STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675887	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph Manor	2333 Manor Dr Bryan, TX 77802

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review the facility failed to ensure nurse staffing information was posted to include: facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift for, registered nurses, licensed practical nurses or licensed vocational nurses, certified nurse aides, and resident census for 1 of 1 day (07/09/25) reviewed for posted nurse staffing information. The facility failed to have daily nurse staffing posted on 07/09/25. This failure could place residents at risk of not knowing how many nursing staff should be present in the facility. Based on observation, interview and record review the facility failed to ensure nurse staffing information was posted to include: facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift for, registered nurses, licensed practical nurses or licensed vocational nurses, certified nurse aides, and resident census for 1 of 1 day (07/09/25) reviewed for posted nurse staffing information. The facility failed to have daily nurse staffing posted on 07/09/25. This failure could place residents at risk of not knowing how many nursing staff should be present in the facility. Findings include: Observation on 07/09/25 at 05:10 AM revealed no posted nurse staffing in the building. There was a binder in the front lobby which contained the schedules, but this document did not include the required number of licensed nursing staff for each shift. The lobby, the 2nd floor nurse's station, the 3rd floor nurse's station, and all walls of all hallways were checked for the posted nurse staffing information, and the posting was not present. During an interview on 07/09/25 at 01:00 PM, the DON stated she thought the schedule binder in the lobby met the posted nurse staffing information requirement. She then stated she did not know there was a requirement to post nurse staffing and did not understand how to get to that report in her system. The DON denied any knowledge of who should be posting the nurse staffing. During an interview on 07/09/25 at 01:05 PM, the RNC stated she was aware of the requirement to post nurse staffing and was not aware the facility was not doing it. She stated she thought the binder in the lobby was the nurse staffing, but she had learned it was the schedule. She stated the schedule did not meet the requirement. She stated it was the DON's responsibility to ensure staffing information was posted. She stated she had shown the DON how to pull the report in their electronic system. Record review of the facility's, undated, policy titled Nurse Staffing Posting Information reflected the following: Policy: it is the policy of this facility to make sure nurse staffing information readily available in a readable format to residence, staff, and visitors at any given time.Policy explanation and compliance guidelines>The nurse staffing sheet will be posted on a daily basis, and will contain the following information:-Facility name-The current date-Facility's current resident census>The total number and the actual hours worked by the following categories of licensed and unlicensed, nursing staff, directly responsible for resident care per shift:-Registered nurses-Licensed practical nurses/licensed vocational nurse-Certified nurse aidesThe facility will post the nurse staffing sheet at the beginning of each shift.The information posted will be:>Presented in a clear and readable format>In a prominent place, readily accessible to residents, staff, and visitors.

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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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 of 3 residents (Resident #1) reviewed unnecessary drugs. The facility failed to ensure PT/INR laboratory tests (to measure blood clotting time and thus ensure safe blood levels of the anticoagulant, warfarin) were obtained weekly as ordered for Resident #1 on 04/14/25, 04/28/25, 05/05/25, 05/12/25, 05/26/25, 06/09/25, 06/16/25 and 06/30/25. Resident #1 was presented with multiple, unexplained bruising to her face, tongue, and extremities on 07/05/25 and was hospitalized for a warfarin overdose on 07/07/25. An Immediate Jeopardy (IJ) was identified on 07/09/25. While the IJ was removed on 07/11/25, the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of adverse effects from high-risk medication such as bruising, uncontrolled bleeding, and death. Findings include: Record review of Resident #1's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included chronic atrial fibrillation (irregular heartbeat), congestive heart failure (long term condition in which the heart cannot pump blood well enough to meet the body's needs), chronic respiratory failure with hypoxia (breathing problems with low blood oxygen), chronic obstructive pulmonary disease (chronic breathing disorder), asthma, hypertension (high blood pressure), major depressive disorder, unsteadiness on feet, abnormalities of gait and mobility, dementia, fibromyalgia (long-term condition that involves widespread body pain), hyperlipidemia (high cholesterol), muscle weakness, lack of coordination, dependence on supplemental oxygen, obstructive sleep apnea (sleep-related breathing disorder), anxiety disorder, cochlear implant (electronic hearing device that provides a sense of sound to people with severe hearing loss) status, chronic migraine (headache), and mild cognitive impairment of uncertain or unknown etiology (origin). Record review of Resident #1's annual MDS reflected a BIMS score of 15, which indicated intact cognition. Resident #1 received anticoagulant medication during the 7-day lookback period. Record review of Resident #1's care plan, dated 01/10/25, reflected the following: The resident is on Anticoagulant therapy r/t A-fib. The resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Daily skin inspection. Report abnormalities to the nurse. Labs as ordered. Report abnormal lab results to the MD. Monitor/document/report to MD PRN s/sx of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, , diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s. Resident/family/caregiver teaching to include the following: Take/give medication at the same time each day, Use soft toothbrush, Use electric razor, Avoid activities that could result in injury, Take precautions to avoid falls, Signs/symptoms of bleeding, Avoid foods high in Vitamin K. These include greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussels sprouts, milk and cheese. Review medication list for adverse interactions. Avoid use of aspirin or NSAIDS. Record review of physician orders for Resident #1 reflected the following:-Warfarin Sodium oral tablet 4 mg- take 2 tablets one time per day for chronic atrial fibrillation start date 03/18/25-PT/INR on Mondays- one time a day every Monday due to anticoagulant use send lab order Sunday start date 06/22/25-PT/INR on Mondays- one time a day every Monday due to anticoagulant use start date 09/30/24 end date 06/21/25-Side effects to anti-coagulant medication 1) Discolored urine 2) black tarry stools 3) muscle/joint pain 5) lethargy 6) increased bruising 7) sudden changes in mental status/vitals 8) shortness of breath 9) nosebleeds. Every shift for preventative measure if side effects were noted, documentation and physician notification were required.-Diphenhydramine HCl 25 mg Benadryl, one time administration 07/07/25 Record review of Resident #1's MAR/TAR from April 2025 to July 2025 reflected the following dates were marked as complete for PT/INR04/14/25 (no corresponding laboratory test)04/28/25 (no corresponding laboratory test)05/05/25 (no corresponding laboratory test)05/12/25 (no corresponding laboratory test)05/19/25 (correlating lab test on 05/20/25)06/02/25 06/09/25 (no corresponding laboratory test)06/16/25 (no corresponding laboratory test)06/23/2506/30/25 (no corresponding laboratory test, documented by LVN K)The following dates were not marked as complete for PT/INR:04/07/2504/21/25 Record review of PT/INR results for Resident #1 reflected the following:04/07/25 PT 23.3 and INR 2. 104/21/25 PT 34.5 and INR 3.405/20/25 PT 28.1 and INR 2.606/02/25 PT 35 and INR 3.506/23/25 PT 30 and INR 2.8(Note: A normal INR range for people who take warfarin is 2-3 but can vary from patient to

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure laboratory services were provided or obtained to meet the needs of its residents for 1 of 3 residents (Resident #1) reviewed for laboratory services. The facility failed to ensure PT/INR laboratory tests were obtained weekly as ordered for Resident #1 on 04/14/25, 04/28/25, 05/05/25, 05/12/25, 05/26/25, 06/09/25, 06/16/25 and 06/30/25. Resident #1 was presented with multiple, unexplained bruising to her face, tongue, and extremities on 07/05/25 and was hospitalized for a warfarin overdose on 07/07/25. An Immediate Jeopardy (IJ) was identified on 07/09/25. 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Patients who tend to clot more