

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 11/26/2025
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility failed to ensure the MDSN, and the ST knocked on Resident #1's door before entering the resident's rooms. This failure could place residents at risk of feeling like their privacy was invaded or cause psychosocial harm and emotional distress. Findings included: Record review of Resident #1's face sheet, dated 11/26/2025, revealed s a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnoses included muscle weakness, difficulty in walking, lack of coordination, cognitive communication deficit (problems with communication), malaise (feeling of general discomfort), insomnia, (difficulty sleeping) major depressive disorder (mental health disorder characterized by persistent depressed mood), and hypertensive emergency (a severe, acute elevation in blood pressure). Record review of Resident #1's admission MDS assessment dated [DATE], revealed Resident #1 had a BIMS score of 15 indicating cognitive response. During an observation of 200-hall on 11/26/2025 at 11:01a.m., revealed Resident #1 was in the bathroom and her call light was on. The MDSN did not knock on Resident #1's door before entering. During an observation of 200-hall on 11/26/2025 at 11:04a.m., revealed Resident #1 was sitting in her wheelchair by her bed when the ST walked into her room without knocking. During an interview with the MDSN on 11/26/2025 at 11:03a.m., revealed she was trained on resident rights. She said staff were to knock on the door and get permission to enter, introduce themselves. She said staff were supposed to knock anytime they wanted to enter a resident's room. She said the resident may feel like their privacy was invaded. She said the nurses was responsible for monitoring to ensure staff were knocking. She said the charge nurse monitored through observations. She said the resident's door was open and her light was on. She said that she should have knocked before entering. During an interview with the ST on 11/26/2025 at 11:09a.m., revealed she was trained on resident rights. She said the policy was that she needed to knock on a resident's door and say therapy. She said staff should knock anytime they wanted to enter a resident's room. She said staff not knocking on the resident's door was disrespectful and intrusive. She also said all residents should get the same respect. She said any administrative staff who were walking around should be monitoring staff not knocking. She said she did not knock on Resident #1's door because she was trying to get the light off before someone else came to the room. she said she should have knocked before entering the room. During an interview with Resident #1 on 11/26/2025 at 11:15a.m., revealed staff always walked into her room without knocking. She said she would like for staff to knock anytime they wanted to come into her room. She said it upsets her when staff just walk into her room and invade her privacy. During an interview with the DON on 11/26/2025 at 3:34p.m., revealed she and staff were trained on resident rights. She said the policy for knocking was a resident right dignity issue. She also said that staff needed to knock and announce themselves. She said the facility was the resident's home and staff were to always knock before entering the resident's room. She said how the resident felt when staff did not knock depended on the resident. She said the DON and the ADM monitored to ensure staff were knocking. She said the DON and ADM monitored by doing observations. She said she did not know why the MDSN, and the ST did not knock before entering Resident #1's room. During an interview with the ADM on 11/26/2025 at 4:02p.m., revealed she and staff were trained on resident rights. She said the policy for knocking was staff were to knock and wait for a response. She said she would knock on a resident's door even when she would put up a resident's clothes. She said all staff should knock before entering a resident's room. she also said if staff were in the middle of a task and had to walk out to get something, she would not expect the staff to knock again. She said if staff did not knock a resident could get startled or upset. She also said it was disrespectful for staff not to knock before entering a resident's room. She said that the management team monitored to ensure staff were knocking. She said management monitored by doing rounds and should be asking the resident's if staff were knocking. She said she did not know why the MDSN, and the ST did not knock on Resident #1's door. Record review of Resident Rights Policy, dated 03/09/2000, revealed, A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must respect the residents right to personal</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident bedside and toilet and bathing facilities were adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 2 of 14 residents (Resident #2 and Resident #3) reviewed for resident call system . The facility failed to provide a working communication system that was easily at reach, which would allow Resident #2 and Resident #3 the ability to safely call staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living. Findings include:Resident #2 Record review of Resident #2's face sheet, dated 11/26/2025, revealed s an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2's diagnoses included dementia (memory, thinking, difficulty), chronic obstructive pulmonary disease (chronic progressive lung disease), heart failure (hypertension (high blood pressure), malaise (feeling of general discomfort), muscle wasting, muscle weakness, history of falling and lack of coordination. Record review of Resident #2's quarterly MDS assessment dated [DATE], revealed Resident #2 had a BIMS score of 09 indicating moderate impairment. The MDS also revealed Resident #2 was partial to moderate assistance with transfers for toileting and shower transfers. Resident #2 was supervision or touching assistance with bed transfers. Record review of Resident #2's care plan dated 11/11/2025 revealed Potential for falls due to reported history of frequent falls while at home. Osteoporosis (disease that weakens the bones and make them more likely to break), impaired cognitive functioning and safety awareness with dementia, incontinence with some control present, Arthritis and arthritic joint pain, neuropathy, decline in functional independence, weakness, impaired balance, unsteady gait, and cardiovascular and psychotropic medication administration. Interventions were Call light in easy reach. Remind resident to call for staff assistance when needed and answer call promptly. Check on the resident at routine intervals to assess needs, monitor safety issues and offer assist as needed. Resident has experienced a decline in functional independence for mobility with increased weakness and reduced endurance. Potential for improved function and return to prior levels of independence with skilled PT interventions. Interventions were Call light in easy reach. Encourage/remind resident to call for staff assist as needed. Check on her at routine intervals to assess needs, monitor safety issues and offer assistance as needed. Resident #3 Record review of Resident #3's face sheet, dated 11/26/2025, revealed s a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3's diagnoses included heart failure, dementia (memory, thinking, difficulty), protein-calorie malnutrition (inadequate intake of both protein and calories), atrial fibrillation (abnormal heart rhythm), skin cancer, anxiety (feeling of uneasiness or worry), constipation and major depressive disorder (mental health disorder characterized by persistent depressed mood). Record review of Resident #3's admission MDS assessment dated [DATE], revealed Resident #3 had a BIMS score of 00 indicating severe cognitive impairment. The MDS also revealed Resident #3 was partial/moderate assistance with all transfers. Record review of Resident #3's care plan dated 11/08/2025 revealed The resident has Oxygen Therapy intervention was Provide reassurance and allay anxiety (to calm or relieve feeling of worry and nervousness): Have an agreed-on method for the resident to call for assistance (call light,). Stay with the resident during episodes of respiratory distress. The resident has a communication problem related to Neurological symptoms. Interventions were Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, avoid isolation. Resident is at risk of falls related to actual fall on 11/19/2025. Interventions were Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. During an observation of Resident #2 on 11/26/2025 at 8:07a.m., revealed her call light was on the floor under the top of her bed. Resident #2 was lying in her bed. During an observation of Resident #3 on 11/26/2025 at 8:15a.m., revealed was on his bedside table out of Resident #3's reach. Resident #3 was laying in his bed. An interview was attempted with Resident #3 on 11/26/2025 at 8:16a.m., revealed Resident #3 was nonverbal. During an interview with Resident #3's private sitter on 11/26/2025 at 10:57a.m., revealed that she had worked for Resident #3's family for two weeks. She said Resident #3's call light has always been on his bedside table and not in his reach ever since she started working with him. She said that she felt like Resident #3 could use the call light if needed something. During an interview with the ADM on 11/26/2025 at 2:47p.m. revealed the facility did not have policy for call light</p>		