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	04/02/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews, and record review, the facility failed to ensure prompt resolution of grievances regarding the resident's right to file a grievance for 4 of 4 confidential residents reviewed for grievances.The facility failed to notify residents in writing of the findings and actions of the grievances they filed. This failure could affect resident's right to a written decision regarding the resolution of their grievance.Findings included:Review of the March 2026 grievance log revealed 17 grievances. The column titled Disposition of Grievance* revealed the nature of the grievance for each grievance. The column titled Date of Written Decision was left blank for each grievance. The March 2026 grievance log revealed * Disposition of Grievance: Confirmed/Not Confirmed, Resolved/Not Resolved across the bottom of the log.Review of the March 2026 grievances revealed 10 of the 17 grievances did not have the section titled Findings of Investigation completed.During an interview and record review on 04/02/2026 at 01:15 PM, the ADON stated she had signed 12 of the 17 grievances for March 2026. She stated she had not been trained on how to complete a grievance or the process to follow when investigating a grievance. The ADON stated when a resident had a grievance that related to nursing, the SSD would give the grievance to either herself or the DON. She stated frequent in-services and re-education were administered to the nursing staff and sometimes it included 1:1 in-servicing with the staff involved in the grievance. The ADON stated the facility ensured the in-services were effective by performing angel rounds daily and making sure the resident was happy with the outcome. She stated there was not any record of the in-services or re-education performed in relation to the grievances. The ADON stated there were not any significant changes to the in-services from one grievance to another. She stated she was unsure if the residents were receiving written decisions related to the grievances they filed.During an interview and record review on 04/02/2026 at 02:14 PM, the SSD stated she was responsible for receiving, reviewing, and passing the grievances to the appropriate department in which the grievance is related to. She stated that after the appropriate department did their investigation, they returned the grievance form to her and she filed it. The SSD stated the person doing the investigation was responsible for completing the grievance form in relation to the investigation, outcome and notification. She stated she was not responsible for ensuring the form was completed correctly, the investigation was done thoroughly, or notification to the person who filed the grievance. She stated she was not sure if residents received written communication after the conclusion of the investigation related to their grievance. The SSD stated, we need to document better on our grievances and the education provided.During an interview on 04/02/2026 at 03:11 PM, the DON stated she had not recently read the policy related to grievances, but she had reviewed it in the past. She stated the department head in which the grievance related to was responsible for ensuring the grievance is completed correctly. She stated all the investigations related to each grievance were documented on their respective grievance forms. The DON stated there was not any other documentation anywhere else related to the education and in-services provided to staff related to grievances unless it is independently documented in the employee's human resources file. She stated the current process was to have the department head notify the person who filed the grievance verbally about the outcome of the investigation and to her knowledge (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there were no written responses sent to the person filing the grievance. She stated the ADM was updated on grievances and their investigation daily during the morning meeting.During an interview and record review on 04/02/2026 at 04:00 PM, the ADM stated she had not reviewed the grievance policy since the new company had taken over. The ADM was provided with a copy of the facility's grievance policy to review. The ADM reviewed the policy and stated, I don't feel like the policy is being followed 100% at this time. The ADM stated they were not providing the person who filed a grievance with a written follow up for the grievance they filed. The ADM was provided with all the grievances for March 2026. After the ADM reviewed the grievances, she stated she felt the policy was not being followed because there were blank spaces left on the grievances which indicated they were not completed. The ADM stated it could negatively impact resident by not completing grievances and providing written notification at the completion of a grievance by making the resident not feel comfortable with raising concerns, the resident may talk bad about the facility, or make the resident feel disgruntled, angry, or like they are not being heard.Record review of the facility's policy titled Grievances/Complaints, Filing, dated 2001 and last revised April 2017, revealed: Policy StatementResidents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman).The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative.Policy Interpretation and Implementation.3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing including a rationale for the response.8. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint.12. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems.a. The administrator, or his or her designee, will make such reports orally within ___[left blank] working days of the filing of the grievance or complaint with the facility.b. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drug and biological) to meet the needs of each resident for one of four residents (Resident #1) reviewed for medications and pharmacy services.The facility failed to ensure Resident #1 had his prescribed clonidine (a medication for high blood pressure) 0.3mg/24HR transdermal (applied to the skin) patches available for administration.This failure could place residents at risk of not receiving the intended therapeutic benefits of the medication and symptomatic changes in vital signs.Findings included:Record review of Resident #1's face sheet, dated 04/01/2026, reflected a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: chronic kidney disease, unspecified (the gradual loss of kidney function), essential hypertension (high blood pressure), and unspecified atrial fibrillation (irregular heart rhythm).Record review of Resident #1's comprehensive MDS, dated [DATE], reflected a BIMS score of 12, which indicated moderate cognitive impairment.Record review of Resident #1's order summary, dated 04/01/2026, reflected clonidine Transdermal Patch Weekly 0.3 MG/24HR (Clonidine) Apply 1 patch transdermally one time a day every Sat related to ESSENTIAL (PRIMARY) HYPERTENSION with an order date of 01/12/2026 and start date of 01/17/2026; Isosorbide Mononitrate ER Oral Tablet Extended Release 24 Hour 60 MG Give 1 tablet by mouth two times a day for chest pain Do not crush. Hold SBP<110, HR<60, Metoprolol Tartrate Oral Tablet 100 MG Give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION Hold SBP <110, HR <60,Furosemide Oral Tablet 40 MG Give 1 tablet by mouth two time a day for BLE swelling, and Spironolactone Oral Tablet 25 MG Give 0.5 tablet by mouth one time a day for swelling.Record review of Resident #1's comprehensive care plan, dated 01/12/2026 and last revised 03/30/2026 reflected a focus area of The resident has hypertension (HTN) with interventions that reflected Give anti hypertensive medications as ordered.Record review of Resident #1 medication administration record for March 2026 reflected Resident #1 was scheduled to receive clonidine Transdermal Patch on 03/09/2026, 03/14/2026, 03/21/2026, and 3/28/2026, but did not receive the medication. Instead, the area to indicate the medication was administered was marked with 9 and initials. The key at the bottom of the medication administration record reflected 9 indicated medications not available.Record review of Resident #1's blood pressures for March 2026 reflected:03/01/2026 11:04 AM - 141/70 mmHg03/01/2026 07:50 PM - 145/72 mmHg03/02/2026 11:59 AM - 123/66 mmHg03/02/2026 05:12 PM - 148/70 mmHg03/03/2026 08:46 AM - 169/79 mmHg03/03/2026 07:04 PM - 148/84 mmHg03/04/2026 09:10 AM - 166/71 mmHg03/04/2026 05:09 PM - 166/88 mmHg03/05/2026 12:11 PM - 132/88 mmHg03/06/2026 11:47 AM - 152/85 mmHg03/06/2026 07:02 PM - 130/63 mmHg03/07/2026 12:33 PM - 154/84 mmHg03/07/2026 05:26 PM - 116/62 mmHg03/08/2026 09:30 AM - 136/66 mmHg03/08/2026 04:28 PM - 162/75 mmHg03/09/2026 11:06 AM - 153/92 mmHg03/09/2026 08:11 PM - 158/86 mmHg03/10/2026 01:28 PM - 141/79 mmHg03/11/2026 11:15 AM - 127/79 mmHg03/11/2026 06:15 PM - 137/71 mmHg03/12/2026 08:28 AM - 162/70 mmHg03/12/2026 05:54 PM - 145/88 mmHg03/13/2026 07:41 AM - 144/65 mmHg03/13/2026 09:27 PM - 142/75 mmHg03/14/2026 12:44 PM - 145/78 mmHg03/14/2026 06:16 PM - 146/79 mmHg03/15/2026 01:15 PM - 144/62 mmHg03/15/2026 06:27 PM - 163/68 mmHg03/16/2026 12:50 PM - 150/83 mmHg03/16/2026 06:10 PM - 147/83 mmHg03/17/2026 12:31 PM - 145/65 mmHg03/17/2026 10:19 PM - 140/66 mmHg03/18/2026 07:27 PM - 144/64 mmHg03/19/2026 12:11 PM - 155/80 mmHg03/20/2026 12:35 PM - 152/80 mmHg03/20/2026 06:36 PM - 149/71 mmHg03/21/2026 12:26 PM - 167/76 mmHg03/21/2026 08:02 PM - 170/79 mmHg03/22/2026 09:10 AM - 145/76 mmHg03/22/2026 04:53 PM - 117/63 mmHg03/23/2026 01:31 PM - 142/68 mmHg03/23/2026 07:22 PM - 144/64 mmHg03/24/2026 12:10 PM - 138/77 mmHg03/24/2026 07:53 PM - 146/82 mmHg03/25/2026 08:30 AM - 161/76 (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mmHg03/25/2026 07:55 PM - 141/72 mmHg03/26/2026 12:19 PM - 154/76 mmHg03/26/2026 08:24 PM - 154/78 mmHg03/27/2026 01:10 PM - 161/74 mmHg03/27/2026 09:03 PM - 156/74 mmHg03/28/2026 12:47 PM - 122/64 mmHg03/28/2026 09:04 PM - 150/78 mmHg03/29/2026 02:13 PM - 148/81 mmHg03/29/2026 07:00 PM - 148/85 mmHg03/30/2026 01:25 PM - 182/78 mmHg03/30/2026 05:32 PM - 161/74 mmHg03/31/2026 10:55 AM - 127/61 mmHg03/31/2026 05:50 PM - 191/99 mmHgDuring an interview on 04/01/2026 at 02:10 PM, Resident #1 stated the facility had changed pharmacies recently and he had concerns about not receiving his patch for his blood pressure. He stated he had not received the patch in over a week, and he thought his blood pressure was elevated due to the missed patch. He stated he did not currently have a patch on. During an observation on 04/01/2026 at 06:15 PM of the unit 3 medication cart revealed a box of clonidine 0.3mg/24hr patches with 3 patches inside and labeled with Resident #1's name and dated 03/10/2026 in the top left drawer in the front left corner.During an interview on 04/02/2026 at 06:30 PM, the DON stated she was unsure what 9 indicated on the MAR. She stated she was not aware that Resident #1 had missed his clonidine patch for the month of March 2026. She stated she was going to go check on Resident #1.During an interview on 04/02/2026 at 07:55 PM, the DON stated Resident #1's clonidine patches were located in the unit 3 medication cart and she had moved it to the unit 3 nurse's cart and moved the medication to the nurse's MAR. She stated she did a skin assessment on Resident #1 and was unable to locate a clonidine patch.During a phone interview on 04/02/2026 at 10:39 AM, MA C stated she was responsible for applying the transdermal patch to Resident #1 on 03/14/2026 and 03/28/2026. She stated the patches were unavailable during medication administration time and she notified her charge nurse that day of the missing medication. MA C stated she was aware that LVN D had contacted the pharmacy within the last month about the missing medication but was unsure when or the outcome of the call. MA C stated she was unsure if the provider was notified each time the medication was not available. MA C stated the patches were located on the evening of 3/29/2026 in the unit 3 nurses medication cart by LVN E. MA C stated she was not sure if the medication was applied to Resident #1 when found by LVN E. MA C stated Resident #1 did not make any complaints to her related to the missing medication. She stated she regularly assessed Resident #1's blood pressure during medication administration and had not seen his blood pressure out of range. MA C stated the nurse attempted to pull the medication from the emergency kit, but the medication was not stocked in the emergency kit.During an interview on 04/02/2026 at 11:30 AM, MA B stated a 9 on the medication administration record indicated a medication was not available for administration at that time. She stated she was responsible for administering medication to Resident #1 on 03/07/2026 but was unable to administer the clonidine 0.3mg/24hr medication due to it not being in the medication cart. MA B stated she notified LVN D that day of the unavailability of the medication but did not remember the response from LVN D when notified. She stated the policy for medication administration was to notify the nurse if a medication was not available. MA B stated if Resident #1's clonidine transdermal patch was not administered, then his blood pressure could increase and put him at risk of having a stroke. MA B stated she had not worked with Resident #1 since 03/07/2026.During a phone interview on 04/02/2026 at 11:53 AM, LVN D stated if a medication is not available for administration, then the policy is to check with the pharmacy to see how long it will take to deliver the medication if the medication is not in the emergency kit. She stated if the medication cannot be delivered in a timely manner, then the next step is to notify the provider and try to obtain an alternative order for something that is available. LVN D stated she was not informed that Resident #1 was out of his clonidine 0.3mg/24hr transdermal patches by any other staff members. LVN D stated she did not recall observing Resident #1's transdermal patches at all in March 2026. LVN D stated the clonidine patches are a slow release of medication to control blood pressure, so it could cause changes in the resident's blood pressure.During a phone interview on 04/02/2026 at 12:12 PM, LVN E stated that she had not been notified by any staff member that Resident #1's clonidine patches were unavailable. LVN E stated that Resident #1 mentioned missing his clonidine patch this past week and she found a box (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Resident #1's patches in the unit 3 nurses medication cart and she moved it to the unit 3 medication cart. LVN E stated she remembered observing his patches in the nurses' medication cart earlier in March 2026 but is unsure exactly when.During an interview on 04/02/2026 at 12:42 PM, LVN A stated she was responsible for administering a clonidine 0.3mg/24hr patch to Resident #1 on 03/21/2026, but he did not have any available that day. She stated the 9 on the medication administration record was to indicate the medication was unavailable. LVN A stated she notified LVN D that day about the medication not being available and they both searched the unit 3 medication cart looking for the medication. LVN A stated she did not remember what the ordering status in the computer from the pharmacy was that day. LVN A stated if a resident were to miss their dose of clonidine patch, then it could affect the resident's blood pressure.During an interview on 04/02/2026 at 12:56 PM, the MD stated if a resident were to miss their clonidine 0.3mg/24hr patches for a month, then their blood pressure could go up. The MD stated he was not aware the medication had not been administered to Resident #1 for the month of March 2026, but he had reviewed Resident #1's medical record and his blood pressure had been stable with occasional spikes. The MD stated he talked with the NP about Resident #1's missing medication and was told she was notified by staff through text message.During an interview on 04/02/2026 at 03:11 PM, the DON stated the policy if a medication is not available is to get on the application for the pharmacy and notify the pharmacy that the medication is not available. She stated the pharmacy would then send the medication needed. The DON stated she would expect the medication aides to notify the charge nurse who would then notify herself about missing medications. The DON stated there was a Pyxis(a medication dispensing machine used for emergency medications) machine available to provide emergency medication that was unavailable. She stated the Pyxis had common medications that can be pulled and used in case the medication was out of stock. The DON stated she was not notified that Resident #1 was out of his clonidine 0.3mg/24hr patches by any staff members in March 2026. She stated if a resident missed this medication, then their blood pressure could increase.During an interview on 04/02/2026 at 04:00 PM, the ADM stated if a medication was not available, she expected the medication aide or person responsible for passing the medication to notify the charge nurse immediately. She stated if the charge nurse was unavailable at the time, then she would expect that staff member to contact the DON or the ADON. The ADM stated she would expect the charge nurse to search all the medication carts to ensure the medication is not in there. She stated if the medication could not be located then she expected the charge nurse to contact the pharmacy to get the medication in the building. She would also expect the charge nurse to notify the provider about the missed dose of medication and to attempt to obtain an alternative medication until the arrival of the missed medication. She stated she also expected to be notified of the missed medication. The ADM stated she was not notified Resident #1 has missed his clonidine 0.3mg/24hr patch for March 2026. She stated she is unaware of any outcomes due to the missed doses. The ADM stated she is not sure how missing the medication could affect a resident.Record review of the facility's policy titled, Administering Medications, dated 2001 and last revised April 2019, reflected: Policy headingMedications are administered in a safe and timely manner, and as prescribed.Policy Interpretation and Implementation.2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions.4. Medications are administered in accordance with prescriber orders, including any required time frame.6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform the process changes and or the need for additional staff training.21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.