| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675892 | A. Building<br>B. Wing | 03/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Gulf Pointe Plaza | 1008 Enterprise Blvd<br>Rockport, TX 78382 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 3 of 10 residents (Resident #18, Resident #57, and Resident #22) reviewed for respiratory care. 1. The facility failed to ensure Resident #18's oxygen was administered at the correct setting on 03/08/2026 as ordered by the physician. 2. The facility failed to ensure Resident #57's oxygen was administered at the correct setting on 03/08/2026 as ordered by the physician. 3. The facility failed to post an oxygen sign outside of the room indicating Resident #57 received oxygen on 03/08/2026 4. The facility failed to ensure Resident #22's oxygen was administered at the correct setting on 03/08/2026 as ordered by the physician. 5. The facility failed to ensure Resident #22's oxygen tubing was connected to humidification. These failures could place residents who receive oxygen at an increased risk of respiratory complications, decreased quality of care, and a risk of fire hazard. The findings included: 1. Record review of Resident #18's face sheet dated 3/8/26 reflected the resident was a 96 -year-old female with an admission date of 4/13/24 and an initial admission date of 4/12/22. Resident #18 had the following diagnosis: chronic obstructive pulmonary disease, (a progressive, chronic inflammatory lung disease that causes obstructed airflow, making it difficult to breathe), acute (sudden) and chronic (over time) respiratory failure (a condition where the lungs cannot adequately supply oxygen to the blood or remove carbon dioxide causing severe shortness of breath, confusion, and cyanosis (bluish skin)) with hypoxia (a condition where the tissues and organs in the body do not receive adequate oxygen), and dementia (a range of progressive neurological disorder that cause a decline in memory, language, problem-solving, and other thinking abilities). Record review of Resident #18's Quarterly MDS assessment, dated 1/17/26, reflected the resident had a BIMS score of 00 which suggests severe cognitive impairment. Self-care assessment reflected Resident #18 required substantial/maximal assistance with personal hygiene, putting on/taking off footwear, shower/bathe self, and toileting hygiene. She required partial/moderate assistance with oral hygiene and lower body dressing. She required supervision or touching assistance with eating and upper body dressing. Health conditions included shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring). Special treatments, procedures, and programs reflected resident received oxygen therapy. Record review of Resident #18s undated care plan reflected the resident had oxygen Therapy r/t COPD. Date Initiated: 1/28/26. Interventions included: Give medications as ordered by physician. Date initiated: 1/28/26. oxygen settings: O2 via nasal cannula/mask at 2L as needed for O2 sats below 90% or SOB. Record review of the Doctor's Order Entry dated 2/24/26 reflected Resident #18 was prescribed O2 at 2 L/minute via NC continuous every shift for SOB. During an observation on 3/8/26 at 1:05 p.m. Resident #18 was observed in her room asleep in bed with head of bed elevated, she was receiving O2 at 4.5 liters via nasal cannula. Resident #18 was not in any distress. 2. Record review of Resident #57's face sheet dated 03/10/2026 revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #57's pertinent diagnoses included Alzheimer's Disease (a progressive disorder which was the most common cause of dementia, characterized by memory<br>(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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | loss, cognitive decline, and behavioral changes), Picks Disease (a progressive and degenerative brain disease which usually affects people under 65's behavior, and sometimes it disrupts the ability to speak or understand others), and Aphasia (a communication disorder which affects a person's ability to process and formulate language, and it could impact various aspects of communication, including speaking, understanding, reading, and writing). Resident #57's face sheet also reflected an Advanced Directive status of DNR. Record review of Resident #57's Quarterly MDS assessment dated [DATE] revealed a BIMS was not conducted as Resident #57 was rarely or never understood. MDS also revealed Resident #57 had no speech and was rarely or never understood. Section O revealed Resident #57 was on oxygen therapy. Record review of Resident #57's care plan revealed there was no specific care plan for oxygen. There was, however, a care plan initiated 03/07/2026 for respiratory infection with the intervention for oxygen therapy as ordered by the physician. Record review of Resident #57's active physician orders dated 03/03/2026 revealed an order for oxygen via nasal cannula at 2 liters per minute continuously. In an observation on 03/08/2026 at 12:00 PM, Resident #57's oxygen concentrator was set at 2.5 liters per minute and there was no red sign outside of her door noting oxygen in use. 3. Record review of Resident #22's face sheet dated 03/10/2026 revealed she was a [AGE] year-old female originally admitted to the facility on [DATE] with a re-admission on [DATE]. Resident #22's pertinent diagnosis included Acute Respiratory Failure with Hypoxia (a life-threatening condition characterized by inadequate oxygenation of the blood, requiring immediate medical intervention). Record review of Resident #22's Quarterly MDS assessment dated [DATE] revealed BIMS of 01, severely impaired cognition. The MDS also revealed Resident #22 was on oxygen therapy and had Respiratory Failure. Record review of Resident #22's care plan initiated 11/25/2025, and revised 01/22/2026, revealed a care plan for oxygen therapy related to ineffective gas exchange. Interventions included oxygen via nasal cannula at 3 liters continuously. Record review of Resident #22's active physician orders dated 12/27/2025 revealed an order for oxygen via Nasal Cannula at 3 liters per minute continuously. In an observation on 03/08/2026 at 11:57 AM, Resident #22's oxygen concentrator was set at 3.5 liters per minute and the oxygen tubing was not connected to the humidification bottle on the oxygen concentrator. The humidification bottle was on the concentrator with separate tubing hanging from it, but Resident #22's nasal cannula tubing was hooked directly into the oxygen concentrator. During an interview on 3/8/26 at 2:11 p.m. LVN A said she was the nurse assigned to Resident #18. She said the nurses were in charge of resident's oxygen settings. LVN A said she checked the O2 settings every shift, first thing in the morning. LVN A said the O2 flow rate was at the same setting when she arrived this morning at 6 a.m., she had not touched it. LVN A checked Resident #18's O2 sats this morning and she was ok. She said Resident #18's O2 sats were at 93% at around 7:30 a.m LVN A re-checked Resident #18's O2 saturations at 2:16 p.m., and they were at 97%. LVN A said she recalled Hospice stated the resident's oxygen flow rate could go up to 5 liters. LVN A said the orders from hospice and the orders on PCC should probably be the same. LVN A said she should follow MD orders. LVN A said she was not sure what could happen if a resident received too much oxygen. LVN A said a resident would become confused with hypoxia, so would become the opposite of hypoxic. LVN A said she did not recall what too much oxygen did because she never had that situation. During an interview on 3/9/26 at 4:20 p.m., RN B said the nurses were in charge of oxygen settings. RN B said she checked O2 flow rate settings upon start of every shift. RN B said she also checked the flow rate when a resident got up to wheelchair to ensure the flow rate was accurate, then would check the flow rate periodically or as needed after. RN B said an MD order was required to administer O2, unless oxygen was given for an emergency. RN B said if a resident must continue on O2, she must get an MD order. RN B said in an emergency, they would also increase the oxygen flow rate a resident was already receiving by .5 increments until the saturation rates were above the MD orders requested, then they would decrease the O2 flow rate back to the original MD order. RN B said if the oxygen cannot be decreased to baseline flow rate, she must call MD for new orders to increase the flow rate. RN B said a resident with COPD who received more oxygen than<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | prescribed could have an adverse effect. RN B said if a resident was given more O2 than needed, it could cause O2 toxicity and symptoms that were not the resident's normal. In an interview on 3/10/2026 at 1:40 PM, the ADON stated residents on oxygen should have the red sign outside of their room warning oxygen was being utilized in the room to help prevent any injuries. He also stated the setting on the oxygen concentrator should match whatever the order for oxygen stated. The ADON stated the charge nurses were the ones who typically set or adjusted the settings on the oxygen concentrators, and the charge nurses should have checked each shift to verify the settings were correct. In an interview on 3/10/2026 at 2:09 PM, the DON stated when residents were on oxygen, they should have the red oxygen sign outside on their door warning oxygen was being utilized in the room. She state it was nursing judgement to place a resident on oxygen if needed, but the nurse must follow up with an MD to obtain the order. The DON stated the settings on the oxygen concentrator should match whatever was in the oxygen order, and the charge nurses were the ones who typically set or adjusted the settings on the oxygen concentrators, as well as verified each shift the settings were correct, but sometimes therapy would adjust the settings depending on how the resident tolerated therapy. The DON stated if a resident was getting more or less oxygen than what was ordered, it would not be considered therapeutic. She also stated if a resident was not getting enough oxygen they could end up with an altered mental status and poor perfusion (process by which blood delivers oxygen to tissues and organs). Record review of the facility's Oxygen Administration policy, revised October 2010, revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. Equipment and Supplies: 3. Humidifier Bottle 4. No Smoking / Oxygen in Use sign. Steps in the Procedure: 2. Place an Oxygen in use sign on the outside of the room entrance door. 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 14. Periodically recheck water level in humidifying jar. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for sanitation.The facility failed to properly label and date open, shelf stable food.The facility failed to dispose of expired shelf stable and refrigerated food.The facility failed to ensure containers and bags of food were sealed appropriately. The facility failed to ensure behind the ice machine and under the sink were clean.The facility failed to ensure all dry and/or shelf stable foods were labeled with received by, opened, and use by dates.The facility failed to ensure pans were free from dents and dings, as well as from having the Teflon scraped off.The facility failed to ensure there were no chemicals stored in the kitchen or serving area.The facility failed to ensure no staff items were being stored in the kitchen refrigerators. These failures could have placed residents at risk of ingesting foreign objects as well as possible foodborne illnesses.The findings included:Observations and initial tour of the kitchen on 03/08/2026 at 11:05 AM revealed the following:*Behind the ice machine and under the sink (dishwasher area) there was a large amount of dirt, debris, and grime built up.Refrigerator: *A small, individual container of open and used milk with no opened or use by dates on them.*Individual bottles of water belonging to the staff.*Multiple bags of bread on the bread cart with no received by, opened, or use by dates on them. In the walk-in cooler there were tortillas on the shelf wrapped in plastic wrap with the date 02/09/2026 written on them. There was a mixture of a food item in a bowl in the walk-in cooler which was half-covered and dated 03/01/2026. Walk-in cooler:*Opened waffles wrapped in plastic with a use by date of 02/27/2026. *A bag of a thick, white substance, wrapped in plastic wrap, with the date 02/28/2026 written on it. *A bag of opened bread with the date 02/22/2026 written on it. *A bag of shredded lettuce with a use by date of 03/06/2026.*Multiple bags of open cheese which were not sealed. There was also a bag of cheese which had been opened and used, but the use by date was 02/10/2026.*Multiple trays with cups of covered juice with no use by date or time on them or the trays. There was, however, a sticker at the top of the juice cart with 8 dates written on it. *A bag of English Muffins with a use by date of 03/06/2026. Further observation revealed in the kitchen serving area, there was a bottle of bleach sitting on top of cereal dispensing containers. There were also pans noted with scrapes, dings and scratches. In an interview on 03/09/2026 at 2:12 PM, the FSD stated the filters, floors, counters, walls, equipment and sinks were cleaned daily. She stated behind the ice machine was a difficult area to reach because it was not mobile, so it tended to get dirtier. She also stated the area under the sink next to the dishwasher was so dirty because it was where the previous dishwasher sat, so it had a lot of build-up behind it, but she had been working on getting it cleaned. The FSD stated food should be labeled with a received by date, opened date, and a use by date, and if it was not dated or sealed appropriately, it should be discarded because it could make the residents sick. The FSD stated she and the kitchen staff were allowed to keep personal items in the kitchen refrigerator as long as they were sealed and dated, and she thought it was what the policy said as well. The FSD also stated she knew the kitchen staff were not supposed to cook with pans which dinged or scraped so badly the Teflon was coming off because it could end up in the residents' food and make them sick. In an interview on 03/09/2026 at 3:05 PM, the RD stated she was not aware of how dirty it was behind the ice machine, but she would look into it. She also stated food should be labeled with a received by date, opened date, and a use by date, and if it was not dated or sealed appropriately, it should be discarded because it could make the residents sick. She stated the cups with juice in them should either have the cups dated, or the trays the cups sat on should be dated. She stated the bread dates were kept on a log on a sheet of paper, but she was not sure how someone inspecting the bread would be able to tell a specific loaf of bread on the bread cart went with the date written on the log. The RD also stated she knew the kitchen staff were not supposed to cook with pans which were<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | dinged or scraped because it could end up in the residents' food and make them sick.In an interview on 03/10/2026 at 3:10 PM, the Adm stated if food was expired or left open it should be discarded, as well as staff should not keep personal items in the kitchen refrigerator because they had a staff refrigerator in the breakroom. Record review of the facility's Food Receiving and Storage Policy, no date noted, revealed 1. Food services, or other designated staff, will maintain clean food storage areas at all times. 6. Dry foods stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in first out system. 7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). 13. D. Beverages must be dated when opened and discarded after twenty-four hours. 14. Pesticides and other toxic substances and drugs will not be stored in the kitchen area or in storeroom for food or food preparation equipment and utensils. 15. Soaps, detergents, cleaning compounds or similar substances will be stored in separate storage areas from food storage. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be fully informed in advance about the risks or benefits of any proposed treatment that may affect the resident's well-being for 2 of 6 (Resident #7 and Resident #10) residents reviewed for psychotropic medication consents. 1. The facility failed to obtain a signed informed consent for Resident #7's Divalproex (a medication used to treat seizures, but could also be used to treat anxiety [intense, excessive and persistent worry and fear about everyday situations], depression [a mood disorder which caused a persistent feeling of sadness and loss of interest], schizophrenia [a severe mental disorder which affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking], and bipolar disorder [a mental health condition characterized by extreme mood swings which include emotional highs and lows]). 2. The facility failed to obtain a signed informed consent for Resident #10's Depakote (a medication used to treat seizures, but could also be used to treat anxiety [intense, excessive and persistent worry and fear about everyday situations], depression [a mood disorder which caused a persistent feeling of sadness and loss of interest], schizophrenia [a severe mental disorder which affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking], and bipolar disorder [a mental health condition characterized by extreme mood swings which include emotional highs and lows]) and Gabapentin (a medication used to prevent and control partial seizures, but could also be used to treat anxiety [intense, excessive and persistent worry and fear about everyday situations], and depression [a mood disorder which caused a persistent feeling of sadness and loss of interest]). These failures could place residents at risk to receive psychotropic medications without consent or knowledge of the possible side effects of the medications. The findings included: 1. Record review of Resident #7's face sheet revealed a [AGE] year-old female with an original admission date on 06/27/2018, and a current admission date on 07/16/2025. Pertinent diagnosis included Schizoaffective Disorder, Bipolar Type (a mental health condition which was marked by a mix of schizophrenia symptoms to include hallucinations, delusions, and a change in or elevated level of mood and energy). Record review of Resident #7's Quarterly MDS dated [DATE] revealed a BIMS score of 06, which indicated severely impaired cognition. Section D for Mood was not conducted as Resident #7 was rarely or never understood. Section I revealed active diagnoses of Depression and Schizophrenia (a severe mental disorder which affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). Record review of Resident #7's care plan, initiated 10/05/2018 and revised 11/17/2021, revealed Resident #7 took mood stabilizing medications with potential for complications. The target behavior was paranoia with delusions. Interventions included obtain consents for medication and monitor and document for behavior every shift. Record review of Resident #7's active physician orders revealed an order started 07/17/2025 for Divalproex 125mg, give 4 capsules by mouth two times daily for Paranoid Disorder. Record review on Resident #7's consents reflected a previous consent for Depakote (Divalproex), dated 06/27/2018, to treat mood disorder with psychotic features. This consent was originally signed by a registered nurse and Resident #7 on 06/27/2018. 2. Record review of Resident #10's admission record reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder, depressive type (mental health problem characterized by thinking and behavior problems and sadness), deaf non-speaking, and other recurrent depressive disorders (various, less specific, non-psychotic, chronic, or situational forms of repeated, significant, and often disabling, low-mood episodes). Record review of Resident #10's quarterly MDS dated [DATE] reflected a BIMS was not able to be completed and her cognitive skills for daily decision-making score was a 3 which indicated she rarely or never made decisions. Her MDS also indicated Resident #10 was taking an antipsychotic, an antidepressant, and an anticonvulsant. Record review of Resident #10's care plan<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | dated 08/14/18 reflected a focus of a mood disorder with the use of Depakote and a targeted behavior of refusal of care initiated on 04/24/25. Interventions included consult with pharmacy, MD to consider reduction when clinically appropriate and monitor target behavior/symptoms and document, initiated on 04/24/25. Record review of Resident #10's physician order summary report on 03/10/26 reflected the following orders: Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125mg. Give 2 capsules by mouth two times a day for Mood disorder. 2-caps = 250mg. Start date: 05/22/25. Gabapentin Oral Tablet 100mg. Give 1 tablet by mouth in the evening for mood disorder. Start date: 03/05/26. Record review of Resident #10's previous orders reflected the following orders for Depakote and Gabapentin: Depakote Oral Tablet Delayed Release 125mg. Give 1 tablet by mouth 1 time a day related to schizoaffective disorder, depressive type that started on 01/09/24 and was discontinued on 05/06/24. Depakote Oral Tablet Delayed Release 125mg. Give 1 tablet by mouth every day and evening shift related to schizoaffective disorder, depressive type that started on 05/06/24 and was discontinued on 07/29/24. Depakote Oral Tablet Delayed Release 250mg. Give 1 tablet by mouth 2 times a day for mood disorder that started on 07/29/24 and was discontinued on 05/22/25. Gabapentin Oral Tablet 100mg. Give 1 tablet by mouth in the evening for restlessness/mood that started on 06/26/25 and was discontinued on 01/15/26. Gabapentin Oral Tablet 100mg. Give 1 tablet by mouth in the evening for restlessness due to chronic pain that started on 01/16/26 and was discontinued on 03/05/26. Record review of Resident #10's miscellaneous forms reflected no consent forms for the use of Depakote or Gabapentin. An interview with Resident #10 was not possible due to her diagnoses of deafness and blindness. An unsuccessful attempt was made to contact Resident #10's RP on 03/10/26 at 3:03 pm. In an interview on 3/10/2026 at 1:40 PM, the ADON stated medications, such Depakote, being utilized as psychotropics or antipsychotic behaviors, required a consent form. He stated even if the medication was typically used to treat another condition but was being utilized in lieu of or as an adjunct to other psychotropic medications, there would need to be a consent obtained so the resident or the RP was informed of what the medication was for and the possible side effects. He also stated consent would need to be done when a new medication was started, if the medication dosage changed, or if the medication had previously been stopped and restarted. He stated the charge nurse that received the order for a new psychotropic medication was responsible for obtaining the consent, and he and the DON checked to ensure the consent was done. He stated it was important to get consents so the resident/RP would understand the reason, possible side effects, and goals of treatment for each psychotropic medication that was used. In an interview on 3/10/2026 at 2:09 PM, the DON stated medication consents should be obtained for psychotropics and/or antipsychotics, but not for other medications being utilized in lieu of psychotropics or antipsychotics. The DON also stated they utilized other medications at times, such as anxiolytics or anti-seizure medications as psychotropics, not as antipsychotics, but these medications did not require a consent. She stated antipsychotic medication would be used to treat more aggressive things such as psychosis or Schizophrenia. The DON stated if a psychotropic was new, changed, or had been stopped and restarted with longer than a day in between, there would need to be a new consent signed. She stated consents were important so residents and their families knew about the medication being utilized or any changes to it, and without a signed consent the facility was giving treatment in which a resident or family had not consented to, and this would be a resident's rights issue. The DON stated it was the charge nurse's responsibility to obtain the medication consent, or whomever got the order could have also gotten the consent. She also stated Valproic Acid (commonly known as Depakote) levels were not needed or drawn unless the medication was being utilized for seizures. Record review of the facility's Psychotropic Medication policy, revised February 2025, revealed 1. Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Informed Consent or Refusal: 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative to obtain documented consent or refusal: a. (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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | non-pharmacological alternatives; b. the indications and rationale for the recommendation; c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); d. the resident's/representative's right to accept or decline the treatment. Gradual Dose Reduction: 3. Categories of medications which affect brain activity such as antihistamines, anti-cholinergic medications, and central nervous system medication are not prescribed or administered for psychotropic medication unless there is documented clinical indication consistent with clinical standard of practice. A. if such medication is prescribed or administered as a substitute for psychotropic medication, and there is documented clinical rationale, the medication is monitored and managed as a psychotropic medication. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675892 | A. Building<br>B. Wing | 03/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gulf Pointe Plaza | 1008 Enterprise Blvd<br>Rockport, TX 78382 |

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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to request, refuse, and or discontinue treatment and to formulate an advance directive for 1 (Resident #57) of 5 residents reviewed for Advance Directives. The facility failed to ensure Resident #57's OOH-DNR was completed. The OOH-DNR form did not have the resident or RP signature. This failure could affect residents who have implemented Advance Directives and established their choice to not be resuscitated to a risk of receiving CPR and being resuscitated against their wishes. The findings included: Record review of Resident #57's face sheet dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #57's diagnoses included Alzheimer's Disease (a progressive disorder which is the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes) and Picks Disease (a progressive and degenerative brain disease which usually affects people under 65's behavior, and sometimes it disrupts the ability to speak or understand others). Resident #57's face sheet also reflected an Advanced Directive status of DNR. Record review of Resident #57's Quarterly MDS assessment dated [DATE] revealed the BIMS was not conducted as Resident #57 was rarely or never understood. The MDS also revealed Resident #57 had problems with short-term and long-term memory recall, and daily decision making was severely impaired. Resident #57 had limited range of motion in all extremities. Record review of Resident #57's care plan initiated [DATE] revealed a code status of OOH-DNR. Interventions dated [DATE] included a copy of the OOH-DNR wouldass be kept in the resident's medical chart and readily available for all to see and the IDT would review code status with Resident #57 and/or the RP during the plan of care meeting. Staff were to verify the code status in Resident #57's medical chart with sudden changes in condition.Record review of Resident #57's active physician order revised [DATE] revealed an order for DNR. Record review of Resident #57's OOH-DNR form dated [DATE] revealed the form was signed in section C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication, was signed by an adult child. The OOH-DNR revealed section F. of the form was not completed by the Resident/Guardian/Agent/Proxy/Relative signature, in which all persons who had signed above section F (to include section C) also needed to sign in section F. In an interview on [DATE] at 1:40 PM, the ADON stated OOH-DNR should be signed in section F. by the physician, two witnesses, and the resident or the RP, and it had not been signed properly or appropriately it was considered invalid. In an interview on [DATE] at 2:09 PM, the DON stated the DNR or OOH-DNR form was discussed upon admission then signed by all parties, to include the physician, two witnesses, the resident or the resident's RP. The DON also stated all parties which signed above section F. should have signed in section F. The DON stated if the OOH-DNR was not completed properly it was not considered valid, and a resident could have received CPR when their wish was to not be resuscitated. Record review of the facility's Do Not Resuscitate policy, revised 2017, revealed the The facility will not use cardiopulmonary resuscitation and related emergency measure to maintain life functions on a resident when there is a Do Not Resuscitated Order in effect. 2. A Do Not Resuscitate order form must be completed and signed by the Attending Physician and resident (or resident's legal surrogate) . The Interdisciplinary Care Planning Team will review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such directives. |