

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with 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 and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, for 2 of 5 residents (Residents #1 and #2) reviewed for comprehensive care plans. 1. The facility failed to develop a comprehensive person-centered care plan with interventions to address Resident #1's behavior of unbuckling the seat belt when transported in the facility van. On 6/13/2025, Resident #1 fell forward while being transported and sustained a laceration to her forehead. 2. The facility failed to develop a person-centered care plan with interventions that addressed Resident #2's fall on 06/18/2025. An IJ was identified on 07/12/2025. The IJ template was provided to the facility on [DATE] at 3:30 PM. While the IJ was removed on 07/13/2025 at 4:20 PM, the facility remained out of compliance at a scope of isolation and severity of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of their plan of removal. These failures could affect residents who have care areas not addressed by the care plans by not having their behavioral needs identified and addressed and putting them at risk of not having their health and safety needs met. The findings included: 1. Record review of Resident #1's admission Record (Face Sheet) dated 07/11/2025 revealed she was a [AGE] year-old resident admitted to the facility on [DATE], readmitted on [DATE] and was discharged on 06/13/2025. Diagnoses listed on the admission Record included heart failure, kidney failure with dependence on dialysis (medical treatment to filter waste and excess water from the blood through a specialized machine), syncope (irregular heartbeat), bradycardia (slow heartbeat), and vascular dementia (impaired cognitive thinking due to constricted blood flow). Record review of Resident #1's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 5 out of 15 which indicated her cognitive skills for daily decision making were severely impaired; was dependent for transfers, and had no other behavioral symptoms not directed toward others. Record review of Resident #1's Physician Order Summary Report, dated 07/12/2025, revealed an order initiated on 01/17/2025 for dialysis on Monday, Wednesday, and Friday at 12:00 PM at a local dialysis center. Record review of Resident #1's Nurses Notes from 03/11/2025 to 06/12/2025 revealed there was no notation of Resident #1 trying to stand up during transport or for trying to unbuckle her seatbelt in the facility van during transport. Record review of Resident #1's Nurses Notes dated 06/13/2025 by the DON, revealed Resident had a fall. Location: in facility van during transport to dialysis. Cognition/Behavior at Time of Event: Cognitive Impairment. The fall caused a skin tear to above left eyebrow.new/bleeding.Administrator received call from Van Driver of resident fall in van. Upon arrival to scene, noted resident on floor of van face down with head partially under 2nd row of seats. Blood noted on floor and on resident's hair. Cream colored emesis (vomit) noted on wc [wheelchair] and unable to check vs [vital signs]. Respirations slow and irregular. 911 called per van driver. Ems arrived and transported to ER. The MD was notified on 06/13/2025 at 12:02 PM. Resident #1's Responsible Party was notified on 06/13/2025 at 11:52 AM. Interventions in place prior to fall: None, Interventions initiated in response to fall: none. Record review of Resident #1's Nurse's Notes dated 06/13/2025 by LVN H revealed the nurse received a call from the hospital emergency room regarding Resident #1's medication list which was faxed to the hospital and the nurse was informed the resident had another episode of vomiting at the hospital and was intubated (a tube inserted into the mouth and throat to hold open the airway so air can be pushed in and out of the lungs via machine) at that time. Record review of Resident #1's Event Nurses' Note-Fall, dated 06/13/2025, revealed the resident had an unwitnessed fall in the facility van during transport to dialysis sustaining a skin tear above her left eyebrow. Resident #1's responsible party was notified on 06/13/2025 at 11:52 AM and her physician was notified on 06/13/2025 at 12:02 PM. Under Interventions in place prior to this fall had None of the above was checked. Under Interventions initiated in response to this fall had None of the above checked and no interventions were listed. Record review of hospital records dated 6/20/2025 revealed Resident #1 had a CT (Computed tomography - type of imaging using x-ray techniques to obtain detailed images) of head was completed 06/19/2025 and showed no acute intracranial finding. Further review reviewed Resident #1 was treated for and placed on seizure precautions and treated also for sepsis-resolved (condition where the body's responses to infection causes injury to its own tissues and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review the facility failed to ensure that the resident's environment remained free of accidents and hazards as possible and each resident received adequate supervision to prevent accidents for 2 of 2 residents (Residents #1 and #2) reviewed for accidents. 1. The facility failed to identify and address hazards and risk in Resident #1's environment when staff failed to ensure they addressed Resident #1's behavior of unbuckling the seatbelt during transport in the facility van. On 06/13/2025, Resident #1 sustained a fall during van transport, with the seat belt noted to be on the wheelchair but the fastener unlatched, resulting in a laceration to her forehead. 2. The facility failed to identify and address hazards and risk in Resident #2's environment when staff failed to ensure they addressed Resident #2's fall on 06/18/2025. An Immediate Jeopardy (IJ) was identified on 07/11/2025. The IJ template was provided to the facility on [DATE] at 10:39 p.m. While the IJ was removed on 07/13/2025 at 4:20 p.m., the facility remained out of compliance at a scope of isolated and a severity of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of their plan of removal. This failure could place residents at risk for accidents injuries, hospitalization and death related to unsafe vehicle transport. The findings included: 1. Record review of Resident #1's admission record dated 07/08/2025 revealed she was a [AGE] year-old woman admitted on [DATE] with re-admission on [DATE], and with diagnoses which included: End-Stage Renal disease (condition where kidneys lose the ability to remove waste and balance fluids in balance requiring dialysis); Syncope (fainting or temporary loss of consciousness) and collapse; Vascular Dementia (impaired cognitive thinking due to constricted blood flow) and Bradycardia (slow heart beat).</p> <p>Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 5, indicating severe cognitive impairment, and was assessed as being dependent for transfers, and had no behavioral symptoms.</p> <p>Record review of Resident #1's Care Plan initiated 07/03/2022 revealed a focus area for "The resident is risk for falls due to dx [diagnosis] of syncope," and included "Resident had action [sic] fall in facility van causing laceration to forehead" initiated 07/03/2022 and revised 06/14/2025. There were no interventions listed which addressed the resident's behavior of unbuckling the seat belt and no new interventions for this fall were listed.</p> <p>Record review of Resident #1's other focus areas in her Care Plan initiated 07/03/2022, revealed there was no other focus areas for her behavior of trying to stand up during transport or for trying to unbuckle her seatbelt in the facility van during transport.</p> <p>Record review of Resident #1's Physician Order Summary Report, dated 07/12/2025, revealed an order initiated on 01/17/2025 for dialysis at 12:05 PM on Monday, Wednesday, and Friday at a local dialysis center.</p> <p>Record review of Resident #1's Nurses Notes from 03/11/2025 to 06/12/2025 revealed there was no notation of Resident #1 trying to stand up during transport or for trying to unbuckle her seatbelt in the facility van during transport.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Progress Note dated 6/13/2025 at 11:22 a.m. by the DON revealed "Resident had a fall. Location: in facility van during transport to dialysis. Cognition/Behavior at Time of Event: Cognitive Impairment. The fall caused a skin tear to above left eyebrow. new/bleeding&amp;hellip;. Administrator received call from Van Driver of resident fall in van. Upon arrival to scene, noted resident on floor of van face down with head partially under 2nd row of seats. Blood noted on floor and on resident's hair. Cream colored emesis (vomit) noted on wc [wheelchair] and unable to check vs [vital signs]. Respirations slow and irregular. 911 called per van driver. Ems arrived and transported to ER&amp;hellip;&amp;rdquo;. The MD was notified on 06/13/2025 at 12:02 PM. Resident #1's Responsible Party was notified on 06/13/2025 at 11:52 AM. "Interventions in place prior to fall: None, Interventions initiated in response to fall: none.&amp;rdquo;</p> <p>Record review of Resident #1's Nurse's Notes dated 06/13/2025 by LVN-H revealed the nurse received a call from the hospital emergency room regarding Resident #1's medication list which was faxed to the hospital and the nurse was informed the resident had another episode of vomiting at the hospital and was intubated (a tube inserted into the mouth and throat to hold open the airway so air can be pushed in and out of the lungs via machine) at that time.</p> <p>Record review of Resident #1's Event Nurses' Note-Fall, dated 06/13/2025, revealed the resident had an unwitnessed fall in the facility van during transport to dialysis sustaining a skin tear above her left eyebrow. Resident #1's responsible party was notified on 06/13/2025 at 11:52 AM and her physician was notified on 06/13/2025 at 12:02 PM. Under "Interventions in place prior to this fall&amp;rdquo; had "None of the above&amp;rdquo; was checked. Under "Interventions initiated in response to this fall&amp;rdquo; had "None of the above&amp;rdquo; checked and no interventions were listed.</p> <p>Record review of hospital records dated 6/20/2025 revealed Resident #1 had a CT (Computed tomography &amp;ndash; type of imaging using x-ray techniques to obtain detailed images) of head was completed 06/19/2025 and showed "no acute intracranial finding&amp;rdquo;. Further review revealed Resident #1 was treated for and placed on seizure precautions and treated also for sepsis-resolved (condition where the body's responses to infection causes injury to its own tissues and organs), likely secondary to aspiration pneumonia (lung infections caused by inhaling something other than air into your lungs, such as food or vomit), and Paroxysmal Atrial Fibrillation (noted she converted to normal sinus rhythm on 6/16/2025).</p> <p>Telephone interview with Family Member #1 on 07/11/2025 at 12:08 p.m. revealed Resident #1 was no longer in hospital and had been moved to a different nursing facility, but was still fighting an infection and very weak. He stated Resident #1 had a history of falls, but expected the facility to know this and take appropriate precautions. He stated he felt the facility should have sent extra staff instead of just the driver to help take care of vulnerable residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/09/2025 at 3:57 p.m., the Van Driver stated that she loaded Resident #1 in the van on 06/13/2025, leaving facility at 11:16 a.m. and after pulling out onto the road, she heard Resident #1 make a loud noise, and saw in the rear-view mirror that Resident #1 had vomit coming from her mouth. She stated that as she attempted to turn to pull off to the side of road, she saw Resident #1 stiffen up and fall forward out of the wheelchair and land face down on the floor of the van. The Van Driver stated she called the Administrator who told her to call 911. The Van Driver further stated that she had secured Resident #1 securely in her wheelchair into the van with 4 straps that were attached to the L-bar of Resident #1's wheelchair frame, but stated she believed Resident #1 had unbuckled her seatbelt, because she had unbuckled her seatbelt during transport in the past.</p> <p>Further interview with the Van Driver on 07/10/2025 at 4:15 p.m. revealed that she stated there were two other prior incidents of Resident #1 removing her seatbelt and trying to stand up in the van. She stated the first incident happened about 2 months prior to the June 13th incident, where Resident #1 took her seatbelt off and she told Resident #1 to keep her seatbelt fastened because she could fall. She stated the second incident happened about 2 weeks prior to the June 13th incident, where Resident #1 attempted to pull herself up to standing by pulling on the seat in front of her during transport. The Van Driver stated she reported one of the incidents to LVN -A, and one incident to the Administrator, who told her to contact therapy to ask what could be done, and therapy told her they could tilt her wheelchair backwards so she couldn't grab things.</p> <p>During an interview with LVN-A on 07/10/2025 at 11:44 a.m., she stated that sometime during that first week of June 2025, the Van Driver came to the Nurse's station after returning Resident #1 back to facility from dialysis, and told her, the DON and former ADON, who were all standing at the nurse's station, that Resident #1 had tried to stand up in the van during transport. LVN-A stated she educated Resident #1 about not standing up in the van, that it was dangerous, and she stated Resident #1 denied that she had done that. LVN-A further stated that she did not report the incident to anyone because the DON was standing at the Nurse's station with her when the Van Driver reported the incident and had instructed her to educate Resident #1 on not unbuckling her seatbelt.</p> <p>During an interview with the DON on 07/10/2025 at 4:54 p.m., the DON stated she was never made aware of any prior incidents of Resident #1 taking off her seatbelt or trying to stand up out of her wheelchair during van transport.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 07/10/2025 at 4:30 p.m. with the Administrator revealed she had inspected the van after the incident and observed vomit on the chest strap when she pulled it out from the retracting device, indicating the chest strap had been in place across Resident #1's chest when she first started to vomit and believed Resident #1 may have pressed down on her abdomen with her hand when she vomited, accidentally pushing on the release button of the seatbelt. When asked about any prior incidents, the Administrator stated that the Van Driver had informed her of an incident where Resident #1 had attempted to slide down out of her wheelchair, could not remember the exact date, but thought it might have been a couple of months prior to the current incident, and that was when she suggested the Van Driver check with therapy to see if wheelchair could be modified. She stated the Van Driver never told her Resident #1 had unbuckled her seatbelt or tried to stand up in van. She stated the Van Driver came back and told her therapy stated the wheelchair could be tilted back slightly, and they agreed that was what they were going to try to do to address the problem. The Administrator further stated that if Resident #1 had intentionally tried to undo her seatbelt or stand up in the van during transport she would expect that to be reported to her, but no one ever had. She stated the team never met to discuss the incident reported to her of Resident #1 trying to slide out of the wheelchair and the intervention they discussed about the therapy assessment of the wheelchair was never care planned but should have been.</p> <p>Interview with PT - B on 07/11/2025 at 11:46 a.m. revealed she confirmed a CNA had come down to ask about what could be done about Resident #1 leaning forward in wheelchair and PT-B instructed CNA and Resident #1's family member how to recline the wheelchair. No documentation available as Resident #1 was not on services at this time.</p> <p>Interview with the Activity Director on 7/11/2025 at 9:41 a.m. revealed that he also transports residents in the van to recreational activities, but will also transport residents at times to their medical appointments when the primary Van Driver is out sick. He stated the primary Van Driver and he are the only staff who transported residents at the facility. The Activity Director stated he had transported Resident #1 in the van many times and had observed her undo her seatbelt or try to stand up in van during transport several times. The Activity Director further stated he educated Resident #1 not to unbuckle her seat belt, but stated she would get anxious at times and forget. The Activity Director stated he reported this behavior of unbuckling her seatbelt during transport to the primary Van Driver so she could be aware and monitor but did not report the incidents to anyone else.</p> <p>During a telephone interview with the Van Driver on 07/11/2025 at 11:54 a.m., she stated that she did not recall the Activity Director ever informing her or warning her about Resident #1's behavior of unbuckling her seatbelt during transport.</p> <p>During an interview with the Administrator on 07/11/2025 at 11:46 a.m., the Administrator stated that had she known Resident #1 had incidents of unbuckling her seatbelt in van during transport, she would have assigned an escort to go along with her during transport or contracted with local company for ambulance transportation services for Resident #1.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #2's admission record dated 07/08/2025 revealed she was an [AGE] year-old woman admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included: Vascular Dementia-Severe (impaired cognitive thinking due to constricted blood flow), Schizoaffective Disorder (a mental health condition that includes both symptoms of schizophrenia, such as hallucinations and delusion and mood disorders), and Poly- osteoarthritis (condition where cartilage in multiple joints wears down causing bones to rub against each other leading to pain and stiffness).</p> <p>Record review of Resident #2's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 4, indicating severe cognitive impairment and she was assessed as needing substantial/maximal assistance for transfers.</p> <p>Record review of Resident #2's Nurses Notes dated 06/18/2025 at 6:06 p.m. by LVN-I, revealed the resident had an unwitnessed fall from the low bed in her room onto the floor next to the bed sustaining a skin tear that was 2cm. to her right hand, and complaining of head, neck, right arm and right leg pain. Under "Interventions in place prior to this fall" had "Floor mat, Low bed." Under "Interventions initiated in response to this fall" had "Floor mat, Low bed, neuro-checks."</p> <p>Record review of Resident #2's Nurses Notes dated 06/18/2025 at 10:55 p.m. by LVN-I revealed resident had returned from the ER with a diagnosis of right knee patella (kneecap) fracture, with knee immobilizer in place.</p> <p>Record review of Resident #2's Care Plan initiated 07/03/2022 for "The resident is risk for falls r/t Poor communication/comprehension"; Resident H/O fall out of bed due to self positions to the point of being on the edge"; initiated 07/03/2022 and last revised 07/07/2023, revealed it was not revised to address the resident's actual fall on 06/18/2025 and no new interventions were listed.</p> <p>Record review of Resident #2's other focus areas of Care Plan initiated 07/03/2022 revealed there was no care plan or new interventions which addressed her fall on 06/18/2025.</p> <p>Interview with CNA-K on 07/09/2025 at 1:52 p.m. revealed she stated she had completed check and change with Resident #2 about an hour before her fall and stated she put the bed in the lowest position, and the head of bed was just slightly elevated. Then as she was walking down hall with LVN-H to leave at end of her shift, she heard Resident #2 mumbling, looked in her room and saw her on the floor, face down. She stated she also observed the bed was not in the lowest position, and the head of the bed was straight up at 90-degree angle. The fall mat was in place by her bed.</p> <p>Interview with LVN-H on 07/10/2025 at 10:40 a.m. revealed she works day shift and was getting ready to leave for the day when she heard Resident #2 talking from her room, and when she went to check on her, found Resident #2 lying on the mat on the floor next to her bed. LVN-H stated she observed that Resident #2's head of bed was up to the full 90 degrees, and the bed was not in lowest position, and stated that Resident #2 had been observed to work the bed controller in the past. LVN H stated she believed Resident #2 had accidentally changed position of bed as she manipulated the bed controller. She stated they always make sure her call light was within reach but does not believe she understands its purpose as Resident #2 will push the button on the call light, but when they answer, she cannot say what she needed or why she activated the light.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 07/10/2025 at 5:59 p.m. with LVN-I revealed she works night shift and had just come on duty on 6/18/2025 when she was called into Resident #2's room after she had been found on the floor. She stated Resident #2 was lying on the mat on the floor next to her bed, and that the mat had been in place. However, she noted the bed was not in its lowest position and the head of the bed was in an upright position and stated Resident #2 will take the bed controller and randomly press buttons on it, which can move her bed out of the lowest position. LVN-I stated they have done interventions to keep her from falling again, such as moving the bed controller to the end of the bed to keep her from moving the bed up higher and moving things away from her bed that she can grab, like the drawers out of her dresser.</p> <p>Interview with the DON on 07/11/2025 at 8:28 a.m. revealed all acute incidents such as falls are discussed in the morning team meetings and the team discusses actions/interventions needed. She did not remember specifically what was discussed regarding Resident #2's fall on 6/18/2025. The DON stated that the MDS Nurse is responsible for revising the care plan per the quarterly and annual MDS assessments, and the DON and ADONs are responsible for updating care plans for acute changes. The DON did not know why there was no care plan revision done following Resident #2's fall on 06/18/2025 and -stated that could result in staff not being aware of the care needs of the residents, and could result in acute events such as falls happening again.</p> <p>During an interview with the Administrator on 07/11/2025 at 10:16 a.m., the Administrator stated that Resident #2's fall on 06/18/2025 was addressed by the team in the morning clinical meeting to review causes of the fall and devise new interventions to prevent other falls in future. The Administrator stated that interventions were put into place, including moving furniture to create a safe space, and moving the bed controller away from Resident #2's reach, so that she could not move the bed out of the recommended low bed position. The Administrator further stated however, that Resident #2's care plan was not revised to include these new interventions to prevent further falls but should have been. She stated that either the MDS Nurse or DON can update the care plan to include new focus areas and interventions after discussion in the morning clinical meeting and did not know why Resident #2's care plan was not revised. The Administrator stated not updating the care plan to include all relevant new information such as interventions put in place to prevent falls, could result in staff not having the needed information to care for the Resident properly.</p> <p>Record review of facility policy titled "Fall Policy", undated revealed "The DON or designee will be responsible for investigating all resident falls to attempt to determine the cause and need for new interventions as requires; and "Appropriate interventions will be addressed immediately on the interdisciplinary plan of care. Reassessment will occur after each fall."</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 07/11/2025. The Administrator was provided with the IJ template on 07/11/2025 at 10:39 PM.</p> <p>On 07/12/2025 the facility provided a plan of removal. The Plan of removal was accepted on 07/12/2025 at 11:33 AM. It is documented as follows:</p> <p>The following in-services were initiated by the Regional Compliance nurse and DON on 7/11/25. Any staff member not present or in-serviced on 7/11/25 will not be allowed to assume their duties until in-serviced.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Direct Staff to include therapy staff.</p> <ol style="list-style-type: none"> <li>1. Implementing interventions to minimize the risk of falls.</li> <li>2. Fall Prevention Policy</li> <li>3. Reporting all incidents and accidents to the administrator immediately.</li> </ol> <p>Facility transportation staff was removed from transport duties and counseled by Administrator on 07/11/2025 on Van Driving policy.</p> <p>All transportation staff retrained on Incident Reporting Policy to Administrator on 7/11/25 by administrator.</p> <p>The medical director was notified of the immediate jeopardy situation on 7/11/25 at 10:30 pm by administrator.</p> <p>Ad Hoc QAPI meeting will be held on 7/11/25 to discuss the IJ and review plan of removal.</p> <p>Any falls/incidents that occur over the weekend will be reported to the facility administrator and/or DON.</p> <p>Monitoring:</p> <p>DON and Administrator will review all falls during the morning meeting to ensure appropriate interventions have been implemented. Monitoring will occur 5 days per week for a minimum of 6 weeks.</p> <p>DON and Administrator will review all falls during the weekly Standard of Care Meeting to ensure appropriate interventions have been implemented. Monitoring will occur weekly for a minimum of 6 weeks.</p> <p>Above will be reviewed during the facility monthly QA meeting for no less than 60 days, or until the Administrator determines substantial compliance has been achieved and maintained.</p> <p>Incidents involving van transport will be reviewed 5x weekly in morning meeting to determine if there were any incidents. This will be continued for a period of 6 weeks and PRN thereafter as determined by the QAPI committee.</p> <p>Verification of the facility's POR for F689 was as follows:</p> <p>Record review of an AD Hoc QAPI Contributors signature page dated 07/11/2025 revealed a meeting was held with the Administrator, DON, Medical Director, Social Services, Activity Director and three other employees.</p> <p>Record review of an undated, untitled sheet revealed the Medical Director was notified on 07/11/2025 at 11:04 AM of the IJ situation by the Administrator.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of an Incident/Fall Review Monitoring Tool revealed all falls would be reviewed 5 days per week for 6 weeks.</p> <p>Record review of a Falls Review Monitoring Tool revealed the Administrator and the DON would discuss falls and interventions implemented weekly at a SOC (Standard of Care) meeting that was held with the Administrator, DON, and other Interdisciplinary Team members.</p> <p>Record review of the QA Monitoring Tool revealed falls and incidents and if interventions were implemented would be reviewed monthly at the QAPI Meetings that will be held on 07/15/2025 and 08/19/2025.</p> <p>Record review of the Van Incident Monitoring Tool revealed all incidents involving van transport were reviewed five times a week for 6 weeks by the DON and Administrator.</p> <p>Record review of an undated employee list revealed the facility had 89 full time employees and 32 part-time/prn employees for a total of 121 employees.</p> <p>Record review of an In-service record log, dated 07/12/2025 revealed all 121 employees had been in-serviced by phone or in person on reporting allegations of abuse/neglect immediately to the administrator; any unsafe conditions must be reported to the administrator immediately; all falls and/or other accidents or unusual occurrences would be reported to the administrator; any unsafe behaviors or incidents that occur on the fan during transport needs to be reported to the administrator and DON immediately; all unsafe behaviors that could lead to a fall must be reported immediately to the administrator; and on the Fall Policy.</p> <p>In an interview on 07/12/2025 at 4:23 PM, the Administrator stated the "SOC" was Standard of Care which was a weekly meeting that was held to discuss resident care.</p> <p>Interviews on 07/12/2025 from 4:40 PM to 7:00 PM and 07/13/2025 from 8:30 AM to 4:00 PM with 29 employees out of 121 employees (25 full time employees, 4 prn/part time employees) which consisted of 1 RA (RA W), 2 MA (MA T, MA U), 2 Housekeepers (Housekeeper Q, Housekeeper R), 10 CNAs (CNA L, CNA M, CNA N, CNA O, CNA X, CNA Y, CNA K, CNA BB, CNA AA, CNA Z) 3 of them worked 6 PM to 6 AM shift, 4 LVNs (LVN I, LVN H, LVN J, LVN P) 2 of them worked 6 PM to 6 AM shift), 3 dietary employees (Dietary Aide T, Dietary Supervisor E, and [NAME] S), 1 Activity Director, 1 Van Driver, 2 PTA (PTA EE, PTA CC), 1 OTA (OTA DD) revealed the had received the in-service training as indicated in the POR for F689. All the employees stated they would report any signs of abuse to the Abuse Coordinator who was the Administrator, they had her phone number to contact her. They also stated they would report immediately to the abuse coordinator any falls or unsafe behaviors to the administrator which included any unsafe behaviors when residents were transported in the van. The employees stated they had been in-serviced on the facility's Fall Prevention policy and interventions to minimize falls and provided examples of how that could be done.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/13/2025 at 10:41 AM the Van Driver stated she works full time as the van driver; and received training on reporting incidents, on when to pull the van over, on when to report anything to the administrator about unusual behaviors that occurred when a resident was transported, reporting unusual behaviors from residents. Van Driver D said she was also trained to report any falls a resident had to the administrator, the DON and nurse. The Van Driver stated she was also trained to report any signs of abuse or neglect to the administrator immediately. The Van Driver said she received one-on-one training about the fall with Resident #1, was retrained by administrator on transporting residents, and the Administrator rode with her for a whole week in June 2025. Then the administrator rode with her twice a week for four weeks, then the administrator would randomly ride with her. The Van Driver stated she the Administrator was riding with her twice a week for two more weeks. The Van Driver said she would print out daily the calendar of the residents who would be transported; record on the calendar any behaviors from the resident when they were transported and provided the calendar to the administrator at the end of the day. The Van Driver stated she was also in-serviced recently on abuse and neglect; and would report it immediately to the administrator.</p> <p>In an interview on 07/13/2025 at 2:03 PM, DON stated they would review in the morning meeting which resident would need an escort when transported to their scheduled appointment. The DON said residents who had falls were reviewed daily in the morning meeting. The DON stated she and the Administrator had in-serviced the employees on Abuse and Neglect, on Falls, who to report to, what to report for abuse or neglect, and fall prevention. The DON stated staff were to report to her or the Administrator if they had witnessed any unsafe behaviors from a resident or when the resident was transported. The DON stated if a resident had a fall, the charge nurse would notify her of the fall. The DON said they would review the falls throughout the day to see how they could be prevented. The DON stated the monitoring would be done with the monitoring tools that were developed and reviewed in the daily morning meeting, the weekly SOC meeting and QAPI meetings. The DON stated they would review which residents need to have an escort or need to have a contracted transport company take a resident to dialysis if needed. The DON said they had an Ad Hoc QAPI meeting on 7/11/2025 with the department heads, the Administrator, the Area Director of Operations; and the Medical Director was informed by the Administrator. The DON said she and the ADON would review the 24-hour summary to see if there were any changes that happened such as falls or behaviors and to see if they were reviewed. The DON stated the resident's dashboard would be reviewed throughout the day for any falls or behaviors that would need to be addressed. The DON said she and the Administrator were reviewing residents who were going to be transported, and it was discussed if the resident needed to have an escort. The DON stated the SOC meeting was held weekly on Fridays, and they would review residents who had a fall or accident to see if any interventions were needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/13/2025
NAME OF PROVIDER OR SUPPLIER  Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3301 E Mockingbird LN 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 07/13/2025 at 2:23 PM, the Administrator stated the interventions implemented included re-educating all staff on reporting unusual occurrences, and an employee could not return to work unless they received the training. The Administrator said all staff were provided her phone number to contact her to report any abuse or unsafe behaviors. The Administrator stated a monitoring tool was implemented to review all falls in the morning meeting to ensure interventions were implemented and was care planned. The Administrator said the SOC tool would be used weekly to verify the interventions were listed, if the staff knew about the interventions, and would be reviewed at the next QAPI meeting. The Administrator stated a van monitoring tool was implemented to ensure if anything happened during transport was recorded. The Administrator said the monitoring sheet was reviewed daily to determine if a resident needed an escort or need an ambulance to transport them. The Administrator stated the van drivers would turn in the van monitoring tool at the end of the day with notes about if a resident tried to stand up, any issues with their chair, or if they looked weak. The Administrator said the Van Driver was retrained on transporting residents in the van. The Administrator stated after the incident with Resident #1 she rode in the van daily for the first week, then the second week she rode in the van a twice a week. The Administrator stated an Ad Hoc QAPI meeting was held on 07/11/2025 with the department heads and Area Director of Operations. The Administrator said staff were retained about un-safe behaviors to be reported immediately to her or the DON. The Administrator stated when employees see a resident exhibiting behaviors, they were to stay with the resident to make sure they are safe, call for help, then report it to the administrator. The Administrator said they have a clinical care meeting and will follow-up on the entries on the resident's clinical record dashboard for behaviors with instructions for that resident, and the interventions were added to the resident's care plan. The Administrator stated if something happened on the weekend, staff would contact the Administrator. The Administrator said the Van Driver and Activity Director were in-serviced to pull over when a resident did something unsafe in the van and then call her. The Administrator said she a calendar was used with residents who have appointments to determine if a resident needed to have an escort to their appointment. The Administrator stated she and the DON would review all falls to make sure the i</p>		