STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shiner Nursing and Rehabilitation Center Inc	1213 N Ave B Shiner, TX 77984

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 facility reviewed for dietary requirements. The Dietary Manager did not have the appropriate certification, education, or qualifications to serve as the Director of Food and Nutrition Services, to include not following policy to substitute foods for 03/17/2026 lunch and not storing a container [whipped topping] appropriately on 03/17/2026. This failure could place the residents who consume food prepared from the kitchen at risk of food borne illness and not receiving adequate nutrition.The findings included: Record review of Resident #5's admission record, dated 03/17/2026, reflected [AGE] year-old female initially admitted [DATE] and re-admitted [DATE]. Record review of Resident #5's quarterly MDS assessment, dated 02/27/2026, reflected a BIMS score of 09 out of 15, indicating moderate cognitive impairment. Record review of Resident #5's Nutritional Risk Assessment, dated 02/27/2026 and authored by the RD, reflected resident had a significant weight loss of 9.1% (14.2 pounds) in 1 month but may be related to hospitalizations in Feb (2/3-2/7 & 2/20-2/24).[Resident #5] is also at risk for weight fluctuations r/t fluid fluctuations AEB BLE edema. and [Resident #5] on diuretic tx and Nutritional interventions were add house shakes BID and add weekly weights for 4 weeks to monitor. Record review of Resident #5's weight summary prior to 02/03/2026 reflect resident had stable weight from November 2025 to January 2026. Record review of the Dietary Manager's certifications reflected no document that reflected she was a Certified Dietary Manager. During an observation and interview on 03/17/2026 at 10:41 AM, the Dietary Manager revealed she was not a Certified Dietary Manager (CDM) and was going to school to become an CDM. She revealed she started working at this facility in October 2025 and did not start her schooling until January 2026. In an observation, there was a container of [whipped topping] in the reach-in refrigerator in the food preparation area. The container reflected that it was received on 03/03/2026 and the use by date was 07/06/2027 if the food product was frozen. The Dietary Manager revealed she was not aware that the container of [whipped topping] said that the discard date was 07/06/2027 if the food product was frozen, because she did not read it. She revealed it was important to follow the directions on the container to prevent residents from getting sick. During an observation, interview, and record review on 03/17/2026 at 11:52 AM, Resident #5 revealed she did not want potato soup instead of chicken and sausage gumbo because she already had potato soup for the soup of the day. Observation revealed Resident #5's lunch meal consisted of 2 bowls of potato soup. Resident #5's lunch meal tray ticket reflected a preference of no sausage and the meal would include: soup, entree, starch, salad, bread, dessert, condiment, and beverage. It revealed the soup was 1 serving soup of the day and the entree was 1 cup of chicken and sausage gumbo. Record review of the lunch menu substitution for Tuesday 03/17/2026's meat (protein) was ham and cheese sandwich. During an interview on 03/19/2026 at 08:19 AM, the ADM revealed the recipe for the loaded baked potato soup that was (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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	served at Tuesday's lunch showed that it should meet the requirement for protein because the recipe called for bacon, cheese, milk, and sour cream. Record review of the Loaded Potato Soup recipe's nutrition facts reflected 1 serving of the soup yielded 9.42 grams of protein. During an interview on 03/20/2026 at 03:36 PM, the RD revealed the Dietary Manager was not certified but was currently in school to be an CDM. She revealed if the Dietary Manager could not get ahold of her, she was allowed to make substitutions for meals if the replacement was similar in nutritive value. She revealed the substitution should be documented on substitution log. She revealed the Dietary Manager should have contacted her about substituting loaded potato soup for chicken and sausage gumbo, because the potato soup would not have as much protein as the chicken and sausage gumbo. She revealed she would have added chicken because 9g of protein from the loaded potato soup was not as much protein as was in the chicken and sausage gumbo. She revealed if the [whipped topping] container read that the discard date was 07/06/2027 if the product was frozen, then it should have been stored in the freezer. The RD further revealed she will review all of this with the Dietary Manager. During an interview on 03/20/2026 at 04:02 PM, the ADM revealed the Dietary Manager was not certified and did not have to be certified if she was in school. Record review of the facility's diet manual, dated 2025, reflected Suggested Meal Patterns Diabetic and Calorie Controlled Diets for 1600 to 1800 calorie diets 2 servings of meat needed to be served at lunch. For 2000 to 2400 calorie diets, 3 servings of Meat needed to be served at Lunch. Further record review of the 2025 diet manual reflected the meat and meat substitute group for 1 serving equated to 7 grams of protein. This would mean 2 servings of meat or meat substitute would be 14 grams of protein and 3 servings would be 21 grams of protein. Record review of the USDA's Dietary Guidelines for Americans, dated 2025-2030, reflected a diet included protein, dairy, healthy fats, vegetables, fruits and whole grains. Record review of the facility's policy MENU APPROVAL AND HONORING SPECIAL REQUESTS, AND FOOD BROUGHT TO THE FACILITY FROM UNAPPROVED SOURCES, dated 2012, REFLECTED . 4. Every attempt will be made to honor resident food preferences. In addition, an appealing option of similar nutritive value is provided for each meal, for those residents who do not like the main menu items being served. Record review of the facility's policy Menu Substitutions Form, dated 2012, reflected .5. Substitutions must be of equal value as the item to be substituted (ie meat for meat, vegetable for vegetable, etc.) Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 1-201.10.10(B) Accredited Program. (1) Accredited program means a food protection manager certification program that has been evaluated and listed by an accrediting agency as conforming to national standards for organizations that certify individuals. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2-102.12. Record review of the facility's job description for the dietary service manager, dated 2014, reflected The following is a non-exhaustive criteria that relates to the job of a Dietary Service Manager, and it is consistent with business needs of the facility. There are legitimate measures of the qualifications for a Dietary Service Manager, and are related to the functions that are essential to the job of a Dietary Service Manager. Base Knowledge: Current certification by state as required. Ability to procure and store all food and supplies.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received and the facility provided food that accommodates residents' food preferences and foods of similar nutritive value for 2 of 8 residents (Resident #5 and Resident #16) reviewed for food preferences and nutritive value.The facility failed to ensure Resident #5 received an entree that was of equal nutritive value as what was originally served for Tuesday 03/17/2026's lunch meal (chicken and sausage gumbo) instead of loaded potato soup.The facility failed to ensure that Resident #5 was not served fried food Friday 03/20/2026 meal as was noted on her dislikes.The facility failed to update Resident #16's meal tray ticket to reflect she could have a regular diet instead of a mechanical soft diet as was reflected in her Negotiated Risk Agreement, dated 06/24/2025.This failure could place residents at risk for a decline in health status due to inadequate or inappropriate nutritional intake. The findings include:Record review of Resident #5's admission record, dated 03/17/2026, reflected [AGE] year-old female initially admitted [DATE] and re-admitted [DATE]. Record review of Resident #5's quarterly MDS assessment, dated 02/27/2026, reflected a BIMS score of 09 out of 15, indicating moderate cognitive impairment. Record review of Resident #5's Nutritional Risk Assessment, dated 02/27/2026 and authored by the RD, reflected resident had a significant weight loss of 9.1% (14.2 pounds) in 1 month but may be related to hospitalizations in Feb (2/3-2/7 & 2/20-2/24).[Resident #5] is also at risk for weight fluctuations r/t fluid fluctuations AEB BLE edema. and [Resident #5] on diuretic tx and Nutritional interventions were add house shakes BID and add weekly weights for 4 weeks to monitor. Record review of Resident #5's weight summary prior to 02/03/2026 reflect resident had stable weight from November 2025 to January 2026. Record review of Tuesday 03/17/2026's lunch menu reflected: chicken and sausage gumbo, steamed rice, tossed salad, cornbread, bread pudding, margarine, and iced tea. During an observation, interview, and record review on 03/17/2026 at 11:52 AM, Resident #5 revealed she did not want potato soup instead of chicken and sausage gumbo because she already had potato soup for the soup of the day. Observation revealed Resident #5's lunch meal consisted of 2 bowls of potato soup. Resident #5's lunch meal tray ticket reflected a preference of no sausage and the meal would include: soup, entree, starch, salad, bread, dessert, condiment, and beverage. It revealed the soup was 1 serving soup of the day and the entree was 1 cup of chicken and sausage gumbo. Record review of the lunch menu substitution for Tuesday 03/17/2026's meat (protein) was ham and cheese sandwich. During an interview on 03/19/2026 at 08:19 AM, the ADM revealed the recipe for the loaded baked potato soup that was served at Tuesday's lunch showed that it should meet the requirement for protein because the recipe called for bacon, cheese, milk, and sour cream. Record review of the Loaded Potato Soup recipe's nutrition facts reflected 1 serving of the soup yielded 9.42 grams of protein. During an interview on 03/20/2026 at 03:36 PM, the RD revealed the Dietary Manager should have contacted her about substituting loaded potato soup for chicken and sausage gumbo, because she would not have agreed that this was an adequate substitution. She revealed the potato soup would not have as much protein as the chicken and sausage gumbo. She revealed she would have added chicken because 9g of protein from the loaded potato soup was not as much protein as was in the chicken and sausage gumbo. Record review of the facility's diet manual, dated 2025, reflected Suggested Meal Patterns Diabetic and Calorie Controlled Diets for 1600 to 1800 calorie diets 2 servings of meat needed to be served at lunch. For 2000 to 2400 calorie diets, 3 servings of Meat needed to be served at Lunch. Further record review of the 2025 diet manual reflected the meat and meat substitute group for 1 serving equated to 7 grams of protein. This would mean 2 servings of meat or meat substitute would be 14 grams of protein and 3 servings would be 21 grams of protein. Record review of the USDA's Dietary Guidelines for Americans, dated 2025-2030, reflected a diet included protein, dairy, healthy fats, vegetables, (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fruits and whole grains. Record review of the facility's policy Menu Substitutions Form, dated 2012, reflected .5. Substitutions must be of equal value as the item to be substituted (ie meat for meat, vegetable for vegetable, etc.) 2. Record review of Friday 03/20/2026's lunch menu reflected: fish sandwich, fried okra, creamy diced coleslaw, hush puppies, double chocolate pie, tartar sauce, and iced tea. Record review, interview, and observation on 03/20/2026 at 11:55 AM, Resident #5's lunch meal tray ticket reflected she disliked fried-breaded foods. Her lunch meal tray included fried okra, fried fish, and hushpuppies. Resident #5's meal tray ticket revealed her meal had too much fried food for her to handle. She revealed after she had her gallbladder removed, she could not eat fried food because it affected her digestion. During an interview and observation on 03/20/2026 at 12:09 PM, LVN I revealed she was checking the meal tray tickets for accuracy before they were given to the residents. She revealed Resident #5 was not supposed to have fried foods and she was given fried food. LVN I could not give a reason why she left fried foods on Resident #5's tray but walked back to the kitchen door and asked if Resident #5 could have any food substitutions instead of the fried foods for lunch today. The Dietary Manager revealed she did not realize that Resident #5 was being served fried food on her tray today and confirmed that Resident #5 should not have fried foods on her tray ticket because it was her preference after her gallbladder removal. She revealed recently Resident #5 told her that the resident felt like she could start including fried foods because it was not upsetting her stomach as much. During an interview on 03/20/26 at 12:26 PM, Resident #5 revealed she did not finish the fried food on her plate but mentioned she did not really feel like she was still hungry and her family was going to visit her and bring her food soon. During an interview on 03/20/2026 at 03:36 PM, the RD revealed the expectation was to follow the preferences for Resident #5 and not serve her fried foods. She was surprised because they typically served baked food and not fried foods. Record review of the facility's policy MENU APPROVAL AND HONORING SPECIAL REQUESTS, AND FOOD BROUGHT TO THE FACILITY FROM UNAPPROVED SOURCES, dated 2012, REFLECTED . 4. Every attempt will be made to honor resident food preferences. In addition, an appealing option of similar nutritive value is provided for each meal, for those residents who do not like the main menu items being served. 3. Record review of Resident #16's admission record, dated 03/20/2026, reflected a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include dysphagia (difficulty or discomfort in swallowing) Record review of Resident #16's admission MDS assessment, dated 02/10/2026, reflected Resident #16 had a BIMS score of 15 out of 15, indicating intact cognition. It reflected that she had no weight loss or weight gain in the last month or in the last 6 months. It further reflected that she had a mechanically altered diet (require change in texture of food or liquids). Record review of Resident #16's care plan, accessed on 03/20/2026 at 12:06 PM, reflected no mention of Resident #16's Negotiated Risk Agreement (NRA) that was dated 06/24/2025 and no mention of Resident #16 allowed to eat a regular diet instead of mechanical soft diet. It reflected [Resident #16] has a diet order other than Regular and is at risk for unplanned weight loss or gain., revised 03/09/2026, with intervention Served diet and snack as ordered., initiated 02/03/2026. Record review of Resident #16's order summary report, dated 03/20/2026, reflected her diet was mechanical soft texture and not regular texture. Record review of Resident #16's Negotiated Risk Agreement, dated 06/24/2025, that Resident #16 preferred to eat regular foods even though she was at risk for aspiration. Interview, observation and record review on 03/20/2026 at 12:08 PM revealed Resident #16 received a lunch meal tray that was mechanically soft, as was reflected on her meal tray ticket. Resident #16 requested a meal that was regular diet. Nursing staff (name unknown) went back to the kitchen to get her a regular textured meal because the kitchen said it was okay to give Resident #16 a regular diet lunch tray and the nursing staff was not aware and said Resident #16's tray ticket shows she should be served a mechanical soft meal. Resident #16 revealed she was allowed to be served a regular diet. The Dietary Manager said Resident #16 was allowed a regular diet because Resident #16 had the right to request this and signed that she was aware she was prescribed a mechanical soft diet and not a regular diet. During an interview on (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/20/2026 at 12:18 PM, the ADM revealed Resident #16 had an NRA because she wanted to eat a regular diet instead of a mechanical soft diet (per her doctor's orders) when she chose to eat a regular diet because it was not all the time. She revealed she was not sure if a doctor's order needed to be in place to show that Resident #16 could have a regular diet instead of the mechanical soft diet at times. She revealed they had not updated the tray ticket to reflect it was okay for Resident #16 to have a regular diet. Record review of the facility's policy Diet Orders/Diet Manual, dated 2012, reflected The physician will prescribe diets in accordance with the approved Diet Manual. A written order must appear on the medical record before the resident may be served.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety.1.The facility failed to keep the kitchen's ice machine free of black circular spots on the inside of the ice machine.2.The facility failed to ensure containers of [whipped topping] were stored properly in the reach-in refrigerator in the food preparation area on 03/17/2026.3.The facility failed to ensure raw protein food products were not stored right next to fully cooked food products.4. The facility failed to ensure a food product had the name of it on its label.5. The facility failed to label 3 buckets of food products in the food preparation area. These failures could place residents at risk for food borne illness.The findings included:During an observation and interview on 03/17/2026 at 10:41 AM it was revealed that the ice machine had black circular spots on the inside of the ice machine above the ice. The DM confirmed there were black circular spots present but that it did not look like mold. She was able to wipe these spots off and showed an unnamed substance on a paper towel. She further revealed that she cleaned the inside of the ice machine once a week by putting plastic bag on top of the ice and cleaned the inside. She revealed it was important to ensure the inside of the ice machine was cleaned because the residents could drink whatever contaminants were in the ice machine. Observation in the reach in refrigerator in the food preparation area revealed there were containers of [whipped topping] (amount unknown), dated 03/03/2026 and use by date 07/06/2027. Further reading of the container of [whipped topping] reflected when frozen-used by 06 July 2027. The DM revealed she was not aware that this food product needed to be frozen for the discard date to be 07/06/2027. During an observation and interview on 03/17/2026 at 10:51 AM revealed in the reach-in freezer, there were raw protein foods stored next to fully cooked food products. [NAME] J and the DM revealed the raw protein foods should not be stored near the fully cooked foods in the reach-in freezer because the blood leaking from the raw protein packages could get into the fully cooked food products and contaminate these fully cooked food products. There was an observation of a food product that did not have its name on it. The DM revealed the food products needed to have the name of the food product to know what the food was. The DM revealed with these labels sometimes they fell off easily. The DM revealed she typically ensured frozen raw proteins were stored in a separate freezer from the fully cooked food products to prevent cross contamination. The DM revealed when she was off from work, she noticed that everything got unorganized with food storage. There was an observation of 3 unlabeled buckets of food products in the food preparation area. [NAME] J revealed these buckets were: cornmeal, flour, and sugar and that they were currently not labeled. The DM and [NAME] J revealed they should be labeled so people knew what was in these buckets. The DM revealed she oversaw the kitchen to ensure everything was in order. During an interview on 03/20/2026 at 03:36 PM, the RD revealed the ice machine should not have black circular spots inside of it. She revealed the kitchen regularly cleaned the ice machine and were responsible for keeping it clean in between scheduled ice machine cleanings. She revealed it was important to keep the ice machine cleaned to prevent any contaminants and any foodborne illnesses from the ice. She revealed it was expected to read the food products to ensure proper food storage and to prevent food spoilage, so if the containers of [whipped topping] had a discard date for when it was frozen then these products should have been frozen. She revealed that raw protein foods should not be stored near fully cooked food products: She revealed she would instruct the kitchen staff to store raw protein food products separate from fully cooked food products to decrease the risk of cross contamination. The RD revealed she had come into the facility to do inspections of the kitchen and had not found any of these deficiencies during her visits, but she will educate the kitchen staff and the DM, as she was overseeing the DM while the DM went to school to become an CDM. Record Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.11, Food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. Record review of the FDA Food Code 2022 reflected, 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below or when combined as ingredients, separating raw animal FOODS during storage, preparation, holding, and display from:. (d) Frozen, commercially processed and packaged raw animal FOOD may be stored or displayed with or above frozen, commercially processed and packaged, ready-to-eat food. Record review of the facility's policy Cleaning of the Ice Machine, dated 2012, reflected . 4. If any type of soil/food stains are present, wash with all purpose cleaner and rinse well. Record review of the facility's policy Storage Refrigerators, dated 2012, reflected . 5. Food must be covered when stored, with a date label identifying what is in the container. 6. Frozen food that has been thawed will be used within three days of thawing. Record review of the facility's policy Dry Storage and Supplies, dated 2012, reflected .3. Dry bulk foods (e.g. flour, sugar) are stored in seamless metal or plastic containers with tight covers or bins which are easily sanitized. Containers are labeled.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 5 residents (Residents #3 and #7) reviewed for infection control, in that: 1. The facility failed to ensure CNA C sanitized between their fingers while providing incontinent care for Resident #3. 2.The facility failed to ensure LVN D wore a gown while providing wound care for Resident #7 who was on enhanced barrier precaution. LVN D also failed to sanitize her hands between change of gloves after cleaning the wound and before applying the treatment, while providing wound care for Resident #7. These failures could place residents at-risk for infection due to improper care practices.The findings were: Record review of Resident #3's face sheet, dated 03/19/2026, revealed an admission date of 08/18/2023 and, a readmission date of 12/04/2025 with diagnoses that included: Dementia (decline in cognitive abilities), Schizophrenia(mental disorder characterized by abnormal thought processes and an unstable mood) , Hyperlipidemia(Elevated level of any or all lipids(fat) in the blood) , Major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), Type 2 diabetes mellitus(high level of sugar in the blood) , Hypertension (High blood pressure) , Chronic kidney disease (gradual loss of kidney function). Record review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact, and was indicated to always be incontinent of bladder and frequently incontinent of bowel. Record review of Resident #3's care plan, dated 08/29/2023, revealed a problem of The resident has bowel incontinence and, and intervention of Provide pericare after each incontinent episode. Observation on 03/19/2026 at 12:35 p.m. revealed while providing incontinent care for Resident #3, CNA C did not sanitize between her fingers when using sanitizer between change of gloves. During an interview on 03/19/2026 at 12:48 p.m. with CNA C, she stated she did not sanitize between her fingers while providing incontinent care for Resident #3. She said she was nervous and forgot. She stated she received infection control training within the year. 2. Record review of Resident #7's face sheet, dated 03/20/2026, revealed an admission date of 11/21/2020 and, a readmission date of 02/14/2024 with diagnoses that included: Hyperlipidemia(Elevated level of any or all lipids(fat) in the blood), Chronic obstructive pulmonary disease (lung condition caused by damage to the lungs), Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure), Neoplasm of uncertain behavior of skin (growth whose potential to be benign or malignant cannot be definitively determined without further evaluation). Record review of Resident #7's quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact, and was indicated to have two pressure ulcers. Record review of Resident #7's care plan, dated 01/13/2026, revealed a problem of Resident requires ENHANCED BARRIER PRECAUTIONS due to wounds. and, and intervention of Gown and gloves necessary when performing high-contact care activities. Observation on 03/20/2026 at 9:30 a.m., revealed while providing wound care for Resident #7, LVN D did not gown up to enter the room and provide care. A sign and protective equipment could be seen by the door of Resident #7's room. Resident #7 is on enhanced barrier precaution due to her wounds. After cleaning the wound, LVN D changed her gloves but did not sanitize her hands and then applied the clean treatment and dressing to the wound During an interview on 03/20/2026 at 9:55AM with LVN D, she stated she forgot Resident #7 was on enhanced barrier precaution. She stated enhanced barrier precaution were a new thing and she was not used to it. She stated she had dipped her fingers in sanitizer but did not sanitize her whole hands between change of gloves. She stated she changed gloves frequently to make sure to stay clean. LVN D stated she just started working at the facility but received infection control through her orientation. During an interview on 03/20/2026 at 10:30 a.m. with the DON, who (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shiner Nursing and Rehabilitation Center Inc	1213 N Ave B Shiner, TX 77984

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was the infection preventionist for the facility, she stated the staff need to wear gown and gloves for resident on enhanced barrier precaution and to sanitize hands between change of gloves for the prevention of infection to the residents but also the staff. She stated when staff used sanitizer, they should sanitize the whole surface of the hands including between the fingers. The DON stated infection control training provided was provided and skills were checked annually. Review of facility's policy, titled Enhanced barrier precautions, dated 04/01/2024, revealed Enhanced barrier precaution are used in conjunction with standard precautions and expand the use of personal protective equipment to donning gown and gloves during high-contact resident care activities. Review of facility's policy, titled Fundamentals of infection control precaution, undated, revealed Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: [ ] after removing gloves. [.] Recommended techniques for performing hand hygiene with alcohol-based hand rub include applying product to the palm of the hand and rubbing hand together, covering all surfaces of hands and fingers, until the hands are dry.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 16 residents (Residents #8 and unknown resident) observed for nursing care, in that: 1.CNAs A and B did not completely close Resident #8's privacy curtain while providing perineal care for the resident.2. The facility failed on 03/17/2026 to ensure the privacy of unknown residents by not locking the laptop screen on the medication cart (1 of 3), so the residents' information could not be seen and/or accessed by someone walking by. This deficient practice could place residents at risk of embarrassment, lack of self-worth, and feeling disrespected. The findings were: 1.Record review of Resident #8's face sheet, dated 03/20/2026, revealed an admission date of 08/22/2024, and a readmission date of 07/22/2025, with diagnoses that included: End stage renal disease (the kidneys lost their filtering abilities, dangerous levels of fluid, electrolytes and wastes can build up in the body), Major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood) , Anxiety disorder (a group of mental illnesses that cause constant fear and worry), Dependence on renal dialysis (a filtering machine is used to remove waste and extra fluid from the blood, and then return the filtered blood into the body). Record review of Resident #8's quarterly MDS assessment, dated 01/19/2026, revealed the resident had a BIMS score of 5, which indicated severe cognitive impairment, and was indicated to always be incontinent of bladder and frequently incontinent of bowel. Record review of Resident #8's care plan, dated 8/22/2024, revealed a problem of The resident has bowel incontinence with an intervention of Provide pericare after each incontinent episode. Observation on 03/20/2026 at 9:18 a.m. revealed CNAs A and B provided perineal care for Resident #8. During care CNAs A and B tried to pull the curtain to offer privacy to the resident but the curtain was too short in width to go around the resident's bed. Further observation revealed Resident #8 could be seen by his roommate and could have been seen by someone opening the room's door. During an interview with CNAs A and B on 03/20/2026 at 9:25 a.m., CNAs A and B stated the privacy curtain was not closed while they provided care for Resident #8 but should have been. CNAs A and B further stated the resident's privacy curtain was not long enough to close completely around the resident's bed. During an interview with the DON on 03/20/2026 at 10:30 a.m., the DON stated privacy must be provided during nursing care and Resident #8's privacy curtain should have been closed completely. Resident rights training was provided for the staff annually. 2. Observation and interview on 03/17/2026 at 11:46 AM revealed a computer screen on a medication cart (located right outside of the dining room, in the entrance hallway) was unlocked and unsupervised with unknown resident information. There were no residents or visitors present. COTA F walked by and confirmed that the computer screen was unlocked and displayed confidential information. COTA F brought MDS Nurse E to the medication cart. MDS Nurse E confirmed she left the computer screen on the medication cart unlocked accidentally. MDS nurse E revealed it was important for the screen to be locked because of HIPAA reasons. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/17/2026 at 4 PM, the ADM revealed the laptop on the medication cart needed to be locked. She said the MDS Nurse E did not typically work on the floor so she may have forgotten. Record review of facility's policy titled, Resident rights, undated, revealed, Privacy and confidentiality -The resident has a right to personal privacy[.] 1. Personal privacy included accommodations, medical treatment [.] 3. The resident has a right to secure and confidential personal and medical records .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 6 residents (Residents #1) reviewed for assessments. The facility failed to ensure Resident #3's quarterly MDS assessment, dated 12/08/2025, reflected his diagnosis of colon cancer. These failures could place residents at risk for inadequate care due to inaccurate assessments.The findings included: Record review of Resident #3's admission record, dated 03/17/2026, reflected a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include gastrointestinal hemorrhage (GI bleeding). Colon cancer was not reflected as a diagnosis on his admission record. Record review of Resident #3's hospital documentation with admit date [DATE] reflected Resident #3 had a diagnosis of invasive colonic adenocarcinoma (cancer that originates in the glandular cells of the colon). Record review of Resident #3's quarterly MDS assessment, dated 12/08/2025, reflected Resident #3 had a BIMS score of 15 out of 15, indicating intact cognition. Colon cancer was not reflected as a diagnosis on his MDS assessment. Record review of Resident #3's care plan, undated, reflected no mention of Resident #3's diagnosis of colon cancer. During an interview on 03/17/2026 at 2:16 PM, Resident #3 revealed he went to chemotherapy because he had colon cancer. During an interview on 03/20/26 at 12:39 PM, the MDS Nurse E and the Reimbursement Consultant revealed Resident #3 came back to the facility on [DATE] with the diagnosis of stage 4 colon cancer. They revealed when a resident came to the facility, they reviewed pertinent documents in residents' medical records to see what diagnoses the residents had. Resident #3 went to the hospital on [DATE] for a GI (gastrointestinal) hemorrhage and that was when colon cancer was found. They revealed Resident #3 was currently on chemotherapy for palliative purposes. The Reimbursement Consultant revealed the DON reviewed medications and diagnoses in pertinent documents in residents' medical record and MDS Nurse E reviewed diagnoses to add to the MDS assessments. They revealed it was a team effort to catch any new diagnoses and that diagnoses were added to the MDS assessments and face sheets (admission records). They confirmed the diagnosis of colon cancer was not reflected on his MDS assessment. They revealed it was important to have the diagnosis on Resident #3's MDS assessment because the MDS assessments drove the care plans, which was important because cancer could affect resident care like the resident experiencing pain and staff needed to know about it. During an interview on 03/20/2026 at 04:02 PM, the DON and the ADM revealed they had to verify that colon cancer was not reflected as a diagnosis in Resident #3's MDS assessment, but it had to be there because he had colon cancer and the nurses had to be aware of it. Record review of facility's policy Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy, dated 08/2025, reflected The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who are family with his/her physical, mental, and psychosocial well-being. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and outside agencies.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and time frames to meet residents' medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 2 of 6 residents (Residents #3 and #16) reviewed for care plans. The facility failed to update Resident #3's care plan to reflect that Resident #3 had colon cancer and was going to chemotherapy after his 12/04/2025 re-admission.The facility failed to update Resident #16's care plan to reflect that Resident #16 had a negotiated risk agreement, dated 06/24/2025, to eat regular texture foods instead of mechanically soft texture diet as was prescribed by her doctor. This failure could place residents at risk of not having their needs met and not receiving appropriate care. The findings included: Record review of Resident #3's admission record, dated 03/17/2026, reflected a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include dementia (decline in cognitive functions (memory, reasoning, and thinking) which interferes with daily life) and gastrointestinal hemorrhage (GI bleeding). Record review of Resident #3's hospital documentation with admit date [DATE] reflected Resident #3 had a diagnosis of invasive colonic adenocarcinoma (cancer that originates in the glandular cells of the colon). Record review of Resident #3's quarterly MDS assessment, dated 12/08/2025, reflected Resident #3 had a BIMS score of 15 out of 15, indicating intact cognition. Colon cancer was not reflected as a diagnosis on his MDS assessment. Record review of Resident #3's care plan, undated, reflected no mention of Resident #3's diagnosis of colon cancer or going to chemotherapy. During an interview on 03/17/2026 at 2:16 PM, Resident #3 revealed he went to chemotherapy because he had colon cancer. During an interview on 03/20/2026 at 12:39 PM, the MDS Nurse E and the Reimbursement Consultant revealed Resident #3 came back to the facility on [DATE] with the diagnosis stage 4 colon cancer. They revealed it was important to have the diagnosis reflected on his care plans because cancer could affect his care like pain management and staff needed to know about it. They revealed CNAs used the Kardex (platform for CNAs to know how to care for residents) to care for residents and the care plan told nursing staff what interventions were CNA tasks. They revealed they had to manually add the diagnosis to the care plan. They further revealed the IDT and even charge nurses could help make sure the care plan was updated, but the task usually fell on the MDS Nurse. During an interview on 03/20/2026 at 04:02 PM, the DON and the ADM revealed Resident #3's cancer diagnosis should be in his care plan, so nurses were aware that he had cancer and knew any treatment that the nursing staff needed to complete. During an interview on 03/20/2026 at 04:21 PM, CNA A, CNA G, and CNA H revealed Resident #3 had cancer. They revealed Resident #3 went to chemotherapy and they knew when he came back that he was weaker and they had to help him more on those days. They revealed they looked at the Kardex for resident care which could include Resident #3's care when he went to chemotherapy. They were unaware if updated care plans affected the Kardex. 2. Record review of Resident #16's admission record, dated 03/20/2026, reflected a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include dysphagia (difficulty or discomfort in swallowing) Record review of Resident #16's admission MDS assessment, dated 02/10/2026, reflected Resident #16 had a BIMS score of 15 out of 15, indicating intact cognition. It reflected that she had no weight loss or weight gain in the last month or in the last 6 months. It further reflected that she had a mechanically altered diet (require change in texture of food or liquids). Record review of Resident #16's Negotiated Risk Agreement, dated 06/24/2025, that Resident #16 preferred to eat regular foods (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	even though she was at risk for aspiration (the accidental inhalation of food, liquid, or foreign materials into the airway and lungs). Record review of Resident #16's order summary report, dated 03/20/2026, reflected her diet was mechanical soft texture and not regular texture. Record review of Resident #16's care plan, accessed on 03/20/2026 at 12:06 PM, reflected the care plan did not address Resident #16's Negotiated Risk Agreement (NRA) and there was no mention that Resident #16 was allowed to eat a regular diet instead of mechanical soft diet. It further reflected [Resident #16] has a diet order other than Regular and is at risk for unplanned weight loss or gain., revised 03/09/2026. Interview, observation and record review on 03/20/2026 at 12:08 PM revealed Resident #16 received a lunch meal tray that was mechanically soft, as was reflected on her meal tray ticket. Resident #16 requested a meal that was regular diet. Nursing staff (name unknown) went back to the kitchen to get her a regular textured meal, and the kitchen said it was okay to give Resident #16 a regular diet lunch tray, and the nursing staff was not aware and said Resident #16's tray ticket showed she should be served a mechanical soft meal. Resident #16 revealed she was allowed to be served a regular diet. The Dietary Manager said Resident #16 was allowed a regular diet because Resident #16 had the right to request it and signed that she was aware she was prescribed a mechanical soft diet and not a regular diet. During an interview on 03/20/2026 at 12:18 PM, the ADM revealed Resident #16 had an NRA because she wanted to eat a regular diet instead of a mechanical soft diet (per her doctor's orders) when she chose to eat a regular diet because it was not all the time. She revealed she was not sure if a doctor's order needed to be in place to show that Resident #16 could have a regular diet instead of the mechanical soft diet at times, but she revealed the NRA did not need to be reflected in the doctor's orders. She revealed they had not updated the tray ticket to reflect it was okay for Resident #16 to have a regular diet. Interview on 03/20/26 at 01:03 PM, MDS Nurse E revealed Resident #16 chose not to follow her mechanical soft diet. She revealed Resident #16 had a Negotiated Risk Agreement because she wanted to eat a regular diet instead of a mechanical soft diet. She further revealed that should be in her care plan, so the staff knew it was okay for Resident #16 to have a regular diet because it was her preference and her right. Record review of the facility's policy Negotiated Risk Assessment, undated, reflected . 6. The resident centered care plan will need to be updated with any new or revised interventions as a result of the NRA Record review of the facility's policy Comprehensive Care Planning, undated, reflected The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care planning drives the type of care and services that a resident receives. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and the use of services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure incontinent care was provided in accordance with appropriate treatment and service practices to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Residents #3) reviewed for incontinent care and catheter care, in that: While providing incontinent care for Resident #3, CNA C did not clean Resident #3's lower abdomen area and the left and right groin areas. These deficient practices could place residents at-risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #3's face sheet, dated 03/19/2026, revealed an admission date of 08/18/2023 and, a readmission date of 12/04/2025 with diagnoses that included: Dementia (decline in cognitive abilities), Schizophrenia(mental disorder characterized by abnormal thought processes and an unstable mood) , Hyperlipidemia(Elevated level of any or all lipids(fat) in the blood) , Major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), Type 2 diabetes mellitus(high level of sugar in the blood) , Hypertension (High blood pressure) , Chronic kidney disease (gradual loss of kidney function). Record review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact, and was indicated to always be incontinent of bladder and frequently incontinent of bowel. Record review of Resident #3's care plan, dated 08/29/2023, revealed a problem of The resident has bowel incontinence and, and intervention of Provide pericare after each incontinent episode, Observation on 03/19/2026 at 12:35 p.m. revealed while providing incontinent care for Resident #3, CNA C did not clean Resident #3's lower abdomen area and the left and right groin areas. During an interview on 03/19/2026 at 12:48 p.m. with CNA C, she stated she did not clean Resident #3's lower abdomen area and the left and right groin areas. She said she was nervous and forgot. She stated she received incontinent care training within the year. During an interview with the DON on 03/20/2026 at 10:30 a.m., she stated that staff should clean residents' lower abdomen area and the left and right groin areas while providing incontinent care to ensure the residents were cleaned properly and prevent infection. She stated incontinent care training was provided annually and the staff skills we rechecked once a year. Record review of facility's policy titled Perineal care, dated 05/11/2022, revealed, wipe across the pubis area[.] continue perineal care to the scrotum and inner thigh .

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure a physician, physician assistant, nurse practitioner, or clinical nurse specialist provided orders for the resident's immediate care and needs for 2 of 6 residents (Resident #3 and Resident #5) reviewed for physician services. The facility failed to ensure Resident #5's RD recommendations, dated 02/27/2026, were signed by a doctor so that the facility could implement interventions for Resident #5's significant weight loss.The facility failed to ensure another doctor oversaw Resident #3's care when Dr. K did not provide clarification in a timely manner for the resident's pharmacy recommendations that he signed on 03/09/2026. These failures could place residents at risk for not receiving appropriate care per physician orders and required oversight by the physician and could place the residents at risk for harm and overall physical health decline.The findings included:Record review of Resident #5's admission record, dated 03/17/2026, reflected [AGE] year-old female initially admitted [DATE] and re-admitted [DATE]. Record review of Resident #5's quarterly MDS assessment, dated 02/27/2026, reflected a BIMS score of 09 out of 15, indicating moderate cognitive impairment. Record review of Resident #5's Nutritional Risk Assessment, dated 02/27/2026 and authored by the RD, reflected the resident had a significant weight loss of 9.1% (14.2 pounds) in 1 month but may be related to hospitalizations in Feb (2/3-2/7 & 2/20-2/24).[Resident #5] is also at risk for weight fluctuations r/t fluid fluctuations AEB BLE edema (swelling caused by excess fluid trapped in the body's tissues). and [Resident #5] on diuretic tx and Nutritional interventions were add house shakes BID and add weekly weights for 4 weeks to monitor. Record review of COMMUNICATION BETWEEN THE DIETITIAN AND THE ATTENDING PHYSICIAN, dated 02/27/2026, reflected Dr. K had not signed diet recommendations for Resident #5. Record review of Resident #5's weight summary prior to 02/03/2026 reflected the resident had stable weight from November 2025 to January 2026. 2. Record review of Resident #3's admission record, dated 03/17/2026, reflected a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include dementia (decline in cognitive functions (memory, reasoning, and thinking) which interferes with daily life) and Type 2 diabetes. Record review of Resident #3's quarterly MDS assessment, dated 12/08/2025, reflected Resident #3 had a BIMS score of 15 out of 15, indicating intact cognition. Record review of Resident #3's care plan, undated, reflected The resident has Diabetes Mellitus, initiated 08/28/2023, with intervention Diabetes medication as ordered by doctor. Record review of Resident #3's Medication Regimen Review, dated 02/25/2026, reflected Recommendation: Can we increased Januvia to 100mg and attempt to DC sliding scale in order to reduce needle sticks and medication burden for this resident authored by Pharmacist L. The review reflected Dr. K signed the medication regimen review on 03/09/2026 and responded yes if we need to do [unable to decipher words written] a c 6 M Record review of Resident #3's order summary report, dated 03/19/2026, reflected Januvia Oral Tablet (50 MG) Give 1 tablet by mouth one time a day. During an interview on 03/20/2026 at 10:13 AM, the DON and the Compliance Nurse revealed the pharmacy and RD recommendations were emailed to the DON and the DON or MDS Nurse sent them to the doctor to have them signed. The signed doctor's orders were sent back to the DON and the DON would input these orders in the residents' medical record. The Compliance Nurse revealed she had found a lot of doctor's orders that had not been signed yet and they had to resend them to the doctor to have them signed. They confirmed that they had not updated Resident #3's doctor's orders because they called Dr. K on 03/09/2026 for clarification on what his note said. They did not know what a c 6 M meant and they had not heard back from Dr. K. The Compliance Nurse revealed responses should take less than 3 days. The Compliance Nurse further revealed the RD recommendations, dated 02/27/2026, had not been signed yet and should have already been signed at this time. They revealed they had gone to the doctor's office in person to get recommendations signed by the doctors and had not gotten all of the recommendations signed yet. During an interview on 03/20/26 at 01:03 PM, the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026
NAME OF PROVIDER OR SUPPLIER Shiner Nursing and Rehabilitation Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1213 N Ave B Shiner, TX 77984	

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS Nurse E revealed there was a problem with the doctors' response times. She revealed if they sent recommendations for doctors to sign, sometimes the facility did not get the orders back. Corporate had had meetings with the doctors. She revealed these doctors had taken care of these residents for a lot of their lifetime, so the residents were [NAME] to those doctors. During an interview on 03/20/2026 at 03:36 PM, the RD revealed the doctors at the facility had always had a strong opinion whether to follow her recommendations or not and most of the doctors did not want to address her recommendations until they visited the facility. The RD revealed this had not affected the residents with significant weight losses or residents with wounds because the kitchen was able to put residents on a Red Glass and Fortified Food Program where the kitchen immediately provided fortified/enhanced foods to increase their nutrition. During an interview on 03/20/2026 at 04:09 PM, the ADM revealed it was difficult to get responses and support with the group of doctors at the facility. She revealed they had been working on improving the situation. She further revealed a lot of the residents at the facility wanted the current group of doctors so the facility would have to follow residents' rights in their selection of their doctor. During an interview on 03/20/2026 at 04:56 PM, the on-call nurse for the Medical Director of the facility did not have information about Resident #5's RD recommendations or Resident #3's pharmacy reviews. She revealed that the expectation for responding to the requested orders should be as soon as possible. An interview was attempted with Dr. K on 03/20/2026 at 04:59PM. A voicemail was left with no call back. Record review of the facility's policy Drug Regimen Review, dated 03/2025, reflected 4. Facility responsibility: To establish policies and procedures that address response timeframes for monthly DRR and procedures the pharmacist should take if immediate action is required. 7. The Consultant Pharmacist Drug Regimen Review reports are processed as follows: A. Drug Regimen Review recommends to physicians: The report is provided by the Consultant Pharmacist or facility to the Primary Physician and the Director of Nursing within seven working days of review, or according to facility policy. The physician provides a written response of the report to the facility within one month after the report is sent. A copy of the report is kept by the facility until the physicians' signed response is returned. The physician response is provided to the Consultant Pharmacist for review and then filed by the facility . Record review of the facility's policy Nutrition Care recommendations, dated 2012, reflected, .8. The form should be sent to the physician where he/she may use the far right column to accept or reject a recommendation. 9. The physician then signs the form and sends back to the facility. Record review of the facility's policy Physician Services, dated 2015, reflected Medical care of each resident must be supervised by a physician. The physician must visit based on a frequency noted below and must review the resident's total program of care, including medications and treatments, at each visit and write, sign and date progress notes. The paper orders may be sent and returned for Physician/Designee signature by U.S. Mail or hand carried. Also, all paper orders must be signed and dated. All electronic orders will electronically [be] signed by the physician. Physician's orders are completed and signed monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shiner Nursing and Rehabilitation Center Inc	1213 N Ave B Shiner, TX 77984

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls for 1 of 3 medication carts (medication cart #1) reviewed for medication storage. The facility failed to ensure medication cart #1 that was stationed right outside of the dining room, in the facility's entrance hallway, was locked when not in use. These failures could lead to residents having unintended access to medications and ingestion. The findings were: Observation and interview on 03/17/2026 at 11:46 AM revealed medication cart #1 (located right outside of the dining room, in the facility's entrance hallway) was unlocked (button where key was inserted to open the medication cart was popped out). There were no residents or visitors present. COTA F walked by the medication cart but turned around to get MDS Nurse E. MDS Nurse E confirmed the medication cart was unlocked and the narcotics that were in the medication cart #1 was in another container that was locked inside medication cart #1. She revealed it was important for the medication carts to be locked so no medication could be taken out by someone who did not know what they were doing. Interview on 03/17/2026 at 4 PM, the ADM revealed the medication carts should be locked when left unattended. She said the MDS Nurse E did not typically work on the floor so she may have forgotten.Record review of the facility's policy Medication Storage in the Facility, dated 03/2025, reflected Medications and biologicals are stored safely, securely, and properly.

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NAME OF PROVIDER OR SUPPLIER Shiner Nursing and Rehabilitation Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1213 N Ave B Shiner, TX 77984	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and were systematically organized, for 1 of 6 residents (Resident #3) reviewed for medical records. The facility failed to ensure Resident #3's admission record, care plan, and MDS assessment included his diagnosis of colon cancer since 12/04/2025. These failures could place residents at risk for inaccurate medical records. The findings included:Record review of Resident #3's admission record, dated 03/17/2026, reflected a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include dementia (decline in cognitive functions (memory, reasoning, and thinking) which interferes with daily life) and gastrointestinal hemorrhage (GI bleeding). Colon cancer was not reflected as a diagnosis on his admission record. Record review of Resident #3's hospital documentation with admit date [DATE] reflected Resident #3 had a diagnosis of invasive colonic adenocarcinoma (cancer that originates in the glandular cells of the colon). Record review of Resident #3's quarterly MDS assessment, dated 12/08/2025, reflected Resident #3 had a BIMS score of 15 out of 15, indicating intact cognition. Colon cancer was not reflected as a diagnosis on his MDS assessment. Record review of Resident #3's care plan, undated, reflected no mention of Resident #3's diagnosis of colon cancer or going to chemotherapy. During an interview on 03/17/2026 at 2:16 PM, Resident #3 revealed he went to chemotherapy because he had colon cancer. During an interview on 03/20/2026 at 12:39 PM, the MDS Nurse E and the Reimbursement Consultant revealed Resident #3 came back to the facility on [DATE] with the diagnosis stage 4 colon cancer. They revealed when a resident came to the facility, they reviewed pertinent documents in residents' medical records to see what diagnosis the residents had. Resident #3 went to the hospital on [DATE] for a GI (gastrointestinal) hemorrhage and that was when colon cancer was found. They revealed the colon cancer diagnosis was not reflected on Resident #3's face sheet (admission record). They revealed It was everybody's responsibility to add this diagnosis to Resident #3's face sheet, so it could pull to the MDS assessment, which drove the care plan. They further revealed the IDT can help make sure the face sheet was updated appropriately. During an interview on 03/20/2026 at 04:02 PM, the DON and the ADM revealed Resident #3's face sheet (admission record) should have the diagnosis of colon cancer because he was going to chemotherapy. During an interview on 03/20/2026 at 04:21 PM, CNA A, CNA G, and CNA H revealed Resident #3 had cancer. They revealed Resident #3 went to chemotherapy and they knew when he came back that he was weaker and they had to help him more on those days. Policy for Accuracy of Records was requested from the ADM on 03/20/2026 at 05:18 PM and not provided.