

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675899	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Matagorda Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4521 Avenue F Bay City, TX 77414	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 of 8 residents (#48 and #59) reviewed for ADL care. The facility failed to ensure Resident #48's fingernails were trimmed, filed, and cleaned on 07/07/2026. -The facility failed on 07/07/2026 to assist Resident #59 to shave his facial hair. These failures could place residents at risk of loss of dignity, risk of infections, and a decreased quality of life. Findings included: Record review of the Face Sheet revealed Resident #48 was an [AGE] year-old male whose original admission date was 04/07/2025 with a readmission date of 02/26/2026. Record review of the history and physical dated 02/17/2026 revealed Resident #48 had generalized weakness, muscle wasting (loss of muscle mass), colon cancer (cancer of the large intestine), type 2 diabetes mellitus (high blood sugar disorder), hypertension (high blood pressure), hyperlipidemia (high cholesterol), and age-related cognitive decline (decreased thinking ability associated with aging). Record review of the quarterly MDS dated [DATE] revealed Resident #48 had a BIMS score of 07, indicating moderately impaired cognition. The MDS revealed under section GG for functional abilities, Resident #48 was dependent on staff with multiple activities of daily living, including personal hygiene and grooming, toileting hygiene, showering, and upper and lower body dressing. Record review of Resident #48's care plan revised on 06/01/2026 revealed interventions directing staff to provide routine hygiene and personal care as part of the resident's daily assistance needs. Resident #48's care plan revealed the resident had diabetes and called for staff intervention to educate the resident, his family and other care givers to monitor his nails and ensuring the should be always cut straight across and to never cut corners, to file rough edges with emery board (a small flat nail file made of stiff carboard with a fine abrasive material). The care plan called for staff intervention to check nail length and trim and clean on bath day and as necessary. During an observation and interview on 07/07/2026 at 9:24 a.m. with Resident #48, the resident was observed lying in bed. The resident's fingernails measured approximately 1.5 centimeters in length and had visible accumulations of dark debris beneath multiple fingernails. The fingernails appeared untrimmed and soiled. Resident #48 stated he did not like his fingernails being long because they would collect dirt, and he would accidentally scratch himself when experiencing an itch or while adjusting his clothing or bed linens. Resident #48 stated he had previously asked facility staff to trim his fingernails but could not recall when he had last made the request. During an observation on 07/08/2026 at 10:02 a.m., Resident #48 was asleep in bed. Observation of the resident's hands revealed they were still long and dirty. Resident #48 still had his fingernails at approximately 1.5 centimeters in length, and they still had visible accumulations of dark debris beneath multiple fingernails. Record review of the face sheet dated 07/09/2026 revealed Resident #59 was a [AGE] year-old male with an original admission date of 06/23/2026 and a (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	readmission on [DATE]. Record review of Resident #59's the history and physical dated 06/06/2026 revealed diagnoses including acute posthemorrhagic anemia (blood loss anemia), atrial fibrillation (irregular heart rhythm), chronic obstructive pulmonary disease (long-term lung disease), hypertension (high blood pressure), panlobular emphysema (advanced damage to the air sacs of the lungs), acute respiratory failure with hypoxia (low oxygen levels), thoracic and lumbar vertebral fractures (broken bones in the spine), generalized weakness, chronic pain, and impaired mobility. Record review of Resident #59's admission MDS dated [DATE] revealed Resident #59 had a BIMS score of 6, indicating severe cognitive impairment. The MDS under section GG for functional abilities revealed the resident required substantial to maximal staff assistance with multiple ADLs, including personal hygiene, dressing, bathing, and grooming. Record review of Resident #59's care plan dated 06/30/2026, revealed interventions directing staff to provide assistance with the resident's daily care needs and maintain personal hygiene while addressing his significant medical conditions and functional limitations. The care plan revealed Resident #59 required assistance with bathing, bed mobility, dressing, and toileting. During an observation and interview on 07/07/2026 at 4:00 p.m., Resident #59 was observed with noticeable facial hair and appeared frustrated while discussing his grooming needs. Resident #59 stated he had been asking facility staff to assist him with shaving because he had been clean-shaven throughout his life and did not like allowing his beard to grow. The resident stated he did not understand why staff had not provided him with an explanation as to why they had not assisted him with shaving or why the facility had not provided him with a razor or an electric razor so he could shave himself. During an observation and interview on 07/08/2026 at 3:22 p.m., Resident #59, continued to have noticeable facial hair and stated he remained frustrated because facility staff had still not addressed his repeated requests for assistance with shaving. Resident #59 stated he was waiting for his physician to communicate with the facility to determine whether he could safely be shaved. The resident stated he was disappointed that no one had followed up with him regarding his requests and that he continued waiting for assistance. During an interview on 07/09/2026 at 10:52 a.m., the DON stated residents had the right to request assistance with personal grooming, including shaving. The DON stated CNAs were primarily responsible for providing shaving during routine care; however, any staff member receiving the request was expected to ensure appropriate follow-up. The DON stated that allowing the request to go unanswered was not acceptable because it could cause the resident to feel ignored, frustrated, and lose dignity. During an interview on 07/09/2026 at 10:59 a.m., the Med Aide stated that when a resident requested to be shaved, the request should be communicated promptly to the assigned CNA or nurse. The Med Aide stated failing to relay the request was inappropriate and could leave the resident feeling overlooked and dissatisfied with his care. During an interview on 07/09/2026 at 11:03 a.m., ADON G stated staff were expected to respect residents' grooming preferences and ensure requests were addressed. The ADON stated unresolved requests did not meet the facility's expectations and could negatively affect the resident's emotional well-being by making the resident feel the staff did not pay attention to him or did not care to assist him. During an interview on 07/09/2026 at 11:17 a.m., ADON G stated licensed nurses were responsible for overseeing that residents' care needs, including grooming requests, were completed. ADON G stated unanswered requests could diminish the resident's dignity and self-esteem. During an interview on 07/09/2026 at 11:28 a.m., the Administrator stated the facility expected staff to respond promptly to reasonable requests for personal care. He stated every caregiver shared responsibility for ensuring concerns reached the appropriate staff member. He stated failing to do so could result in the residents feeling ignored or emotionally distressed. During an interview on 07/09/2026 at 11:46 a.m., the CNA F stated shaving was a routine nursing assistant (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsibility unless indicated differently by a charge nurse or the DON. CNA F stated if the resident declined or the task could not be completed immediately, staff should notify the nurse and follow up. CNA F stated leaving the request unaddressed was unacceptable because the resident could feel neglected or embarrassed. During an interview on 07/09/2026 at 10:52 a.m., the DON stated routine fingernail care was part of personal hygiene provided during ADLs. The DON stated CNAs were primarily responsible for trimming fingernails when appropriate, while all caregivers were responsible for reporting concerns. The DON stated excessively long fingernails were unacceptable because the resident could scratch himself, break the skin, bleed, and develop an infection. During an interview on 07/09/2026 at 10:59 a.m., the Med Aide stated that overgrown fingernails should be reported to nursing for follow-up. Med Aide stated that unresolved nail care increased the risk of accidental skin injury and infection. The Med Aide stated it was not acceptable to leave Resident #48's fingernails that long because they looked dirty, and there was also a risk of the resident getting sick if he ate food with his hand and they were dirty. During an interview on 07/09/2026 at 11:03 a.m., ADON[TW1.1] G stated residents declining nail care should receive additional education and be offered the service again. The ADON stated that allowing fingernails to remain excessively long was not acceptable and could place the resident at unnecessary risk for skin injury including scratching, which could lead to bleeding and infection. During an interview on 07/09/2026 at 11:17 a.m., ADON G stated nursing assistants were expected to monitor grooming needs during bathing and notify nursing when additional intervention was required. ADON G stated failure to address the concern did not meet acceptable care standards. ADON G stated Resident #48 could potentially scratch himself and it could result in him having skin break which could potentially result on him developing an infection due to having dirty fingernails. During an interview on 07/09/2026 at 11:28 a.m., the Administrator stated the facility expected residents to receive assistance maintaining appropriate hygiene and grooming. He stated that prolonged failure to address overgrown fingernails could contribute to preventable injury and infection. During an interview on 07/09/2026 at 11:46 a.m., CNA F stated fingernails were routinely assessed during showers and personal care. CNA F stated that refusals should be documented and reported. He stated long fingernails increased the likelihood of scratches, bleeding, and infection. Record review of the facility's Nursing Policy and Procedure Manual titled Nail Care not dated, read in part: Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticles are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic obstructive pulmonary disease or cardiac disease. Color changes with circulatory or lymphatic impairment and certain drug therapy is common. Ingrown toenails are also common in the elderly. Fungal infections of the toenails, dry, brittle ridges and thickening of the nails ail occur in the elderly with some frequency. Goals Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions The resident will be free from infection. Procedure Should be performed according to the resident center plan of care. 7. Trim the nails with a clipper, straight across for the toenails and rounded for the fingernails. 8. Smooth the nails with an emery board. 9. Apply hose and shoes or slippers as appropriate. Record review of the facility's Nursing Policy and Procedure Manual titled Shaving, Electric/Safety Razors, not dated, read in part: Shaving of the male resident can be performed with an electric or safety razor depending on the preference and availability of equipment. It is usually done as a part of daily personal hygiene, although every other day is sufficient for some based on the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	beard growth. It is done to promote cleanliness and a positive body image. Usually, the resident or a staff member performs the procedure, but the nurse can shave the resident if illness or disability prevents independence. Goals 1. The resident will experience cleanliness and comfort. Procedure Should be performed according to the resident centered plan of care. 1. Assemble the necessary equipment: a basin of warm water (115 degrees F.), shaving cream, the safety razor, a towel, a washcloth, and aftershave. 2. Wash your hands and put on gloves. 3. Explain what you are going to do. 4. Place a towel under the resident=s chin. 5. If the resident wears dentures, be sure they are in his mouth. 6. Put the washcloth in warm water, wring it out, and place it on the face to soften the beard. 7. Apply shaving cream to the face. 8. With the fingers of one hand, hold his skin taut. With the other hand shave in the direction the hair grows. Using short, firm strokes, shave under the sideburns, downward over the cheeks, over the chin, and upward on the neck. 9. Rinse the razor often. 10. Wash the remaining shaving cream off his face. 11. Apply aftershave if the residents desires it. 12. Store all articles in the appropriate place. 13. When finished, dispose of the gloves and wash your hands.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents or their responsible parties were informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment for 1 resident (Resident #1) of 5 residents reviewed for informed consents. The facility failed to ensure Resident #1's responsible party was informed of the risks and benefits prior to anti-psychotic medications being administered. This failure could place the residents at risk of receiving medications with side effects they do not wish. Findings include: Record review of Resident #1's undated admission Record reflected she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included delirium (a sudden change in thinking and awareness that can lead to confusion, memory problems, and hallucinations. Record review of Resident #1's quarterly MDS dated [DATE], reflected a BIMS score of 4 which indicated she had severe cognitive impairment. Section D-Mood indicated she has little interest in doing things and felt down. Her Functional Assessment indicated she used a wheelchair and required substantial assistance with her ADLs. Section I-Active Diagnoses did not include any psychiatric/mood disorder. Record review of Resident #1's care plan, dated 4/30/26, revealed she had depression (a mood disorder that causes persistent feeling of sadness and loss of interest), and receives antidepressant medications. Record review of Resident #1's physician orders, dated 6/09/26, for Mirtazapine (antidepressant medication) beginning 6/30/2026 for anxiety, appetite stimulant, and depression. Record review of Resident #1's July 2026 medication Administration record reflected the resident began receiving Mirtazapine 15mg every evening on 6/30/26. Record review on Resident #1's revealed no record of consent obtained prior to administering. There was no indication the responsible party had given verbal consent. In an interview on 7/9/26 at 3:15 PM the DON stated nurses are responsible for ensuring consents for antipsychotic medications are signed prior to the medication being administered. She stated she is then responsible for double checking the consents. She stated the risk of the resident receiving antipsychotic medications without being informed of the risks, benefits, and side-effects of the medication could be the resident having unexpected outcomes from the medication. In an interview on 7/9/26 at 4:38 PM Resident #1's responsible party stated they did not recall signing the consent for antipsychotic medications or talking with it over the phone with anyone. They stated there was so much paperwork signed and so many phone calls he may have given consent and not remembered it. He had no concerns about the resident taking the medications because she had taken them before being admitted to the facility. In an interview on 7/9/26 at 4:45PM with the Administrator he stated that it is ultimately the DON's responsibility to monitor the process for psychotropic consents. He stated the risk in not obtaining the consent prior to administration could be unwanted side effects. The administrator stated there have been no negative outcomes due to the deficient practice. A record review of the facilities revised 7/1/2026 titled Psychotropic Medication revealed in part: Residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative will be informed of the benefits, risks, and alternatives for the medication.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to have the most recent survey of the facility posted in a place readily available to resident's, family members and legal representatives. The facility failed to ensure that the previous annual survey results were freely available and visible to the public without having to be requested from staff. This failure could place residents at risk of not being able to exercise their right to be aware of the past history of citations of the facility that they reside in. Findings Include: During an observation on 7/7/2026 at 10:10am, no signs or labels could be located within the halls of the facility that would have indicated where the previous annual survey results would have been located. No binders or folders indicated that it would have contained the records of the results were found. During an interview on 7/08/2026 at 3:00pm, during the Resident Council meeting, the residents were not aware of the existence nor of the location of the previous annual survey results. Resident #1 said that he would have liked to have read them if he had known about them or knew where they had been. During an interview on 7/9/2026 at 3:45pm with the Administrator, the previous annual survey results were requested. The Administrator searched in his office and found a yellow folder containing the 2025 survey results inside of his desk. The Administrator said that the results were freely accessible to the residents and public. He said they were usually out in the hallway. He said the records had been in his office as he had been getting ready to prepare a new binder due to it had almost been a year since the prior annual survey. He said that upon entry of the survey team on 07/07/2026, the previous year's annual survey results were in his office, either in his desk or on the bookshelf. The Administrator said that if survey results were not available it would make the records not freely accessible to the public. The Administrator said that the risk of these results not having been freely available is that the public may not have been aware of the past survey history. During an interview on 07/07/2026 at 5:00pm, the Administrator said he locked his office when he was not present in the building, such as outside of his normal work hours. The Administrator stated they did not have any policies on posting survey results.		