STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675871	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Comfort Nursing and Rehabilitation Center	615 Faltin Ave Comfort, TX 78013

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 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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #3) reviewed for quality of care. CNA A transferred Resident #3 using a mechanical lift without the assistance of another staff member. This failure could place residents at risk of accidents, injury, and pain. The findings were: Record review of Resident #3's face sheet dated 8/22/25 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with readmission on [DATE]. The resident's diagnoses included Wernicke's encephalopathy (an acute, life-threatening neurological emergency caused by a severe thiamine (Vitamin B1) deficiency, most often due to chronic alcohol abuse but also associated with poor nutrition or malabsorption. Its classic symptoms include loss of muscle coordination), generalized muscle weakness, muscle wasting and atrophy not elsewhere classified unspecified site (wasting or loss of muscle tissue), and Transient Ischemic Attack (TIA - short period of symptoms similar to those of a stroke. It's caused by a brief blockage of blood flow to the brain). Record review of Resident #3's annual MDS assessment dated [DATE] revealed the resident had a BIMS score of 13 out of 15 indicating the resident was cognitively intact, used a wheelchair, and required extensive assistance of a 2- person physical assist for bed mobility, and transfers. Record review of Resident #3's undated care plan revealed a problem with a start date of 6/6/25 edited on 6/17/25 for ADL function that the resident required a mechanical lift, with a goal of safe travels and an approach to maintain safe transfers. In an observation and interview on 8/21/25 at 10:04 a.m. CNA A opened the door to Resident #3's room and exited the room pushing the mechanical lift out in to the hallway. Resident #3 was in his wheelchair in his room with the mechanical lift sling underneath him. There were no other staff members in Resident #3's room. CNA A stated no one had helped her transfer the resident. CNA A stated she transferred Resident #3 from his bed to his wheelchair alone with the mechanical lift. CNA A stated she was not supposed to transfer the residents with the mechanical lift alone. CNA A stated she did not ask anyone for assistance with the mechanical lift as when she looked down the hall, she did not see anyone and went ahead and transferred the resident without the assistance of another staff member. In an observation and interview on 8/21/25 at 10:08 a.m. Resident #3 was sitting in his room in his wheelchair with the mechanical lift sling underneath him. Resident #3 stated CNA A had transferred him using the mechanical lift by herself without the assistance of another staff member and stated there were no issues with the transfer and he felt safe during the transfer. Resident #3 stated the facility staff including CNA A did not usually use the mechanical lift to transfer him without the assistance of another staff member but he had wanted to get up. In an observation on 8/21/25 at 10:10 a.m. the DON was in-servicing staff on 2-person transfers using mechanical lifts. In an interview on 8/22/25 at 12:00 p.m. the DON stated it was important to use 2-persons for a mechanical lift to ensure control of the mechanical lift, ensure the resident was properly positioned, and for proper guidance of the lift and the resident. The DON stated the possible consequences of not using 2-persons for a mechanical lift could be the resident could fall or sustain an injury from not guiding the resident's legs up and or hitting something. Review of CNA A's training skills checklist revealed she was trained and had passed a 2-person mechanical lift on 3/25/25 and did not need improvement. Review of the facility policy on safe resident handling and transfers with an implementation date of 7-2025 indicated It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and to provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. 10. Two staff members must be utilized when transferring residents with a mechanical lift.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review the facility failed to use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week for 1 of 1 facilities reviewed for nursing services. The facility did not utilize the services of an RN on 2/22/25, 2/23/25, 3/1/25, 3/30/25, 4/13/25, 4/20/25, 4/27/25, 5/4/25, 6/1/25, 6/8/25, 6/15/25, 6/29/25, 7/6/25, 7/13/25, 7/20/25, 7/27/25, 8/3/25, 8/10/25, and 8/17/25 for a total of 19 days. This failure could place residents at risk of not receiving needed care and services.The findings were: Review of the PBJ staffing data report for FY quarter 2 2025 (January 1 - March 31) with a run date of 8/14/25 revealed the facility triggered for no RN hours for Saturday 2/22/25, Sunday 2/23/25, Saturday 3/1/25, and Sunday 3/30/25. Review of the facility time sheets for RNs revealed the facility had no RN coverage for Saturday 3/1/25. Review of the facility time sheets for RNs revealed the facility had no RN coverage for Sundays on 3/30/25, 4/13/25, 4/20/25, 4/27/25, 5/4/25, 6/1/25, 6/8/25, 6/15/25, 6/29/25, 7/6/25, 7/13/25, 7/20/25, 7/27/25, 8/3/25, 8/10/25, and 8/17/25. In an interview on 8/22/2025 at 12:35 p.m. the Administrator stated the facility lost their Sunday nurse and had been doing well with RN hours prior to that. The Administrator stated they had been actively seeking an RN for the weekends and just hired a new weekend nurse, and she had been training this week. The Administrator stated she felt the staff were competent and her licensed nurses (LVNs) were well equipped to deal with situations. The Administrator stated she was unsure of any possible consequences of not having an RN for 8 consecutive hours a day 7 days a week due to always having competent licensed nursing staff on duty and the DON was on call 24/7 and there was also physician telehealth available 24/7 but she understood it was better to have an RN on-site for assessment. In an interview on 8/22/25 at 1:07 p.m. the DON stated the possible consequences of not having an RN 8 hours a day 7 days a week could be not having the advanced assessment and skill set but she was available 24/7 by phone and all staff and many families had her cell phone number plus she had a group chat with all staff that she starts every Monday. Review of the facility policy on nursing services for RN hours implemented 7-2025 indicated It is the policy of the facility to comply with Registered Nursing staffing requirements as per the Social Security Act. 1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.