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	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines Nursing and Rehabilitation	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 4 of 6 residents (Resident #8, #2, #75, and #43) reviewed for accuracy of records: 1. Nursing staff failed to document medication administration in the MAR for Resident #8 on 2/1/2026, 2/9/2026, 2/16/2026 and 2/17/2026.2. The facility failed to document wound care dressing changes on the TAR for Resident #2 on 02/06/2026, 02/07/2026, 02/10/2026, and 02/11/2026.3. The facility failed to ensure Resident #75's MAR accurately reflected when the resident's Fluticasone nasal spray was administered and when it was not for February 2026.4. The facility failed to document wound care dressing changes on the TAR for Resident #43 on 2/5/26, 2/6/26, 2/7/26, and 2/10/26. These failures could affect residents whose records were maintained by the facility and could place the residents at risk of errors in care and treatment.The findings included: 1.Record review of Resident #8's face sheet, dated 02/18/2026 revealed a [AGE] year-old female with an initial admission 2/28/2020 and a readmission on [DATE] with diagnoses of; Ogilvie syndrome (sever, sudden swelling of the large intestine), diverticulitis (digestive disease causing bulging pouches in the intestine), and atherosclerotic heart disease (plaque build up in the arteries). Record review of Resident #8's MDS, dated [DATE] revealed BIMS score of 11, which indicated moderate cognitive impairment. Record review of Resident #8's doctor orders revealed, Dicyclomine HCl Oral Tablet 20 MG (Dicyclomine HCl), Give 1 tablet by mouth every 6 hours for IBS. Record review of Resident #8's MAR indicated no documentation of medication administration on 2/1/2026, 2/9/2026, 2/16/2026 and 2/17/2026. During an interview on 2/20/2026 at 8:50 am, CMA G stated that the Dicyclomine HCl was administered to Resident #7 but he forgot to click the administration box in the MAR. 2.Record review of Resident #2's face sheet dated 02/17/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of unspecified injury of the head. Record review of Resident #2's BIMS assessment dated [DATE] revealed a BIMS of 0 out of 15 suggesting severe cognitive impairment. Record review of Resident #2's Order Summary Report dated 02/17/2026 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- cleanse stage 3 to left heel with normal saline, pat dry with 4 x 4 gauze. Apple Santyl gel and calcium alginate sheet to wound bed and cover with dry dressing every day shift for wound healing until resolved with order date 02/05/2026 with no end date. Record review of Resident #2's MAR/TAR for February 2026 reflected there was no documentation for left heel wound care on 02/06/2026, 02/07/2026, 02/10/2026, and 02/11/2026. Record review of Resident #2's care plan provided on 02/17/2026 revealed a focus area for the following: .Resident with a stage 3 pressure wound to left heel with treatment in place, revision date of 02/10/2026, with interventions including follow facility policies/protocols for the prevention/treatment of skin breakdown initiated on 11/21/2025 During an interview on 02/18/2026 at 2:53 p.m., LVN D stated the missing documentation on Resident #2's MAR/TAR for wound care could have resulted from being pulled to work on the floor and fell behind on her documentation in the electronic record but documented on a paper form instead. LVN D stated she made sure wound care was done for Resident #2 and all other residents requiring wound care. During an interview on 02/19/2026 at 1:45 p.m., LVN D stated if there was missing documentation on the MAR/TAR it looked like it was not completed. 3. Record review of Resident #75's face sheet dated 2/18/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included moderate persistent asthma, anxiety disorder, heart failure, kidney failure, and allergic rhinitis (runny nose). Record review of Resident #75's most recent comprehensive MDS assessment dated [DATE] reflected the resident had a BIMS score of 11, which indicated moderate cognitive impairment. Record review of Resident #75's Order Summary Report dated 2/18/26 reflected the following: - Fluticasone Propionate Nasal Suspension 50 mcg/act, 1 spray in both nostrils two times a day related to allergic rhinitis, with order date 1/5/26 and no end date -Levothyroxine Sodium Tablet 200 MCG, Give 1 tablet by mouth one time a day. Record review of Resident #75's MAR for February 2026 reflected the following for Fluticasone Propionate nasal spray: - AM dose was not administered 2/7, 2/8, 2/9, 2/12, 2/15, 2/16 - PM dose was not administered 2/2, 2/4, 2/9, 2/10, 2/11, 2/16, 2/17 -No documentation of medication administration on 2/17/2026 for Levothyroxine Sodium. Resident #75's MAR reflected the Fluticasone Propionate nasal spray was administered to the resident on the following days: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- AM dose administered 2/1-2/6, 2/10-2/11, 2/13-2/14, and 2/17-2/18 - PM dose administered 2/1, 2/3, 2/5-2/8, and 2/12-2/15 During an interview on 2/18/26 at 2:09 p.m., MA K stated she routinely worked with Resident #75 and stated the resident did not refuse medications. MA K stated when a medication was not available or if a medication was refused, the code other was used on the MAR and then the system would prompt the staff to enter a progress note that indicated why the medication was not given. MA K stated she had marked other on Resident #75's MAR which indicated the resident did not have Fluticasone nasal spray available. MA K stated she had reported the medication not being in the medication cart to the ADON and the night shift nurse LVN L. MA K stated she did not recall Resident #75 ever receiving a dose of Fluticasone nasal spray from her for the month of February 2026 because it had not been available. MA K stated they were not allowed to leave the MAR blank because it could be assumed the medication was not given. During an interview on 2/18/26 at 2:35 p.m., the ADON stated, the electronic MAR was designed in a way in which if a medication was not available, the computer system would prompt the staff to use the code 9 for other and then the system would prompt the staff to write a progress note that would indicate why the medication was not given. The ADON stated she had not been made aware Resident #75's Fluticasone nasal spray was not in stock. The ADON stated there were no designated staff assigned to order medications, it would be whatever floor nurse was working at the time, and a CMA was also capable of ordering medications. The ADON stated she was not aware of a process in place for auditing the MAR for discrepancies. The ADON stated it was not acceptable to leave blanks on the MAR because it would look like the resident did not receive their medication or treatment. The ADON stated if a resident was not getting prescribed medications, and depending on the medication, it could be detrimental to their health. The ADON stated, Resident #75's Fluticasone nasal spray should have been provided by the physician's orders and by the resident's needs. During an interview on 2/19/26 at 8:43 p.m., MA I stated she recalled ordering Resident #75's Fluticasone spray and it's been in the building. MA I stated Resident #75's Fluticasone nasal spray was here the other day, there was none, I could not find it, it was in the building, but I could not find it. MA I stated, I was not intentionally marking that it (Fluticasone nasal) spray was given when the medication was not available, it was probably marked in haste when documenting on the MAR/TAR. MA I stated if a resident was not receiving prescribed medications the resident could get sick and in the case of Resident #75's nasal spray, she could develop a runny nose and have a hard time breathing. MA I stated, it was not acceptable to leave blanks on the MAR because it could indicate the medication was not given. During an interview on 2/19/26 at 9:00 a.m., Resident #75 stated she finally received a dose of Fluticasone spray on 2/19/26, but it had been several weeks since she had been given the medication. Resident #75 stated she was told the nasal spray was on order or was not available. During an interview on 2/19/2021 at 9:07 am, DON stated she investigated why there are holes in the MAR. The DON stated she interviewed the staff that were assigned on those days and found out that medications were given but the staff did not click the administration button. The DON stated that it should have been documented to prove that it was done and to prevent any discrepancies in the MAR. During an interview on 2/20/2026 at 8:50 am, CMA G stated that the Levothyroxine Sodium was administered to Resident #75 but he forgot to click the administration box in the MAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #43's face sheet dated 2/19/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included disorders of bone density and structure. Record review of Resident #43's most recent comprehensive MDS assessment dated [DATE] reflected that the resident was cognitively intact for daily decision-making skills and had a stage 3 pressure ulcer (a full thickness skin loss where the damage extends through the skin into the fatty tissue). Record review of Resident #43's Order Summary Report dated 2/19/26 reflected the following: - cleanse wound to right buttock with normal saline, pat dry with 4 x 4 gauze. Pack wound with collagen powder, calcium alginate sheet, and cover with dry dressing daily and as needed with order date 2/3/26 and no end date. Record review of Resident #43's MAR/TAR for February 2026 reflected there was no documentation for right buttock wound care on 2/5, 2/6, 2/7, and 2/10. Record review of Resident #43's comprehensive care plan with revision date 2/18/26 reflected the resident had a pressure ulcer to the right buttock with interventions that included to follow facility policies/protocols for the prevention of skin breakdown. During an interview on 2/17/26 at 11:22 a.m., Resident #43 stated she had a wound on the right buttock for approximately one month and the bandage was not changed every day, except when needed. During an interview on 2/19/26 at 11:27 a.m., LVN D stated the missing documentation on Resident #43's MAR/TAR for wound care could have resulted from being pulled to work on the floor and fell behind on her documentation. LVN D stated, wound care was not missed, that is something I make sure of. LVN D stated, if there was missing documentation on the MAR/TAR it could be assumed the care was not done. LVN D stated it was not acceptable. Record review of the facility document titled Documentation, undated, reflected in part, .Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatment. It has legal requirements regarding accuracy and completeness, legibility and timing. Special form in the clinical record are utilized in nursing documentation such as.medication sheets.Goal.The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.Complete documentation as needed in a timely manner. Records review of facility policy titled, Documentation reflected, complete documentation in a timely manner. Each entry will be dated and timed. Each entry will be signed with proper signature and title.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 4 of 18 residents (Residents #48, #98, #83, and #43) reviewed for infection control: 1. The facility failed to ensure MA I sanitized the blood pressure cuff used between Resident #48, #98, and #83.2. The facility failed to ensure LVN D wore proper PPE while providing wound care to Resident #43 who was on EBP status. These failures could place residents at risk for cross-contamination and infection and could result in illness due to improper care practices.The findings included: 1. Observation on 2/19/26 beginning at 7:59 a.m. during the medication pass revealed, CMA I obtained Resident #48's blood pressure prior to administering medications, then took the same blood pressure cuff and obtained Resident #98's blood pressure and then took the same blood pressure cuff and obtained Resident #83's blood pressure without sanitizing the blood pressure cuff between resident use. During an interview on 2/19/26 at 8:32 a.m., MA I stated, the blood pressure cuff used on Resident #48, #98, and #83 was a blood pressure cuff she personally owned. MA I stated she did not believe the blood pressure used between the residents was contaminated because I placed the blood pressure cuff over their clothes. MA I stated, I usually spray it (the blood pressure cuff) with bleach sanitizer after the completion of medication pass. MA I stated she had not been taught about sanitizing a blood pressure cuff while working for the facility and used her medication aide knowledge. MA I stated she would have sanitized the blood pressure cuff if a resident had slobber on their arm I would have cleaned it (the blood pressure cuff) after using it, but I don't really think it's necessary. That's my opinion. 2. Record review of Resident #43's face sheet dated 2/19/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included disorders of bone density and structure. Record review of Resident #43's most recent comprehensive MDS assessment dated [DATE] reflected that the resident was cognitively intact for daily decision-making skills and had a stage 3 pressure ulcer (a full thickness skin loss where the damage extends through the skin into the fatty tissue). Record review of Resident #43's Wound Progress Note dated 2/10/26 and authored by the NP reflected the resident had an improving Stage 3 pressure wound to the right buttock and a treatment plan that included to clean the wound with wound cleanser, apply Iodoform packing strip, Calcium alginate and dry dressing changes daily and as needed if dressing was dislodged, saturated, or soiled. Record review of Resident #43's comprehensive care plan with revision date 2/18/26 reflected the resident had a pressure ulcer to the right buttock with interventions that included to follow facility policies/protocols for the prevention of skin breakdown. Resident #43's comprehensive care plan did not reflect the resident was on EBP status related to the pressure wound. During the wound care observation on 2/19/26 at 11:43 a.m., LVN D put on a pair of gloves, did not put on a gown, and removed Resident #43's bandage from the right buttock. Resident #43 was observed with an open wound on the right buttock that had moderate serosanguineous drainage (thin pink to light red drainage) emitting from the wound and observed on the bandage. LVN D was observed squatting over Resident #43's bed and her forearms resting on the resident's bed while providing wound care. During an observation and interview on 2/19/26 at 11:27 a.m., LVN D, after she completed wound care to Resident #43 stated the resident was on EBP status related to the open wound to the right buttock, but there was no evidence of a PPE cart with proper equipment and supplies or an EBP sign which indicated the resident was on EBP status. LVN D stated the EBP sign was gone and the PPE cart was moved. LVN D stated she usually wore a gown when providing Resident #43 with wound care but I can reassure you this was an honest mistake. I was nervous. LVN D stated the purpose for wearing a gown was in case the resident had excessive drainage, and the drainage should get on her and could possibly result in the spread of infection. LVN D stated not wearing proper PPE such as a gown could (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	result in spreading an infection to somebody else. During an interview on 2/19/26 at 4:46 p.m., the DON stated nursing staff, when providing wound care, were supposed to be wearing a gown per the EBP rules. The DON stated the purpose for wearing proper PPE for residents on EBP was because it was to prevent the spread of infection. The DON stated there should have been a sign posted outside of Resident #43's room that indicated the resident was on EBP status. The DON stated the EBP sign was supposed to alert staff to the use of proper PPE when providing direct contact care. Record review of the facility document titled Fundamentals of Infection Control Precautions, undated, reflected in part, .A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions.Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF. Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures.Non-invasive resident care equipment is cleaned daily or as need (sic) between use by the nursing assistant. Record review of the facility document titled Enhanced Barrier Precautions dated 4/1/24 reflected in part, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident activities.EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident activities.EBP are indicated for residents with any of the following.chronic wounds.Examples.pressure ulcers.The facility will ensure PPE and alcohol-based hand rub are readily accessible to staff. Discretion may be used in the placement of supplies which may include placement near or outside the resident's room.Communication to Staff.The facility will utilize postings outside the room and [electronic record] to communicate to staff if a resident requires EBP.

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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. **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 promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 18 residents (Resident #50, and #90) reviewed for dignity. 1. The facility failed to ensure the ADON was not standing while feeding Resident #50.2. The facility failed to ensure MA H was not standing while feeding Resident #90. These failures could place residents at risk for diminished quality of life, loss of dignity and self-worth. The findings included: 1. Record review of Resident #50's face sheet, dated 2/20/26, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (progressive mental deterioration), dementia (decline in cognitive function), and Trisomy 21 (genetic condition caused by presence of an extra copy of chromosome 21). Record review of Resident #50's most recent quarterly MDS assessment, dated 1/13/26, reflected the resident was severely cognitively impaired for daily decision-making skills, required setup or clean-up assistance with eating, had a swallowing disorder which caused coughing or choking during meals, and required a mechanically altered diet. Record review of Resident #50's comprehensive care plan with initiation, date 7/11/25, reflected the resident had an ADL self-care deficit and interventions included to provide supervision with eating as needed. During an observation and interview on 2/20/26 at 9:12 a.m. revealed the ADON standing over Resident #50's left side feeding the resident. The ADON stated she was not supposed to be standing while feeding the resident because it was not respectful or dignified. The ADON stated, I'll take accountability, you should never stand while feeding the resident. 2. Record review of Resident #90's face sheet, dated 2/20/26, reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dementia with behavioral disturbance, diabetes, and muscle weakness. Record review of Resident #90's most recent quarterly MDS assessment, dated 2/5/26, reflected the resident was severely cognitively impaired for daily decision-making skills, required setup or clean-up assistance with eating, and required a mechanically altered diet. Record review of Resident #90's comprehensive care plan with revision date 1/28/23 reflected the resident had an ADL self-care performance deficit with interventions that included one-person staff assistance with eating. During an observation and interview on 2/20/26 at 9:17 a.m., revealed MA H standing over Resident #90's right side feeding the resident. MA H stated she should feed the resident at eye level; I was just trying to get her to eat. During an interview on 2/20/26 at 9:36 a.m., the DON stated, standing while feeding a resident was a dignity issue. The DON stated, we should be at eye level while feeding a resident, otherwise it looks like it's intimidating. Record review of the facility document titled Resident Rights, undated, reflected in part, .The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy.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 .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the residents' right to personal privacy and confidentiality of his or her personal medical records for 1 of 18 residents (Resident #84) reviewed for privacy and confidentiality: The facility failed to ensure RN C did not leave Resident #84's patient information exposed on her computer screen. This failure could place residents at risk of having personal medical information disclosed and placed them at risk for misuse of the information. The findings included: Record review of Resident #84's face sheet dated 1/19/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included cellulitis (swelling and skin infection), diabetes, asthma, and shortness of breath. During an observation and interview on 2/19/26 at 7:23 a.m., the computer screen mounted on top of the medication cart in the 100 unit revealed Resident #84's medical information. CMA I stated the computer mounted on the medication cart was being used by RN C who was assessing a resident in the resident's room. During an observation and interview on 2/19/26 at 7:26 a.m., RN C stated she was in a room assessing a resident who had a fall. RN C stated she should not have left her computer screen open exposing Resident #84's medical information because it was considered a HIPPA violation. During an interview on 2/19/26 at 4:4a p.m., the DON stated exposed resident information on a computer screen was considered a HIPPA violation. Record review of the facility document titled Resident Rights, undated, reflected in part, .The facility must protect and promote the rights of the resident.Privacy and confidentiality - The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for level II resident review upon a significant change in status assessment for 1 of 7 residents (Resident #3) reviewed for PASARR accuracy. The MDS Coordinator failed to refer Resident #3 after newly diagnosed mental illness for level II resident review. This deficient practice could place the residents at risk of not receiving the necessary mental health care and services.The findings included: Record review of Resident #3's face sheet, dated 02/17/2026, revealed a [AGE] year-old female admitted to the facility on [DATE], with a primary diagnosis of unspecified dementia (decline in cognitive function). Record review of Resident #3's MDS, dated [DATE], revealed the resident's BIMS score was 10 out of 15 which suggested moderate cognitive impairment. Record Review of Resident #3's diagnosis information on the face sheet dated 02/17/2026 revealed diagnoses of Schizoaffective disorder, bipolar type (mental health condition characterized by symptoms both schizophrenia and mood disorder, specifically mania) with an onset date of 03/09/2023 and Bipolar disorder, current episode depressed, moderate (a mental condition characterized by significant mood swings, including manic episodes and depressive episodes) with an onset date of 02/29/2024. Record review of Resident #3's PASARR Level 1 screening, dated 02/27/2023 and completed at the hospital, revealed section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness recorded as a no. Record review of Resident #3's PASARR Level 1 screening, dated 02/27/2023 and completed at the nursing facility, revealed section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness recorded as a no. Record review of Resident #3's PASARR screenings revealed no referral for level II review. During an interview on 02/19/2026 at 11:40 a.m., the MDS Coordinator M stated they were responsible for looking over PASSAR documents when a resident is admitted and reviewing the clinical record for accuracy for the PASSAR assessment. The MDS Coordinator M confirmed Resident #3 had mental health diagnoses after being admitted to the nursing facility. The MDS Coordinator M stated the importance of an accurate PASSAR would be residents receiving the services they need. The MDS coordinator M stated they would need to submit form 1012 to correct the PASSAR assessment. The MDS Coordinator M stated Resident #3 had not been referred for a level II review but that they should have been referred to the local mental health authority upon a new mental health diagnosis. During an interview on 02/19/2026 at 4:49 p.m., the DON stated the MDS coordinators should be reviewing the PASSAR assessments for accuracy. The DON stated if a resident has a newly diagnosed mental illness it is important to refer the resident so they can get the proper services they need. Record review of the facility's policy, Form 1012 Policy & Procedure with instructions, no date, revealed: Procedure: When to Prepare: The NF completes Form 1012 following:-an individual's diagnosis is changed

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to preadmissions screen for individuals with a mental disorder and individuals with intellectual disability for 2 of 7 residents (Resident #3 and Resident #36) reviewed for PASARR accuracy.The MDS Coordinator failed to accurately screen Resident #3 for mental illness upon admission to the facility. The MDS Coordinator failed to accurately screen Resident #36 for mental illness upon admission to the facility. This deficient practice could place the residents at risk of not receiving the necessary mental health care and services.The findings included: 1. Record review of Resident #3's face sheet, dated 02/17/2026, revealed a [AGE] year-old female admitted to the facility on [DATE], with a primary diagnosis of unspecified dementia (decline in cognitive function). Record review of Resident #3's MDS, dated [DATE], revealed the resident's BIMS score was 10 out of 15 which suggested moderate cognitive impairment. Record Review of Resident #3's diagnosis information on the face sheet dated 02/17/2026 revealed a diagnosis of Major Depressive Disorder, recurrent, moderate (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life without behaviors not normal to resident) with an onset date of 02/27/2023. Record review of Resident #3's PASARR Level 1 screening, dated 02/27/2023 and completed at the hospital, revealed section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness recorded as a no. Record review of Resident #3's PASARR Level 1 screening, dated 02/27/2023 and completed at the nursing facility, revealed section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness recorded as a no. 2. Record review of Resident #36's face sheet, dated 02/18/2026, revealed a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe). Record review of Resident #36's MDS, dated [DATE], revealed the resident's BIMS score was 6 out of 15 which suggested severe cognitive impairment. Record Review of Resident #36's diagnosis information on the face sheet dated 02/11/2026 revealed a diagnosis of bipolar disorder, unspecified, (a mental condition characterized by significant mood swings, including manic episodes and depressive episodes) with an onset date of 10/14/2024. Record review of Resident #36's PASARR Level 1 screening, dated 10/14/2024 and completed at the hospital, revealed section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness recorded as a no. Record review of Resident #36's PASARR Level 1 screening, dated 10/14/2024 and completed at the nursing facility, revealed section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a mental illness recorded as a no. During an interview on 02/19/2026 at 11:40 a.m., the MDS Coordinator M stated they were responsible for looking over PASSAR documents when a resident is admitted and reviewing the clinical record for accuracy for the PASSAR assessment. The MDS Coordinator M confirmed both Resident #3 and Resident #36 were marked as no for mental illness on their PASSAR. The MDS Coordinator M confirmed both Resident #3 and Resident #36 having a mental illness. The MDS Coordinator M stated the importance of an accurate PASSAR would be residents receiving the services they need. The MDS coordinator M stated they would need to submit form 1012 to correct the PASSAR assessment. During an interview on 02/19/2026 at 12:07 p.m., the MDS Coordinator N stated they were responsible for looking over PASSAR documents when a resident is admitted and reviewing the clinical record for accuracy for the PASSAR assessment. The MDS Coordinator N confirmed Resident #36 was marked as no for mental illness on their PASSAR. The MDS Coordinator N confirmed Resident #36 with having a mental illness. The MDS Coordinator N stated the importance of an accurate PASSAR would be residents having a good quality of life, getting their full benefits and for their safety. During an interview on 02/19/2026 at 4:49 p.m., the DON stated the MDS coordinators should be reviewing the PASSAR assessments for accuracy. The DON stated it is important for PASSAR screenings to be accurate, so residents are (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided with their appropriate care. Record review of the facility's policy, PASRR Level 1 Screen Policy and Procedure, revised 3-6-2019, revealed:Procedure:The Facility will review the PL1 Screening Form for completion and correctness prior to admission and submit the PL1 form per regulations.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 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 1 of 18 residents (Resident #43) reviewed for care plans: The facility failed to ensure Residents #43's Care Plan reflected she was on EBP status related to a pressure wound. This deficient practice could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services.The findings included: Record review of Resident #43's face sheet dated 2/19/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included disorders of bone density and structure. Record review of Resident #43's most recent comprehensive MDS assessment dated [DATE] reflected that the resident was cognitively intact for daily decision-making skills and had a stage 3 pressure ulcer (a full thickness skin loss where the damage extends through the skin into the fatty tissue). Record review of Resident #43's Wound Progress Note dated 2/10/26 and authored by the NP reflected the resident had an improving Stage 3 pressure wound to the right buttock and a treatment plan that included to clean the wound with wound cleanser, apply Iodoform packing strip, Calcium alginate and dry dressing changes daily and as needed if dressing was dislodged, saturated, or soiled. Record review of Resident #43's comprehensive care plan with revision date 2/18/26 reflected the resident had a pressure ulcer to the right buttock with interventions that included to follow facility policies/protocols for the prevention of skin breakdown. Resident #43's comprehensive care plan did not reflect the resident was on EBP status related to the pressure wound. During the wound care observation on 2/19/26 at 11:08 a.m., LVN D removed Resident #43's bandage from the right buttock and the resident was observed with an open wound that had moderate serosanguineous drainage (thin pink to light red drainage) emitting from the wound and observed on the bandage. During an observation and interview on 2/19/26 at 11:27 a.m., LVN D, after she completed wound care to Resident #43 stated the resident was on EBP status related to the open wound to the right buttock, but there was no evidence of a PPE cart with proper equipment and supplies or an EBP sign which indicated the resident was on EBP status. LVN D stated the EBP sign was gone and the PPE cart was moved. During a joint interview on 2/19/26 at 4:07 p.m., RN F and RN E, who developed MDS assessments revealed the comprehensive care plan was developed collaboratively with the nursing staff. RN F and RN E, after reviewing Resident #43's comprehensive care plan stated EBP status was not care planned and should have been. RN E stated LVN D, who provided wound care to Resident #43, or the unit nurses should have revised the comprehensive care plan to include EBP status. RN E and RN F stated the comprehensive care plan was important because it tells the residents' story and it helps the staff to know what to do. During an interview on 2/19/26 at 4:46 p.m. the DON stated, resident comprehensive care plans could be developed by any nursing staff, including nurses who worked on the units, members of the interdisciplinary team, the ADON, and the DON. The DON stated EBP status for a resident was supposed to be care plan because it provided a picture of the residents and how to take care of them.

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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** Based on observation, interview and record review the facility failed to ensure the resident's environment remains as free of accident hazards as is possible, for 2 of 2 residents (Resident #58, Resident #71), reviewed for accidents, in that: 1.The facility failed to ensure Resident #58 did not have scissors in her room. 2.The facility failed to ensure Resident #71 did not have scissors in her room. These failures could place residents at risk of injury and contribute to avoidable accidents and a decline in health.The findings include: 1.Record review of Resident #58's face sheet dated 02/18/2026 revealed a [AGE] year-old female admitted to the facility on [DATE], with a primary diagnosis of Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (experiencing a decline in cognitive abilities). Record review of Resident #58's MDS dated [DATE] revealed a BIMS of 6 out of 15 indicating severe cognitive impairment and recorded the needed use of supervision or touching assistance with hygiene and dressing. Record review of Resident #58's care plan provided on 02/18/2026 revealed a focus area for the following: Resident prefers to manicure own nails with nail clippers but is not safe to keep at bedside, initiated on 11/04/2016, with interventions including Encourage/remind resident to use bell to call for assistance. Check on resident at routine intervals to assess needs, monitor safety issues and offer/provide assistance as needed initiated on 11/04/2016. 2. Record review of Resident #71's face sheet dated 02/18/2026 revealed a [AGE] year-old female admitted to the facility on [DATE], with a primary diagnosis of unspecified protein-calorie malnutrition (severe nutritional disorder). Record review of Resident #71's MDS dated [DATE] revealed a BIMS of 4 out of 15 indicating severe cognitive impairment and recorded the needed use of supervision or touching assistance to set up or clean-up assistance with hygiene and dressing. Record review of Resident #71's care plan provided on 02/18/2026 revealed a focus area for the following: . the resident has impaired cognitive function/dementia or impaired thought processes, initiated on 10/11/2025, with interventions including Monitor/document/report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status initiated on 10/11/2025. During an observation on 02/17/2026 at 11:28 a.m., revealed Resident #71 had scissors lying on their bed. During an observation on 02/17/2026 at 12:02 p.m., revealed Resident #58 had scissors by their bedside. During an observation on 02/18/2026 at 7:58 a.m., revealed Resident #71 had scissors lying on their chair next to the bedside. During an observation on 02/18/2026 at 8:00 a.m., revealed Resident #58 had scissors lying on their dresser. During an interview on 02/18/2026 at 8:00 a.m., Resident #58 stated she was not aware that she could not have scissors and has not been told anything about them by staff. Resident #58 stated they use the scissors to open things because staff can take a while to come to the room. Resident #58 stated other residents do not come into their room and they have not hurt themselves with the scissors either. During an interview on 02/18/2026 at 3:05 p.m., Resident #71 stated staff have not said anything to Resident #71 about having scissors. Resident #71 stated they use scissors to open things like cookies or wrapped items. Resident #71 stated other residents do not come in their room and they have not hurt themselves with the scissors either. During an interview on 02/18/2026 at 3:07 p.m., CNA A stated Resident #58 needed assistance with going to the restroom and had more falls. CNA A stated Resident #71 needed assistance with bathing. CNA A stated residents are not allowed to have nail clippers or scissors in their rooms and if they did, CNA A would have to let a nurse know. CNA A stated Resident #58 should not have scissors because they have become less alert. CNA A stated right now Resident #71 was more alert but if Resident #71 was not CNA would take the scissors. CNA A stated sometimes residents may wander in and out of rooms due to confusion. CNA A stated the risk to residents that have scissors in their (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room could be residents might cause danger to themselves. During an interview on 02/18/2026 at 3:27 p.m., LVN B stated Resident #58 has declined a lot and is currently on hospice. LVN B stated Resident #71 needed assistance with their hygiene care. LVN B stated residents cannot have anything that can be harmful to them or sharps in their rooms. LVN B stated if a resident could have something sharp it would be in their care plan. LVN B confirmed both Resident #58 and Resident #71 did not have scissors care planned. LVN B stated they had not seen residents wander in and out of other residents' rooms. When asked what the danger would be for a resident to have scissors in their room, LVN B stated it could be fatal. During an interview on 02/18/2026 at 3:55 p.m., the DON stated residents cannot have any sharps, anything that can be used as a weapon or anything that is a safety hazard in their rooms. The DON stated if a resident could have sharps in their room, it would be care planned and there would have been an associated risk assessment completed but that the facility tries not to allow sharps in residents rooms at all. The DON stated they were not aware of any resident in the facility that is care planned to have scissors in their room. When asked what the danger would be for a resident to have scissors in their room the DON stated the resident could hurt themselves or others. When asked what policy is used for sharps in residents' rooms the DON stated the Event reporting policy. Record review of the facility's policy, Event Reporting; Completion of, no date, did not address hazards or residents having scissors but revealed:The facility will complete an Event report on variances that occur within the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 6 residents (Resident #75) reviewed for pharmacy services. The facility failed to ensure Resident #75 received Fluticasone Propionate Nasal Spray (a steroid spray used to treat nasal allergy symptoms) as prescribed by a physician. This failure could place residents at risk of not receiving their prescribed medications and a decreased quality of life.The findings included: Record review of Resident #75's face sheet dated 2/18/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included moderate persistent asthma, anxiety disorder, heart failure, kidney failure, and allergic rhinitis (runny nose). Record review of Resident #75's most recent comprehensive MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #75's Order Summary Report dated 2/18/26 reflected the following:- Fluticasone Propionate Nasal Suspension 50 mcg/act, 1 spray in both nostrils two times a day related to allergic rhinitis, with order date 1/5/26 and no end date Record review of Resident #75's MAR for February 2026 reflected the following for Fluticasone Propionate nasal spray:- AM dose was not administered 2/7, 2/8, 2/9, 2/12, 2/15, 2/16- PM dose was not administered 2/2, 2/4, 2/9, 2/10, 2/11, 2/16, 2/17 During an interview on 2/18/26 at 2:09 p.m., MA K stated she routinely worked with Resident #75 and stated the resident did not refuse medications. MA K stated when a medication was not available or if a medication was refused, the code other was used on the MAR and then the system would prompt the staff to enter a progress note that indicated why the medication was not given. MA K stated she had marked other on Resident #75's MAR which indicated the resident did not have Fluticasone nasal spray available. MA K stated she had reported the medication not being in the medication cart to the ADON and the night shift nurse LVN L. MA K stated she did not recall Resident #75 ever receiving a dose of Fluticasone nasal spray from her for the month of February 2026 because it had not been available. During an interview on 2/18/26 at 2:35 p.m., the ADON stated, the electronic MAR was designed in a way in which if a medication was not available, the computer system would prompt the staff to use the code 9 for other and then the system would prompt the staff to write a progress note that would indicate why the medication was not given. The ADON stated she had not been made aware Resident #75's Fluticasone nasal spray was not in stock. The ADON stated there were no designated staff assigned to order medications, it would be whatever floor nurse was working at the time, and a MA was also capable of ordering medications. The ADON stated she was not aware of a process in place for auditing the MAR for discrepancies. The ADON stated if a resident was not getting prescribed medications, and depending on the medication, it could be detrimental to their health. The ADON stated, Resident #75's Fluticasone nasal spray should have been provided by the physician's orders and by the resident's needs. During an interview on 2/19/26 at 8:43 p.m., MA I stated she recalled ordering Resident #75's Fluticasone spray and it's been in the building. MA I stated Resident #75's Fluticasone nasal spray was here the other day, there was none, I could not find it, it was in the building, but I could not find it. MA I stated she had trained MA K on ordering medications and was aware all the nursing staff, including the MA staff, could order medications. MA I stated if a resident was not receiving prescribed medications the resident could get sick and in the case of Resident #75's nasal spray, she could develop a runny nose and have a hard time breathing. During an interview on 2/19/26 at 9:00 a.m., Resident #75 stated she finally received a dose of Fluticasone spray on 2/19/26, but it had been several weeks since she had been given the medication. Resident #75 stated she was told the nasal spray was on order or was not available. During an interview on 2/19/26 at 9:51 a.m., the DON stated Resident #75's Fluticasone nasal spray (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was found in a medication cart after the ADON was instructed to check all the medication carts on 2/18/26. The DON stated there was no procedure for checking regular medication deliveries and how they were distributed except for controlled medications. Record review of the facility document titled Medication Orders dated 2025 reflected in part, .Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe.Procedure.Call, fax, or electronically submit the medication orders to [pharmacy].Medication orders are recapped on a monthly basis when the prescriber signs the computer physician order summary. This is reviewed by a designated nurse each month before giving it to the prescriber to sign. Record review of the facility document titled Receiving Medications from Pharmacy dated 2025 reflected in part, .Medications and related products are received from the pharmacy supplier on a timely basis. The facility maintains accurate records of medications ordered and receipt of.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 6 medication carts reviewed for storage of drugs and biologicals.The facility failed to ensure the 100-hall medication cart was locked and secured.These deficient practices could place residents at risk of medication misuse or drug diversion.The findings included: During an observation and interview on 2/19/26 at 7:23 a.m. revealed the 100-hall medication cart was left unlocked and unattended. Interview with MA I revealed the unlocked medication cart observed on the unit was assigned to RN C. MA I stated, RN C was in a resident room assessing a resident. During an interview on 2/19/26 at 7:26 a.m., RN C stated she was in a room assessing a resident who had fallen. RN C stated she should not have left the 100-hall medication cart unlocked and unattended because other residents or visitors could gain access to the cart and take medications that did not belong to them which could result in an adverse reaction and depending on the medication not prescribed for them, they could overdose. During an interview on 2/19/26 at 4:41 p.m., the DON stated a medication cart should never be left unlocked and unattended because it was potential for medication discrepancies. The DON stated an unlocked medication cart could provide access to somebody who should not have access to the cart and could result in a medication being taken that did not belong to them. Record review of the facility document titled Medication Storage in the Facility dated 2025 reflected in part, .Medications and biologicals are stored safely, securely, and properly.The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide or obtain laboratory services to meet the needs of its residents for 1 of 4 residents (Resident #66) reviewed for laboratory services: The facility failed to obtain a digoxin drug level (digoxin is a medication used to manage atrial fibrillation [rapid heart rate] or heart failure; obtaining digoxin levels determines therapeutic effects and toxicity effects) for Resident #66 as ordered by the physician. This deficient practice could place residents at risk for a delay in identifying or diagnosing a problem, adjusting medications, and ensuring treatment needs were identified and addressed.The findings included: Record review of Resident #66's face sheet dated 2/19/26 reflected an [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included hypertensive heart disease without heart failure, hyperlipidemia (high cholesterol), hypertension (elevated blood pressure) and atrial fibrillation (irregular heart rhythm). Record review of Resident #66's most recent quarterly MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #66's Order Summary Report dated 2/19/26 reflected the following:- CBC, and CMP, TSH every 3 months (Jan, Apr, Jul, Oct) with order date 7/29/24 and no end date- Digoxin [levels] every 3 months with routine labs (Oct, Jan, Apr, July) with order date 9/11/24 and no end date- Digoxin tablet 125 mcg, give 1 tablet by mouth one time a day related to atrial fibrillation; hold for heart rate less than 60, with order date 7/29/24 and no end date Record review of Resident #66's comprehensive care plan with revision date 9/11/24 reflected the resident had hypertension, and hyperlipidemia related to coronary artery disease with interventions that included to administer medications as ordered. Resident #66's comprehensive care plan reflected the resident had hyperlipidemia with interventions that included to administer medication as ordered and lab to be drawn as ordered, promptly reviewing results and reporting to the MD. Record review of Resident #66's medical record reflected there were no digoxin level results in the record after July 2025. Resident #66's record was missing physician ordered digoxin level results for October 2025, and January 2025. During record review and interview on 2/19/26 at 1:48 p.m., LVN J stated she had worked for the facility for approximately 14 years and gave up her position as the facility ADON around October 2025 and was now on the schedule as a floor nurse. LVN J stated she was aware Resident #66 was prescribed Digoxin routinely. LVN J reviewed Resident #66's medical record and stated, the last digoxin level drawn for Resident #66 was July 2025, but no digoxin levels were drawn for October 2025 and January 2025 per physician's orders. LVN J stated, as the former ADON, she used to be responsible for ensuring routine physician ordered labs were carried out by obtaining a physician order and inputting the lab order into the computer system which would then be sent electronically to the lab. LVN J stated, somehow the labs got missed (for Resident #66) and was not sure what the system (for carrying out lab orders) was now. LVN J stated it was important to obtain digoxin levels because it determined whether or not the medication was working effectively by determining if the resident received too much or not enough digoxin. During an interview on 2/19/26 at 2:05 p.m., the DON stated she had recently been given the position as the DON approximately two months ago and had educated the nursing staff at the time she accepted the position. The DON stated she instructed the nursing staff, at the time a resident was admitted , to obtain physician orders for labs and at that time, fill out a lab requisition form and place it in a lab binder that was labeled for each month which indicated when a lab test was due. The DON stated, this is for all of the floor nurses. Including myself and the ADON. The DON stated she felt the missing digoxin levels for Resident #66 fall on me, but my staff needs to take accountability. The DON stated, it was her expectation that standing lab orders had to have requisitions and placed in the lab binder under the tab in which the lab was due. The DON stated she routinely audited medical records, including auditing for completed scheduled labs. The DON stated, we are accountable for that, I cannot make (continued on next page)

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	02/20/2026

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

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	excuses. Right now, we have a system failure. During an interview on 2/19/26 at 3:30 p.m., requested by the NP, she stated, the facility recently switched to a new lab and nobody knew how to use it. The NP stated, at the time the facility switched to the new lab the former DON was responsible for ensuring scheduled labs were carried out, but when she left, nobody had been fully trained on it. The NP stated that the new lab system required lab requests be input into the computer system, but paper requisitions still had to be used and placed in the lab binder. The NP stated obtaining digoxin levels was important because if the level was too high it could mean toxicity and if the digoxin levels were too low it could mean the medication was not working or not therapeutic. The NP stated that digoxin level results typically for Resident #66 showed the resident had been stable and realistically could be monitored every 6 months instead of every 3 months.