STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675638	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines Nursing and Rehabilitation	3301 E. Mockingbird Lane Victoria, TX 77904

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observations, interviews, and record reviews the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #1) of 3 residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1 was coded on his Quarterly MDS assessment, signed as completed on 02/11/2025, for a fall with major injury that occurred on 01/12/2025. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: Record review of Resident #1's Admission Record, dated 04/17/2025, reflected a [AGE] year-old male. He was admitted to the facility on [DATE]. Record review of Resident #1's Diagnosis Report, dated 04/17/2025, reflected a primary and admitting diagnosis of Hemiplegia (partial to complete loss of muscle function of one side of the body) and Hemiparesis (muscle weakness of one side of the body) following an unspecified cerebrovascular disease (a group of conditions that affect the blood flow and blood vessels in the brain) affecting the left non-dominant side, epilepsy (a brain disorder that causes seizures), and other reduced mobility. Record review of Resident #1's Nursing Note, dated 01/12/2025 at 09:31 p.m. by LPN A, reflected Resident #1 had an unwitnessed fall in his room on 01/12/2024. LPN A noted the fall caused a fracture to Left leg. Record review of Resident #1's Fall Nurses Note 12hr, signed 01/17/2025 with effective date 01/15/2025 by LPN A, reflected Resident #1 sustained a fracture to his left leg with swelling and a brace applied for intervention. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Quarterly MDS, signed as completed on 02/11/2025 by the RN Assessment Coordinator B, reflected assessment observation end date of 01/29/2025. Resident #1 had a BIMS score of 10 indicating he was mildly impaired, he required substantial/maximal assistance for transferring from lying to sitting on the side of the bed or sitting to standing; and he had two or more falls since admission/entry or reentry or the prior assessment with no injury. He was documented as had no major injury since admission/entry or reentry or prior assessment. The assessment description for major injury included bone fractures. An observation and interview with Resident #1 on 04/17/2025 at 04:25 p.m., revealed Resident #1 was lying in his bed with his head and shoulders slighted elevated watching television. Resident #1 appeared clean and groomed. His call light, a side table, and a bedside urinal bottle were in reach. The resident had two grab bars attached to both sides of his upper bed. Resident #1 revealed he had fallen a couple times at the facility. He stated on one fall he broke his leg. He stated staff responded okay and he felt safe at the facility. He revealed he continued to go to therapy. During an interview on 04/17/2025 at 05:55 p.m., RN Assessment Coordinator B stated for falls, the DON would discuss the falls that were active or historical with the care team. She stated the DON was also responsible for care planning and assigning the interventions for a resident. She stated the facility had not had a DON since around Thanksgiving of the prior year, and the new DON had just started. She stated without a DON, the responsibility had fallen to the ADONs. She stated she and the other facility MDS Assessment Coordinator were responsible for ensuring the accuracy of the MDS Assessments; however, she stated they had to go off the information they could see, and they did not have a system in place to manually track the facility falls. She revealed when completing an MDS assessment there was a tab in the EMR that would trigger for any active or historical falls the resident being assessed had. She revealed when the information on a fall or incident was not completed or still open, then that fall history would not pull into the information they used to complete the assessments. She stated a missed fall on the MDS assessment would not have impacted the resident's care in the slightest if the care plan was updated with the interventions enacted for that fall. During an interview and record review on 04/17/2025 at 06:21 p.m., RN Assessment Coordinator B stated in the EMR, when reviewing the risk management tab, it showed a resident's active incidents and, on another page, the closed incidents. Record review of Resident #1's Historical Incidents Report, undated and accessed on 04/17/2025 by RN Assessment Coordinator B, revealed Resident #1 had a fall incident on 01/12/2025 at 08:05 p.m. The incident was noted as closed on 03/11/2025 at 02:50 p.m. RN Assessment Coordinator B stated she assumed Resident #1's fall on 01/12/2025 was not closed until 03/11/2025 because they were unable to determine his injury. During an interview on 04/17/2025 at 07:13 p.m., the DON stated she had just started working at the facility on 04/09/2025. She stated it would be the MDS Coordinator's responsibility to ensure the MDS assessments were accurate. She stated an RN was required to review a completed MDS assessment and sign it to indicate the assessment was accurate and complete. She stated if an MDS assessment was not accurate for fall history, but the care plan was updated with the appropriate interventions following the fall, then the inaccuracy in the assessment would not impact the resident's care. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 07:18 p.m., the ADMIN revealed every weekday morning she would go over the incidents and accidents that occurred during the night with the care team, and then the care team would also have a stand down meeting at the end of the day to discuss anything that happened during that day. She stated she also believed incidents and accidents would appear on the staff's dashboard when they logged into the EMR. She stated during the care team discussions, they discussed what happened, interventions, and the necessity to update the care plan. She stated the MDS Coordinators were supposed to attend both daily meetings. She stated she believed it was the MDS Consultant's responsibility to initially catch MDS errors, but the facility also had a compliance nurse. She stated the MDS Coordinator would sign the MDS Assessments, but then the MDS Consultant would check them. She stated she was unsure if the MDS Consultant checked every MDS Assessment. The ADMIN stated the DON would normally be the person responsible for completing the facility incident documentation in the EMR, but in the absence of the DON, the compliance nurse was working on them. She stated the compliance nurse would have been able to see if any incidents were still open and she was usually at the facility weekly or able to do them offsite. The ADMIN stated the compliance nurse was able to communicate with the ADONs if there were any sections of an incident report that needed completion. The ADMIN revealed that if the care plan was updated appropriately after a resident fall, then an inaccurate MDS Assessment would not impact the residents care but may impact the facility's reimbursement for that care. Record review of facility policy, Resident Assessment, noted as a section of the Nursing Policy & Procedure Manual 2003, revealed 7. Each assessment will be conducted or coordinate with the appropriate participation of health professionals. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.