

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675815	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2025
NAME OF PROVIDER OR SUPPLIER Kingsville Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3130 S Brahma Blvd Kingsville, TX 78363	

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 - Minimal harm or potential for actual harm</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one of eight residents (Resident #2) reviewed for accidents and hazards.</p> <p>The facility failed to ensure a floor mat was in place beside Resident #2's bed as indicated on her current comprehensive care plan and current physician's orders.</p> <p>This failure could place residents at risk for an injury.</p> <p>The findings include:</p> <p>Record review of Resident #2's face sheet, dated 06/17/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included unspecified dementia(A group of thinking and social symptoms which interferes with daily functioning), unspecified osteoarthritis (Type of arthritis that occurs when flexible tissue at the ends of bones wears down), age related osteoarthritis(A degenerative joint disease where cartilage, the cushioning tissue in the joints breaks down over time, leading to pain and stiffness), and mild cognitive impairment.</p> <p>Record review of Resident #2's MDS dated [DATE] indicated she had a BIMS (Brief Interview for Mental Status) score of 3 which indicated, severe cognitive impairment. The ma also indicated she was dependent on staff for ADL's (Activities of Daily Living.)</p> <p>Record review of Resident #2's care plan dated 11/26/24 indicated:</p> <p>08/23/23 unwitnessed fall- no injury</p> <p>4/3/2024 an unwitnessed fall with no injury</p> <p>05/20/24 Witness fall without injury</p> <p>07/31/24 Fall w/o injury Add floor mats X2 for safety precautions</p> <p>01/04/25 Witness fall with injury laceration to left forehead hematoma to left side of forehead.</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>01/30/2025 Fall without injury</p> <p>Record review of Resident #2's July 2024 physician orders reflected there was an order for floor mats X2 usage as precaution.</p> <p>Record Review of Resident #2's Fall Risk Assessment/ Morse Fall Scale reflected 30 -a moderate risk or falling.</p> <p>Observation on 06/18/25 at 11:15 AM, revealed Resident #2 was lying in bed with eyes closed. Resident #2 had a floor mat on the floor on the left side of her bed but not on her right side.</p> <p>In an interview on 06/18/25 at 12:03 PM, CNA B and CNA C said all staff was responsible to check to see if mats was in place. They said the CNA's are the front-line staff and should notice if the floor mat is not in right place or missing. Both staff said if mats were missing the resident could sustain an injury which can lead to a major injury or possibly death. Both staff said last fall prevention in-service was just a week ago.</p> <p>In an interview on 06/18/24 at 12:11 PM LVN A said she was responsible for making sure the fall mats were in place. The resident only had one mat and is to have two mats per care plan. Resident is at risk for injury for not having both mats alongside each side of her bed. The supply clerk is responsible for supplying mats and did not know the reason why she did not have other mat on right side of bed.</p> <p>In joint an interview 06/18/2025 at 12:15 PM with the Administrator and DON, the Administrator stated the resident was to have two fall mats in place as indicated in her care plan and physician's orders. The Admin and the DON stated not having the fall mats could place the resident at risk for a major injury or death. Both the Admin and DON stated it was all staff's responsibility to ensure the mats are in place for the safety of the resident, but the main responsibility fell on the nurse caring for the resident at the time.</p> <p>Record review of the facility's Fall Prevention Program Policy dated 8/15/22 reflected Each resident will be assessed for fall risk and will receive care and services in accordance with their Individualized level of risk to minimize the likelihood of falls. When a resident who does not have a history of falling experiences a fall, the facility will update the care plan and interventions.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 5 residents (Resident #1) reviewed for pharmacy services.</p> <p>1. The facility failed to clarify the blood pressure parameters for Resident #1's Hydrochlorothiazide (a diuretic that helps treat high blood pressure and fluid retention) orders for April and May of 2025.</p> <p>2. The facility failed to administer Resident #1's Hydrochlorothiazide per the recommended and prescribed blood pressure parameters in April and May of 2025.</p> <p>These failures could place resident at risk for complications, as well as jeopardize their health and safety.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 06/17/25, revealed a [AGE] year-old male with an original admission date of 10/17/2023, and a current admission date of 05/22/25. Resident #1's diagnoses included Wernicke's Encephalopathy (an acute neurological condition caused by vitamin B1 deficiency), Dementia with Mood Disorder (decline in cognitive function severe enough to interfere with daily life), and Essential Hypertension (high blood pressure).</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 05/25/25, revealed Resident #1 rarely or never makes self understood. The Brief Interview for Mental Status was skipped and not conducted.</p> <p>Record review of Resident #1's care plan revealed risk for decreased cardiac tissue perfusion initiated 10/16/23 and revised on 02/16/24. Goals included: the resident would remain free from signs and symptoms of hypertension, and the resident would remain free of complications related to hypertension. Interventions included: administer Hydrochlorothiazide routinely as ordered. Monitor for side effects such as orthostatic hypotension, increased heart rate, and effectiveness.</p> <p>Record review of Resident #1's physician orders, revealed Hydrochlorothiazide 12.5 MG give 1 tablet by mouth one time a day for Hypertension started 10/20/23 and ended 05/12/25 (check blood pressure, may hold if less than 100/60), started 05/23/25 and ended 05/23/25, started 05/24/25 and ended 05/27/25, started 05/28/25 and ended 06/10/25 (check blood pressure, hold if less than 100/60).</p> <p>Record review of Resident #1's April 2025 MAR revealed Resident #1's blood pressure on 04/29/25 was 124/54. Hydrochlorothiazide was still administered.</p> <p>Record review of Resident #1's May 2025 MAR revealed Resident #1's blood pressure on 05/01/25 was 98/62. Hydrochlorothiazide was still administered. No blood pressures were documented for this medication on 05/23/25, 05/24/25, 05/25/25, 05/26/25, and 05/27/25.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's progress notes (orders administration notes) dated 06/05/25 and 06/09/25, revealed a medication note for Hydrochlorothiazide 12.5 MG, give 1 tablet by mouth one time a day for Hypertension; Check blood pressure and hold if less than 100/60.</p> <p>In an interview with the DON on 6/17/25 at 2:50 PM she stated Hydrochlorothiazide was a diuretic not a blood pressure medication, but it could affect the blood pressure. She also stated she knew who the initials belonged to, but she was not sure why the nurses gave the medication outside of the recommended parameters. The DON stated the check mark above the nurse's initials on the MAR meant the medication was administered. She was unsure why some of the Hydrochlorothiazide orders had blood pressure parameters, but some did not, and stated this should have been clarified with the provider, and she was going to get with the provider to clarify if he wanted to have parameters on this order or not when the resident returned back to the facility since he was currently away at a psychiatric hospital. The DON stated if Resident #1's blood pressure dropped too low he may have experienced possible dizziness, weakness, and organ failure.</p> <p>In an interview with the ADON on 06/17/25 at 3:00 PM, she stated she did not remember giving the medication outside of parameters and was unsure why she had not looked at or paid attention to the blood pressure parameters. She stated she typically looked at blood pressure parameters prior to administering Hydrochlorothiazide and held it if the blood pressure was too low. She also stated if this medication was given while his blood pressure was already low, his blood pressure could have continued to drop, and he could get dizzy and faint, and there could even be a risk of death. She did not recall receiving any in-services in the past regarding blood pressure medications or blood pressure parameters, but she stated they went over blood pressure medications and parameters on their annual skills checkoff. She stated she did not remember when their most recent annual skills checkoff was, but she thought it was sometime this year.</p> <p>In an interview with LVN-A on 6/17/25 at 3:09 PM, she stated it was just an error, and she should not have administered Resident #1's medication with his blood pressure below the recommended parameters. She also stated she typically looked at the medication and parameters before administering, but she did not remember why she had not look at the parameters that day other than she was probably busy and overlooked it. LVN-A stated if the blood pressure dropped too low Resident #1 could have had dizziness, passed out, or even possibly death. She stated she thought they had been in-serviced recently regarding blood pressures and medications but she could not remember for sure, but she did state they went over it in their annual skills checkoffs that were sometime this year.</p> <p>In a record review of the Medication Administration Policy, implemented 10/24/22, 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 14. Administer medications as ordered in accordance with manufacturer specification. 17. For those medications requiring vital signs, record the vital signs onto the MAR. 20. Correct any discrepancies and report to nurse manager.</p>		