration was 2-3 weeks ago. LVN D stated the nurses, charge nurses, and the DON are responsible for making sure the orders were accurate. LVN D stated if there was an order that was not accurate, they would notify the DON, the administrator, and the physician. LVN D stated an order could not be changed without notifying the physician. LVN D stated the last in service on SBAR and notification was not too long ago. In an interview on 12/4/24 at 12:15pm the DON stated he did not know why the Tresiba was held since there were no hold orders. The DON stated it was important to follow physician orders for the Tresiba administration to make sure Resident #8's sugar did not go higher, the medication had the desired effect, and the resident did not have any undesired consequences. The DON stated he and the ADON were responsible for making sure that orders made sense and were followed. The DON stated if a medication was held, the physician should have been notified by telephone at that time, and it was supposed to be documented in the progress notes right away. The DON stated the last in-service on medication administration was in October and nurses were checked off on medication administration during orientation. The DON stated every morning they would pull an orders report that would show all of the new orders and any orders that were placed on hold, but they did not have a report to tell them when medications were not given. The DON stated he did not recall seeing that there was a pattern with Resident #8's Tresiba being held. The DON stated information regarding medications, treatments, etc. were put into the 24-hour report to pass along to the next shift, but he did not recall hearing anything about Resident #8 not getting her Tresiba during morning meetings. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/4/24 at 2:43pm the MD stated he was not aware of Resident #8's Tresiba being held and he would have expected to have been notified when it was held. The MD stated if he had been notified that the medication was not given, he would have asked the nurse why it was held and provided clarification of his order. The MD stated if medications were not given when they were supposed to be, it could cause the resident to have complications. The MD stated that if he was not notified of medication issues, he would not know what was going on with the resident and would not be able to provide effective care and treatment for the residents. The MD stated he would talk with the DON and the nurse to find out why the medication was not given and why he was not notified. Record review of the facility's Change of Condition and Physician/Family Notification policy dated 8/11/20 and reviewed 5/17/24 reflected in part: Purpose: To ensure that resident's family and/or legal representative and physician are notified of resident changes that fall under the following categories: A need to significantly alter treatment. Procedure: When any of the above situations exist, the licensed nurse will contact the resident's family and their physician. Non-emergency notifications may be made [to the physician] the next morning if the situation occurs on the late evening or night shift. This applies to any day of the week including holidays. In a non-emergency situation, the primary physician will be called unless he/she has left an alternate name to call. Each attempt will be charted as to time the call was made, who was spoken to, and what information was given to the physician. Examples of significant changes: Medication error. Record review of the facility ' s Medication Administration Policy dated 4/1/19 and reviewed 7/8/24 reflected in part: 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident ' s attending physician or the facility's medical director to discuss the concerns.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46038 49157 Based on observation, interview, and record review the facility failed to 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 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 (Resident #14, Resident #24, and Resident #37) of 8 residents reviewed for care plans. 1. The facility failed to ensure that Resident #14's care plan reflected the need for Enhanced Barrier Precautions regarding Resident #14's right chest wall dialysis catheter. 2. The facility failed to ensure that Resident #24's care plan reflected the fact that the resident frequently removed her own oxygen cannula and tubing and refused to wear it. 3. The facility failed to ensure Resident #37's care plan reflected Resident #37 had an arterial wound (painful injuries in your skin caused by poor circulation) to right heel. These failures could place residents at risk of not receiving the care and treatments necessary to achieve or maintain their highest practicable level of health and well-being. The findings included: 1. Record review of Resident #14's admission record reflected a [AGE] year-old male that was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident #14's diagnoses included End Stage Renal Failure (a condition in which the kidneys no longer function), dependence on renal dialysis (a treatment used to remove waste and excess fluid from the blood), dementia (a group of symptoms that affect memory and thinking and interferes with daily life), and hypertension (high blood pressure). Record review of Resident #14's quarterly MDS dated [DATE] reflected a BIMS score of 5, which indicated that Resident #14 had severe cognitive impairment. Record review of Resident #14's order summary report reflected the following orders: -Monitor Perma catheter (a special intravenous tube that is used for hemodialysis that is inserted into a large vein in the neck or upper chest) to right upper chest wall dressing in place, if dislodged or soiled, cover with a clean dressing and inspect for s/s of infection qshift and pm. Note changes in skin color, temperature, and exudate from access. Report changes to physician. Order date: 10/12/24. -Monitor Perma catheter to right upper chest wall pressure dressing for excessive bleeding every shift upon return from dialysis and remove dressing morning after dialysis. Order date: 10/12/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident to receive dialysis 3 days a week on T-Th-Sat at [name of dialysis facility and phone number] under the care of [name of nephrologist]. Chair time 11:00am. Order date: 8/8/24. Record review of Resident #14's care plan reflected the following: Focus: The resident needs dialysis r/t renal failure at [name of dialysis facility] at 11:00am on T, Th, and Sat. Monitor Perma catheter to right upper chest. Date initiated: 4/6/23. Revision on: 11/2/24. Goal: The resident will have no s/s of complications from dialysis through the review date. Date initiated: 4/6/23. Revision on: 4/29/23. Goal: The resident will have immediate intervention should any s/s of complications from dialysis occur through the review date. Date initiated: 4/6/23. Revision on: 12/14/23. Interventions/ Tasks: Monitor/document/report PRN (as needed) any s/s of infection to access site: redness, swelling, warmth, or drainage. Date initiated: 4/6/23. The interventions/task section does not have an intervention for Enhanced Barrier Precautions related to the Perma catheter in his right upper chest wall. 2. Record review of Resident #24's Optional State Assessment MDS dated [DATE] revealed Resident #24 has a BIMS of 15, which means Resident #24 is cognitively intact. Record Review of Resident #24's physician orders on 12/2/24 at 4:00 PM revealed an order for Oxygen at 3 liters per minute via nasal cannula continuously. May titrate to 4 liters per minute to keep oxygen saturation above 90%. Observation on 12/1/24 at 1:58 PM revealed Resident #24's oxygen tubing hung over the side of her bed. The oxygen concentrator was on, and you could her the oxygen running through the tubing, but Resident #24 was not wearing her oxygen. In an interview on 12/1/24 at 1:58 PM, Resident #24 stated she puts her oxygen back on when she needs it, and she can tell when she needs it. In an interview on 12/2/24 at 2:45 PM, LVN-F stated that Resident #24 removes her oxygen frequently and wears it over or her or will hang it on her bed. In an interview on 12/4/24 at 12:45 PM, the DON stated Resident #24 takes her oxygen off repeatedly and wears on her head or hangs on her bed, and we should have care planned the fact she frequently removes it on her on. He also stated that DON, MDS and staff nurses were responsible for updating the care plans. 3. Record review of Resident #37's face sheet dated 12/03/24 reflected an [AGE] year-old-male with an original admitted [DATE]. Diagnoses included dementia (a group of symptoms that affect memory, thinking and interferes with daily life), hypertension (high blood pressure), and atrial fibrillation (irregular and often very rapid heart rhythm). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #37's physician orders dated 11/20/24 reflected an arterial wound to right heel. Cleanse with NS, pat dry, apply skin prep (protective film or barrier), leave open to air, every day/shift. Record review of Resident #37's care plan initiated on 8/13/24 did not reflect Resident #37 had an arterial wound to right heel. Record review of Resident #37's quarterly MDS dated [DATE] reflected Resident #37 had a BIMS score of 9 (moderate cognitive impairment), had one arterial ulcer present, and was at risk of developing pressure ulcers/injuries. In an interview on 12/3/24 at 2:50pm the MDS Coordinator stated she was in charge of initial care plans and as conditions and needs of the resident changed, the DON, ADON, and nurses could make changes in care plan as needed. The MDS Coordinator stated she audited care plans quarterly, but the DON was in charge of ensuring overall accuracy. In reference to Resident #14's Enhanced Barrier Precautions, the MDS Coordinator stated, Our corporate people were back and forth on whether it should or should not be care planned. It would be a good idea to care plan EBP, but corporate never stated yes or no about care planning that (EBP). The MDS Coordinator stated Resident #37's arterial wound should have been care planned. In reference to Resident #37's wound, the MDS Coordinator stated it was important to have any wounds care planned so they can be monitored, and direct care staff could be aware of Resident #37's individualized plan of care and needs. The MDS Coordinator stated she was not sure how Resident #37 would be affected by not having his wound care planned. The MDS Coordinator stated when a resident had a new order or condition it was discussed in morning meetings, and she was in charge of updating the care plan but Resident #37's wound was overlooked. In an interview on 12/4/24 at 9:47am the DON stated Resident 37's wound should have been care planned to make sure everyone was aware of the wound and the plan of care. The DON stated it was an oversight. The DON stated nurses usually initiated the care plans, MDS would check it, and the DON oversees accuracy. The DON stated Resident #37 could be affected but the resident did have an order for wound care and was getting weekly skin assessments (verified through record review). The DON stated that even though the Enhanced Barrier Precautions were not care planned for Resident #14, the facility was using EBP for him and that there was a sign on the door to his room and PPE available in the hallway (verified through observation). The DON stated that he did not think the facility had done an in-service on care plans or revisions lately. Record review of the facility's Care Plans, Comprehensive Person-Centered policy dated 10/22 and reviewed 11/24 stated in part: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Record review of the facility's Enhanced Barrier Precautions policy and procedure dated 4/1/24 reflected in part: 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 an MDRO. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. Because EBP do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of the resident ' s stay in the facility or until the discontinuation of the indwelling medical device that placed them at higher risk. Communication to staff/ medical professionals: The facility will utilize postings outside the room and Point Click Care (the facility's electronic health record) to communicate to staff if a resident requires EBP. 50969

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on observation, interviews and record reviews the facility failed to ensure that the comprehensive care plan was periodically reviewed and revised by a team of qualified persons after each assessment, including both the comprehensive and quarterly review assessments for 1 (Resident #14) of 8 residents reviewed for care plan revision. The facility failed to update Resident #14 ' s care plan when he no longer had a urinary catheter. This failure could place residents at risk of not receiving the care and services necessary to meet their current needs and achieve or maintain their highest practicable level of health and well-being. The findings included: Record review of Resident #14 ' s admission record reflected a [AGE] year-old male that was admitted to the facility on [DATE] with an original admitted [DATE]. Resident #14 ' s diagnoses included End Stage Renal Failure (a condition in which the kidneys no longer function), dependence on renal dialysis (a treatment used to remove waste and excess fluid from the blood), dementia (a group of symptoms that affect memory and thinking and interferes with daily life), and hypertension (high blood pressure). Record review of Resident #14 ' s quarterly MDS dated [DATE] reflected a BIMS score of 5, which indicated that Resident #14 had severe cognitive impairment. Section H- Bladder and bowel reflected that Resident #14 did not have a urinary catheter present. Record review of Resident #14 ' s care plan reflected the following: Focus: The resident has a F/C (foley catheter) r/t obstructive uropathy d/t BPH (benign prostatic hypertrophy- a condition in which the prostate is enlarged). Date initiated 6/2/23. Revised on: 6/2/23. Record review of Resident #14 ' s EHR (electronic health record) reflected 2 documented care plan meetings dated 7/6/23 and 11/9/23 in which Resident #14 ' s urinary catheter was not reviewed. No other care plan meetings were documented in Resident #14 ' s EHR (Electronic Health Record). Observation on 12/1/24 at 3:20pm reflected that Resident #14 did not have a urinary catheter. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/3/24 at 2:50pm the MDS Coordinator stated she was in charge of initial care plans and as conditions and needs of the resident changed, the DON, ADON, and nurses could make changes in care plan as needed. The MDS Coordinator stated she audited care plans quarterly, but the DON was in charge of ensuring overall accuracy. In reference to Resident #14 ' s foley catheter, the MDS Coordinator stated that Resident #14 had the urinary catheter removed and replaced a couple of times but that it was discontinued on 9/10/24. The MDS Coordinator stated Resident #14 ' s last quarterly MDS was on 11/21/24 and that the urinary catheter was not marked on it, so it should have been discontinued on the care plan when Resident #14 was no longer using a catheter. The MDS Coordinator stated when a resident had a new order or condition it was discussed in morning meetings, and she was in charge of updating the care plan, but she missed Resident #14 ' s urinary catheter removal. In an interview on 12/4/24 09:47am the DON stated the nurses usually initiated the care plan, the MDS Coordinator would make any changes that were needed then the DON would look at it. The DON stated that Resident #14's urinary catheter should have been taken off the care plan when the orders were discontinued and that the MDS Coordinator or the DON would have been responsible for taking it off. The DON stated it was just oversite on their part as to why it was not taken off. Record review of the facility ' s Care Plans, Comprehensive Person-Centered policy dated 10/22 and reviewed 11/24 stated in part: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident. 13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents ' conditions change. 14. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident ' s condition; d. At least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 F-tag initiation Based on observations, interviews and record reviews, the facility failed to ensure, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for 1 of 2 residents (Resident #24) reviewed for quality of care. 1. The facility failed to ensure Resident #24's implanted medi-port was accessed and flushed appropriately per policy and physician's orders. 2. The facility failed to ensure nurses documented the access and flush of the implanted med-port appropriately and accurately. 3. The facility failed to ensure the nurses were properly trained to access and flush the implanted med-port appropriately. These failures could place residents at risk for complications such as infection, blood clot, occlusion of catheter and/or infiltration. The findings include: Record review of Resident #24's face sheet revealed a [AGE] year-old female with an original admitted [DATE] and a current admitted [DATE]. Resident #24 had diagnoses which included, but are not limited to: Epilepsy (a seizure disorder), Intermittent Explosive Disorder (impulsive anger outbursts), Generalized Anxiety (anxiousness), Heart Failure, Unspecified Sequelae of Cerebral Infarction (long term effects of a stroke), Dysphagia and Gastrostomy. Record review of Resident #24's Optional State Assessment MDS dated [DATE] revealed resident had a BIMS score of 15, which indicated the residents was cognitively intact. Record review of Resident #24's Medication Administration Records and Treatment Administration Records revealed: **December 2024 MAR had no saline flush of implanted medi-port due until 12/31/24; **November 2024 MAR revealed Medi-port accessed via Huber needle on 11/2/24; **November 2024 MAR revealed normal saline flush of implanted medi-port scheduled for 11/20/24, but never signed that it was performed. **October 2024 MAR revealed Huber needle access scheduled for 10/02/24, but never signed that it was performed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**October 2024 MAR revealed normal saline flush of implanted medi-port scheduled and signed as completed for 10/31/24. **September 2024 MAR revealed Huber needle access scheduled for 9/2/24, but never signed that it was performed. **September 2024 MAR revealed normal saline flush of implanted medi-port scheduled and signed as completed 9/30/24. Record review of Resident #24's physician orders revealed the Huber needle order showed a revised date of 11/30/2024 with a new start date of 12/1/2024, and the normal saline flush was originally ordered on 8/31/2024, revised 8/22/2024, and put on hold on 9/12/2024. There were no new or revised orders after this to resume or restart the medi-port flush. Physician's orders also revealed there was never an order to flush the medi-port with heparin. Record review of Resident #24's progress note, dated 11/30/2024, revealed the physician had given orders to discontinue implanted medi-port flush due to high risk of infection due to Resident #24's lack of hygiene. Record review of Attendance/In-Service Records revealed a Medication Administration in-service was done with the nursing staff on 10/15/2024. Record review of Resident #24's care plan, initiated 8/27/24, revealed Resident #24 has an implanted port that could be used with physician's orders and access of a Huber needle. Observation 12/1/24 at 1:58 PM revealed an almost empty bottle of water at Resident #24's bedside. Resident #24's Foley Catheter hung on the bedside. The urine was yellow but clear. Observation also revealed the medi-port to the upper chest wall was not accessed at this time. Observation on 12/2/24 at 2:30 PM revealed almost empty Pepsi bottle and an almost empty large bag of candy and cookies in Resident #24's room, which reveals that resident is getting some form of nutrition and hydration. Interview with Resident #24 on 12/01/24 at 1:58 PM, she stated she was still not eating, except cream of wheat and tomato soup because no one was watching her eat. Resident #24 stated she thought she was dehydrated and had a urinary tract infection but could not drink water because it made her sick to her stomach unless it had Kool-Aid in it. She stated her urine has been dark. She stated she had some low back pain, but mostly her chronic lower extremity pain. She had a 3/4 eaten fruit cup as well as a large package of cookies at bedside that was approximately 3/4 empty, as well as a very large bag of candy that was probably 3/4 gone. Interview with Resident #24 on 12/02/24 at 02:30 PM, Resident #24 stated she told at least three nurses that her urine looked bad and she didn't want her kidneys to go out again. She was unsure of which three nurses she told. She stated she bought her own sodas to drink and sell, and she also keeps some in her fridge. Resident #24 stated she asked about IV fluids through her medi-port because she felt dehydrated, but they wouldn't do it for her. She stated they (the nurses at this facility) were supposed to be flushing her medi-port, but that the administrator told her they were not going to pay $500 for kits to flush her port if she was not going to let them do it correctly. (continued on next page)

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	12/04/2024

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA-E on 12/4/24 at 12:00 PM, she stated she has worked here approximately 1.5 years, so she knows this resident, and Resident #24 refused hygiene frequently. She refused 6-2, 2-10 and 10-6 shift. There was a specific CNA on 2-10 that she preferred to have perform her hygiene, and Resident #24 would only accept bed baths from that CNA. She was still scheduled for 10- 6 shift for shower or bed bath, but the other 2-10 CNA would give them if she was working. CNA-E stated Resident #24 had not complained about urinary tract infections or dehydration to her or anyone else she knew of. She stated the CNAs were the ones who emptied the foley, and if the urine was dark, the nurse was notified, but stated Resident #24's urine had not been dark or had an odor to it. Interview with LVN-F on 12/02/24 at 02:45 PM, she stated the Resident had not complained of low back pain, urinary tract infection or feeling dehydrated. She stated Resident #24 never requests specific snacks, Gatorade or Pedialyte and has never requested IV fluids from her or anyone else that she knows of. LVN-F also stated Resident #24 had not complained of urgency, burning or low back pain, and she bought her own Kool-Aid and sodas to drink, but she has never buys Gatorade or Pedialyte. LVN-F stated Resident #24 had no recent infections, to include urinary tract infections. LVN-F also stated no medications or treatments were withheld, and the Medi-port had only been accessed and flushed by RNs. Interview with RN-H on 12/2/24 1:58 PM, she stated Resident #24 had not voiced any concerns to the nurses about her foley or urine, as well as had not complained of any low back pain, urgency or frequency. She usually complained about lower extremity pain, but that was it. RN-H stated she had accessed the medi-port to flush it as ordered monthly. She stated she prepped the area first, held the port, felt for the center, accessed the port, pulled back to check for blood return, then flushed with normal saline and then heparin. She stated she did not know why the MARs showed the port and flush were being done on separate days/times because they are done together. She attempted to pull up the order on her computer but couldn't find the order because it was discontinued. She also stated she was not sure why any of the nurses would continue to access and flush the port if the order was discontinued or held. When asked to show the order for Heparin, she stated she was wrong, there was no order for Heparin, and they did not flush the port with Heparin. RN-H also looked and could not find the order to discontinue the saline flush, even though it was not showing up in her medications anymore. Interview with the DON on 12/02/24 at 03:13 PM, he stated Resident #24 had Medi-port prior to admission to this facility, and nursing had been flushing the port monthly since she had been here at the facility. He stated these should be documented on the Treatment Administration Record, but he would look to see if they were documented somewhere else. DON also stated that he is not sure why the flush is showing that it is being done on a different day than the port is being accessed because they are supposed to be done together. The DON looked at the order for the saline flush, which was put on hold when Resident #24 was admitted to the hospital in September 2024, and never could find an order to resume flushes when the Resident came back to the facility. He stated it was only supposed to be a three day hold, then resumed or renewed. He stated if the order was never resumed or renewed, the nurses would not have been able to sign, so something must be wrong with the order. He also stated he was not sure why there was a progress not to discontinue the flush. Interview with the DON on 12/4/24 at 12:45 PM, he stated the nurses were not trained, in-serviced or had annual skills checkoffs for implanted medi-port access or maintaining the medi-port. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Intravenous Catheter Policy, updated 10/2022 and reviewed 01/2023, revealed under general guidelines, paragraph 1, facility staff who manage infusion catheters will have training and demonstrated clinical competency in intravenous therapy; 2 - staff may only insert catheter types for which they have adequate training and demonstrated skill. Record review of the facility's Intravenous Therapy Policy, with a revision date of 03/2022, revealed for a port that is not being accessed for infusing or intermittent medication administration, under the Frequency section, 4 - flush implanted venous ports not accessed for infusions with at least 10ml preservative-free 0.9% sodium chloride and 3-5ml heparin 100 units ml every 3 months for maintenance flushing or refer to manufacturer's instruction. Record review of the facility's Charting and Documentation Policy, revised 07/2017, revealed under Policy Interpretation and Implementation: 2 - the following information is to be documented in the resident medical record: objective observations, medications administered, treatment of services performed, changes in resident's condition, events involving the resident, progress or changes in the care plan goals or objectives.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51216 Based on observations, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one of five residents (Resident #44) reviewed for accidents and hazards. The facility failed to ensure floor mats were in place beside Resident #44's bed . This failure could place residents at risk for an injury or a major injury. The findings include: Record review of Resident #44's face sheet, dated 12/02/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #44 had a diagnosis which included cerebral infarction (a serious that occurs when brain tissue die due to lack of blood flow to brain). Record review of Resident #44's Significant Change Minimum Data Set, dated dated dated [DATE] indicated she had severe cognitive impairment with unclear speech. Record review of Resident #44's care plan dated 11/26/24 indicated: The resident has had an actual fall 4/3/2024 unwitnessed fall-no injury 4/6/2024 unwitnessed fall- no injury 4/15/24 unwitnessed fall 4/15/24 intervention- fall mats Record review of Resident #44's December 2024 physician orders reflected there was no order for floor mat usage Record Review of Resident #44 Fall Risk Assessment/ Morse Fall Scale reflected 30 -a moderate risk or falling. Observation on 12/02/24 at 11:42 AM revealed Resident #44 was lying in bed with eyes closed. Resident #44 had a floor mat on the floor on the left side of her bed but not on her right side. Observation on 12/02/24 at 03:27 PM revealed Resident #44 was lying in bed on her right side with her eyes closed. Resident #44 has a floor mat on the floor on the left side of her bed but not on her right side. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA C on 12/02/14 at 3:45 PM revealed the floor mats were to be in place to prevent any injury to the resident in case she rolled over and fell out of bed. CNA C stated it was the CNAs nurse and DON's responsibility to ensure the mats were in place. CNA C said she checked the Kardex which informed her the mat was required for the resident. CNA C said she did not notice the right floor mat was not in place since she just started her shift at 3:00 PM. CNA C said if Resident #44 fell on her right side she may acquire an injury. Interview with LVN B on 12/02/24 at 03:47 PM revealed the purpose of the floor mats were to prevent any major injury if Resident #44 fell out of bed. LVN B said Resident #44 should have a floor mat on each side of the bed. LVN B said she had not noticed the right floor mat was not in place and that's because she walked through that part of the area to move the oxygen concentrator and feeding pump. LVN B said it was the responsibility of all nursing staff to ensure the floor mats were in place on both sides of the bed. LVN B said if the mats were not in place and Resident #44 fell out of bed, she could acquire a major injury. Interview with the DON on 12/03/24 at 2:35 PM, the DON stated the floor mats were used to prevent injuries in case of a fall. The DON stated the floor mats should be at each side of the bed if the bed was centered in the room. The DON said nothing should be placed on top of the floor mats. The DON said the nurses and CNAs were responsible for monitoring the position of the floor mats. The DON stated the Resident could injure herself if the floor mat was not properly placed. Injuries could include bruising, skin tears, and fractures. The DON said he and the ADON conducted daily rounds to monitor preventive devices were placed correctly. Record review of the facility's Fall Prevention Program policy dated 06/10/24 reflected All residents will be assessed for the risk for falls at the time of admissions, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be to minimize falls and avoid repeat falls and minimize falls resulting in significant injury 3. The following is a list of commonly used interventions that may be considered to minimize falls and injury . K. Utilizing adaptive equipment such as - walker, cane, grab bars, etc.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on interviews and record reviews, the facility failed to provide resident with he appropriate competencies and skills sets to provide nursing and related services to assure residents safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for 1 of 5 residents (Resident #24). The facility failed to ensure that nursing staff were educated on the steps and protocols to access and flush Resident #24's implanted medi-port. These failures could place residents at risk for complications such as infection, blood clot, occlusion of catheter and/or infiltration. The findings include: Record review of Resident #24's face sheet revealed a [AGE] year-old female with an original admitted [DATE] and a current admitted [DATE]. Resident #24 had diagnoses which included, but are not limited to: Epilepsy (a seizure disorder), Intermittent Explosive Disorder (impulsive anger outbursts), Generalized Anxiety (anxiousness), Heart Failure, Unspecified Sequelae of Cerebral Infarction (long term effects of a stroke), Dysphagia and Gastrostomy. Record review of Resident #24's Optional State Assessment MDS dated [DATE] revealed resident had a BIMS score of 15, which indicated the residents was cognitively intact. Record review of Resident #24's Medication Administration Records and Treatment Administration Records revealed: **December 2024 MAR had no saline flush of implanted medi-port due until 12/31/24; **November 2024 MAR revealed Medi-port accessed via Huber needle on 11/2/24; **November 2024 MAR revealed normal saline flush of implanted medi-port scheduled for 11/20/24, but never signed that it was performed. **October 2024 MAR revealed Huber needle access scheduled for 10/02/24, but never signed that it was performed. **October 2024 MAR revealed normal saline flush of implanted medi-port scheduled and signed as completed for 10/31/24. **September 2024 MAR revealed Huber needle access scheduled for 9/2/24, but never signed that it was performed. **September 2024 MAR revealed normal saline flush of implanted medi-port scheduled and signed as completed 9/30/24. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's physician orders revealed the Huber needle order showed a revised date of 11/30/2024 with a new start date of 12/1/2024, and the normal saline flush was originally ordered on 8/31/2024, revised 8/22/2024, and put on hold on 9/12/2024. There were no new or revised orders after this to resume or restart the medi-port flush. Physician's orders also revealed there was never an order to flush the medi-port with heparin. Record review of Resident #24's progress note, dated 11/30/2024, revealed the physician had given orders to discontinue implanted medi-port flush due to high risk of infection due to Resident #24's lack of hygiene. Record review of Attendance/In-Service Records revealed a Medication Administration in-service was done with the nursing staff on 10/15/2024. Record review of Resident #24's care plan, initiated 8/27/24, revealed Resident #24 has an implanted port that could be used with physician's orders and access of a Huber needle. Observation 12/1/24 at 1:58 PM revealed an almost empty bottle of water at Resident #24's bedside. Resident #24's Foley Catheter hung on the bedside. The urine was yellow but clear. Observation also revealed the medi-port to the upper chest wall was not accessed at this time. Observation on 12/2/24 at 2:30 PM revealed almost empty Pepsi bottle and an almost empty large bag of candy and cookies in Resident #24's room, which reveals that resident is getting some form of nutrition and hydration. Interview with Resident #24 on 12/01/24 at 1:58 PM, she stated she was still not eating, except cream of wheat and tomato soup because no one was watching her eat. Resident #24 stated she thought she was dehydrated and had a urinary tract infection but could not drink water because it made her sick to her stomach unless it had Kool-Aid in it. She stated her urine has been dark. She stated she had some low back pain, but mostly her chronic lower extremity pain. She had a 3/4 eaten fruit cup as well as a large package of cookies at bedside that was approximately 3/4 empty, as well as a very large bag of candy that was probably 3/4 gone. Interview with Resident #24 on 12/02/24 at 02:30 PM, Resident #24 stated she told at least three nurses that her urine looked bad and she didn't want her kidneys to go out again. She was unsure of which three nurses she told. She stated she bought her own sodas to drink and sell, and she also keeps some in her fridge. Resident #24 stated she asked about IV fluids through her medi-port because she felt dehydrated, but they wouldn't do it for her. She stated they (the nurses at this facility) were supposed to be flushing her medi-port, but that the administrator told her they were not going to pay $500 for kits to flush her port if she was not going to let them do it correctly. Interview with CNA-E on 12/4/24 at 12:00 PM, she stated she has worked here approximately 1.5 years, so she knows this resident, and Resident #24 refused hygiene frequently. She refused 6-2, 2-10 and 10-6 shift. There was a specific CNA on 2-10 that she preferred to have perform her hygiene, and Resident #24 would only accept bed baths from that CNA. She was still scheduled for 10- 6 shift for shower or bed bath, but the other 2-10 CNA would give them if she was working. CNA-E stated Resident #24 had not complained about urinary tract infections or dehydration to her or anyone else she knew of. She stated the CNAs were the ones who emptied the foley, and if the urine was dark, the nurse was notified, but stated Resident #24's urine had not been dark or had an odor to it. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN-F on 12/02/24 at 02:45 PM, she stated the Resident had not complained of low back pain, urinary tract infection or feeling dehydrated. She stated Resident #24 never requests specific snacks, Gatorade or Pedialyte and has never requested IV fluids from her or anyone else that she knows of. LVN-F also stated Resident #24 had not complained of urgency, burning or low back pain, and she bought her own Kool-Aid and sodas to drink, but she has never buys Gatorade or Pedialyte. LVN-F stated Resident #24 had no recent infections, to include urinary tract infections. LVN-F also stated no medications or treatments were withheld, and the Medi-port had only been accessed and flushed by RNs. Interview with RN-H on 12/2/24 1:58 PM, she stated Resident #24 had not voiced any concerns to the nurses about her foley or urine, as well as had not complained of any low back pain, urgency or frequency. She usually complained about lower extremity pain, but that was it. RN-H stated she had accessed the medi-port to flush it as ordered monthly. She stated she prepped the area first, held the port, felt for the center, accessed the port, pulled back to check for blood return, then flushed with normal saline and then heparin. She stated she did not know why the MARs showed the port and flush were being done on separate days/times because they are done together. She attempted to pull up the order on her computer but couldn't find the order because it was discontinued. She also stated she was not sure why any of the nurses would continue to access and flush the port if the order was discontinued or held. When asked to show the order for Heparin, she stated she was wrong, there was no order for Heparin, and they did not flush the port with Heparin. RN-H also looked and could not find the order to discontinue the saline flush, even though it was not showing up in her medications anymore. Interview with the DON on 12/02/24 at 03:13 PM, he stated Resident #24 had Medi-port prior to admission to this facility, and nursing had been flushing the port monthly since she had been here at the facility. He stated these should be documented on the Treatment Administration Record, but he would look to see if they were documented somewhere else. DON also stated that he is not sure why the flush is showing that it is being done on a different day than the port is being accessed because they are supposed to be done together. The DON looked at the order for the saline flush, which was put on hold when Resident #24 was admitted to the hospital in September 2024, and never could find an order to resume flushes when the Resident came back to the facility. He stated it was only supposed to be a three day hold, then resumed or renewed. He stated if the order was never resumed or renewed, the nurses would not have been able to sign, so something must be wrong with the order. He also stated he was not sure why there was a progress not to discontinue the flush. Interview with the DON on 12/4/24 at 12:45 PM, he stated the nurses were not trained, in-serviced or had annual skills checkoffs for implanted medi-port access or maintaining the medi-port. Record review of the facility's Intravenous Catheter Policy, updated 10/2022 and reviewed 01/2023, revealed under general guidelines, paragraph 1, facility staff who manage infusion catheters will have training and demonstrated clinical competency in intravenous therapy; 2 - staff may only insert catheter types for which they have adequate training and demonstrated skill. Record review of the facility's Intravenous Therapy Policy, with a revision date of 03/2022, revealed for a port that is not being accessed for infusing or intermittent medication administration, under the Frequency section, 4 - flush implanted venous ports not accessed for infusions with at least 10ml preservative-free 0.9% sodium chloride and 3-5ml heparin 100 units ml every 3 months for maintenance flushing or refer to manufacturer's instruction. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Charting and Documentation Policy, revised 07/2017, revealed under Policy Interpretation and Implementation: 2 - the following information is to be documented in the resident medical record: objective observations, medications administered, treatment of services performed, changes in resident's condition, events involving the resident, progress or changes in the care plan goals or objectives.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews and record review, the facility failed ensure residents were free of any significant medication errors for 1 of 8 residents (Resident #8) reviewed for significant medication errors. The facility failed to ensure that RN A administered Resident #8's Tresiba Flex Touch Solution Pen Injector on 8 of 9 opportunities from 11/1/24 to 11/30/24. This failure could place residents at risk of a decline in condition or hospitalization . The findings included: Record review of Resident #8's admission record reflected a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #8 ' s diagnoses included type 2 diabetes mellitus with hyperglycemia (persistently high blood sugar), type 2 diabetes mellitus with diabetic polyneuropathy (nerve damage caused by persistently high blood sugar) and cognitive communication deficit. Record review of Resident #8's quarterly MDS dated [DATE] reflected a BIMS of 8 which indicated moderate cognitive impairment. Record review of Resident #8's order summary report reflected the following orders: Check blood sugar levels via accucheck one time a day related to type 2 diabetes mellitus with hyperglycemia ordered on 7/9/24. Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 units/ml (Insulin Degludec) Inject 62 units subcutaneously one time a day for diabetes ordered on 11/1/24. Record review of Resident #8's November 2024 MAR reflected the following: An order for Tresiba FlexTouch Subcutaneous Solution Pen Injector 100 units/ml (Insulin Degludec) Inject 62 units subcutaneously one time a day for diabetes at 6:00am (There were no hold parameters). Ordered on 11/1/24 at 3:51pm. This medication was held by RN A on 11/3/24 (BS 108), 11/10/24 (BS 97), 11/11/24 (BS 84), 11/17/24 (BS 81), 11/18/24 (BS 101), 11/24/24 (BS 83), 11/25/24 (BS 91), and 11/28/24 (BS 106) which was 8 of 9 opportunities that RN A had to administer the medication. Attempts were made to contact RN A for interview on 12/3/24 at 3:33pm, 12/4/24 at 9:15am and 12:39pm by the state surveyor and on 12/04/24 at 09:43am, 12:36pm, and 12:37pm, by the DON with no success. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/4/24 at12:15pm the DON stated he did not know why the Tresiba was held since there were no hold orders. The DON stated it was important to follow physician orders for the Tresiba administration to make sure Resident #8's sugar did not go higher, the medication had the desired effect, and the resident did not have any undesired consequences. The DON stated he and the ADON were responsible for making sure that orders made sense and were followed. The DON stated if a medication was held, the physician should have been notified by telephone at that time, and it was supposed to be documented in the progress notes right away. The DON stated the last in-service on medication administration was in October and nurses were checked off on medication administration during orientation. The DON stated every morning they would pull an orders report that would show all of the new orders and any orders that were placed on hold, but they did not have a report to tell them when medications were not given. The DON stated he did not recall seeing that there was a pattern with Resident #8's Tresiba being held. The DON stated information regarding medications, treatments, etc. were put into the 24-hour report to pass along to the next shift, but he did not recall hearing anything about Resident #8 not getting her Tresiba during morning meetings. In an interview on 12/4/24 at 2:43pm the MD stated he was not aware of Resident #8's Tresiba being held and he would have expected to have been notified when it was held. The MD stated if he had been notified that the medication was not given, he would have asked the nurse why it was held and provided clarification of his order. The MD stated if medications were not given when they were supposed to be, it could cause the resident to have complications. The MD stated that if he was not notified of medication issues, he would not know what was going on with the resident and would not be able to provide effective care and treatment for the residents. The MD stated he would talk with the DON and the nurse to find out why the medication was not given and why he was not notified. Record review of the facility ' s Medication Administration Policy dated 4/1/19 and reviewed 7/8/24 reflected in part: Medications are administered in a safe and timely manner, and as prescribed. 2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident ' s attending physician or the facility ' s medical director to discuss the concerns.