STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676000	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Health Care LLP	1620 US 59 N Livingston, TX 77351

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 - Few	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** 33460 Based on observations, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene for 1 of 18 residents (Resident #41) reviewed for ADLsS. The facility failed to ensure Resident #41's fingernails were trimmed. This failure could place the residents at risk of not receiving the care and services to maintain their highest level of physical, mental, and psycho-social well-being. Findings included: Record review of Resident #1's face sheet dated 03/25/25 indicated he was [AGE] years old, admitted on [DATE], and his diagnoses included diabetes (disease that results in too much sugar in the blood) and end stage kidney disease (kidney failure). Record review of Resident #41's quarterly MDS assessment dated [DATE] indicated a BIMS score of 13 which demonstrated he was cognitively intact. He required one person to assist with bathing and grooming. The section on behaviors indicated no refusal of care was noted. Record review of Resident #41's care plan dated 02/04/25 indicated he had an ADL self-care performance and required 1 staff for personal hygiene; assist as needed. During an interview and observation on 03/25/25 at 1:30 p.m., Resident #41 stated I asked someone to cut my finger nails a couple weeks ago and they never did cut my nails. He said he was unsure who he had asked. He raised his hands up and turned his hands over with palms up. Resident #41's fingernails had a thick dark brown substance on the underside of all the nails. Resident #41's fingernails extended passed the tips of his fingers approximately 1/4 inch to 3/4 inch. Four of his nails were jagged not smooth and all nails were unkempt. During an interview and observation on 03/25/25 at 2:00 p.m., the DON said the nurses were to perform nail care as needed for the residents with diabetes. She looked at Resident #41's fingernails and said they needed to be cleaned and cut to prevent infections. (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 - Few	During an interview on 03/25/25 at 2:15 p.m., RN A said she was responsible for nail care for Resident #41, and she said she would clean, and trim nails as needed. She said nail care was not on a certain day of the week. She said she was trained to perform care on the diabetic resident's fingernails to prevent injury. During an interview on 03/26/25 at 8:26 a.m., the Administrator said she expected the staff to follow the facility policy about nail care and assist the residents as need. Record review of the nail care policy dated 12/2024 indicated The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health.3. Routine cleaning and inspection of nails will be provided ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing. 5. b. Only licensed nurses shall trim or file fingernails of residents with diabetes. Procedure: . b. Fill wash basin with warm water. Soak hands/ feet in wash basin for 10 - 20 minutes. c. Gently clean underneath nails with orange stick.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36214 Based on observation, interview, and record review, the facility failed to ensure the resident maintained acceptable nutritional status, such as usual body weight or desirable body weight, unless the resident clinical condition demonstrated this was not possible for one of 18 residents (Resident #12) reviewed for nutritional status. The facility failed to identify Resident #12's significant weight loss over the previous 6 months. This failure could place residents at risk for not receiving care and services to maintain their highest practicable level of physical, mental, and psychosocial well-being. Findings included: Record review of a face sheet dated 03/26/25 indicated Resident #12 was an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), cognitive communication deficit (a communication difficulty arising from a cognitive impairment ultimately affecting an individual's ability to communicate),and dysphagia (difficulty swallowing foods and liquids, arising from the throat or esophagus). Record review of physician orders indicated Resident #12's dietary orders included: - 02/20/24: Regular diet with regular texture, thin/regular liquids consistency, and probiotic yogurt at breakfast. - 08/29/24: House shakes two times daily for malnutrition. Give with breakfast and dinner. Record review of Resident #12's monthly weight log indicated her weight on 10/11/24 was 155.2 pounds. Record review of Resident #12's monthly weight log indicated her weight on 11/08/24 was 143.0 pounds. Record review of Resident #12's monthly weight log indicated her weight on 10/11/24 was 155.2 pounds and 03/06/25 her weight was 138.0 pounds indicating a significant weight loss of 11.08% in six months. Record review of the most recent dietician note dated 11/27/24 and signed by the Dietician indicated Resident #12 had a weight loss of 11.51% in 180 days and she was on a regular diet and received house shakes twice daily. Dietician indicated she had talked with the resident's family member, and she felt weight loss was better with facility interventions. Family member assisted the Dietician in picking out food the resident would eat well from the menu. There was no documentation of physician notification of Resident #12's weight loss and no new interventions were put in place. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an annual MDS dated [DATE] indicated Resident #12 had a BIMS score of 0 indicating she had severe cognitive impairment, she was sometimes understood and sometimes understood others, she was dependent for all ADLs, and her weight was 142 pounds. Record review of physician orders indicated Resident #12's dietary orders included: 02/05/25: Magic cup (a special diet frozen dessert cup for adding calories and protein for those experiencing involuntary weight loss). Record review of a malnutrition risk evaluation dated 02/07/25 and signed by LVN C indicated Resident #12 was at risk for malnutrition. Record review of an undated care plan indicated Resident #12 was at risk for malnutrition related to cognition, Alzheimer's disease, and dysphagia. During an observation on 03/26/25 at 7:55 a.m., Resident #12 was sitting up in bed being fed breakfast by CNA E. CNA E repeatedly called Resident #12's name and asked her to wake up and eat. Resident #12 kept her eyes closed but was drinking the house shake offered by the CNA. The CNA said the resident never woke up and ate breakfast well, but she usually drank her house shake and ate less than 25%. She said the resident usually ate 50% or less of her lunch. She said the resident was always fed by a CNA or family and CNAs reported to the charge nurse when a resident ate 50% or less of their meal. During an interview on 03/26/25 at 7:55 a.m., LVN F said the CNAs notified her when the resident eats less than 50% of a meal. She said measures were put in place for Resident #12's weight loss included getting her up to eat in the dining room for lunch and dinner, health shakes, and magic cups. She said the resident usually ate better for her spouse when he visted, bu her usual intake was less than 50% of meals. During an interview on 03/26/25 at 8:10 a.m., the DON said she had put a quality assurance (QA) plan in place in January 2025 because weights were not being monitored consistently. She said she had closed the QA plan 03/21/25 because she was recording and monitoring all weights and running a monthly report which triggered if a resident had a significant loss. She said Resident #12's weights never triggered for significant loss. She said the Dietician also monitored all weights and had not notified her of Resident #12's significant weight loss. She said she would increase Resident #12's weights to weekly instead of monthly and consult the Dietician. She said possible negative outcome for not being aware of the resident's significant weight loss could be the resident continuing weight loss with no additional interventions put in place. During an interview on 03/26/25 at 9:17 a.m., LVN C said she had completed a malnutrition risk assessment for Resident #12 on 02/04/25 while completing her annual MDS. She said the resident triggered for low risk of malnutrition, and she contacted the resident's physician on 02/07/25 and received an order for magic cup three times daily with meals. She said she did not notify the dietician of the risk assessment results and did not notice a significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/25 at 11:05 a.m., the Dietician said she noticed Resident #12's significant weight loss while reviewing weights last week. She said she did not notify the DON of Resident #12's significant weight loss because she was still in the process of writing her reports and recommendations to the DON. She said she did not know that a significant weight loss should be reported immediately to the DON because this was her first job in long term care. She said after the DON's call regarding the resident's significant weight loss (after surveyor intervention) she had called Resident #12's family member and obtained consent to begin administration of an appetite stimulant medication. During an interview on 03/26/25 at 11:52 a.m., the Administrator said her expectations was for all weights to be monitored and interventions put in place to slow or stop weight loss. She said of a resident's current interventions were not working she expected the DON to consult the Dietician. She said failure to consult the Dietician could result in additional weight loss. Record review of a facility policy titled Weight Monitoring last revised 03/26/25 indicated . Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Weight analysis: The newly recorded weight should be compared to the previous recorded weight. A significant change in weight is defined as: a. 5% weight change in weight in 1 month (30 days). b. 7.5% change in weight in 3 months (90 days). c. 10% change in weight in 6 months (180 days).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22183 Based on observations, interviews, and record reviews the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs to each resident for 1 of 10 residents reviewed for medications. (Resident #111) The facility failed to ensure Resident #111 was not administered a saline IV flush before administration of an IV antibiotic, IV saline, and an IV heparin flush after medication administration (SASH-saline administer, saline heparin) without a physician's order. This failure could place residents at risk of consuming unprescribed medications, harm, and hospitalization . Findings included: Record review of Resident #111's face sheet indicated she was a [AGE] year-old-female admitted [DATE] with a diagnosis of pneumonia (an infection that inflames air sacs in the lungs which may fill with fluid). Record review of Resident #111's Physician orders dated 03/2025 indicated she was to receive antibiotic Azithromycin 500mg intravenously via midline IV catheter one time a day related to pneumonia starting on 03/22/2025 until 3/28/2025 and antibiotic Cefepime HCL 2gm intravenously two times a day related to pneumonia for 7 days. There were no orders for midline intravenous NS 0.9% 10 ml or Heparin 500 units/5 ml (100 units/ml) flushes. Record review of Resident #111's baseline care plan dated 03/21/25 indicated URI (upper respiratory infection)/pneumonia, Goal was to resolve the infection and interventions were to administer antibiotics as ordered. Record review of Resident #111's Admission MDS dated [DATE] was incomplete at this time due to required time frame of completion. Record review of Resident #111's Admission/Readmission Evaluation dated 03/21/25 indicated she received antibiotic therapy and intravenous infusion, and her cognition status was checked for oriented to person, place, self, situation, and time. Record review of Resident #111's March 2025 MAR indicated she received antibiotic Azithromycin 500mg intravenously one time a day at 8:00 a.m. until 03/28/25 with a start date of 03/22/25. There was no indication of the SASH IV flush. She received antibiotic Cefepime HCL 2gm intravenously two times a day for 7 days with a start date of 03/22/25 with no indication of the SASH IV flush. During an observation on 03/26/25 at 8:45 a.m., LVN B prepared and administered Cefepime HCL 2gm intravenously in NS 100 ml at 200 ml per hour to Resident #111. Prior to administration, LVN B flushed Resident #111's midline catheter with NS 0.9% 5 ml. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/26/25 at 9:30 a.m., after completion of Cefepime infusion, LVN B flushed Resident #111's midline catheter with NS 0.9% 5 ml followed by Heparin 50 units/5 ml (10 units/ml). During an interview and record review on 03/26/24 at 9:45 a.m., LVN B said Resident #111 did not have a physician order for flushing her midline and did not have the SASH midline catheter flushes documentation on the MAR. She said it should be. LVN B said the nurse who flushed the IV and administered the antibiotic was responsible for updating and obtaining physician orders to include the SASH into the computer system to show up on the MAR. LVN B said she was educated on following physician's orders, IV administration and documentation with the yearly check offs, sometime in the year 2024 she could not remember the exact date. She said the potential negative outcome of not having or following physician's order for SASH was a nurse may not flush the midline IV in the correct order and the midline IV lumen could clot and not be usable. During an interview on 03/26/25 at 2:04 p.m., the DON said the nurse administering medications intravenous was responsible for ensuring the physician order for SASH was in the computer system for all IV antibiotics before administering the medication and the DON was ultimately responsible for all medication administration. The DON said Resident #111's MAR should have included physician orders for SASH for her IV antibiotic and it was overlooked. The DON said any resident with an IV line was to have physician orders to administer SASH per facility protocol. She said the nursing staff were educated on the IV process and following physician orders during orientation and annually or as needed. The DON said the potential negative outcome of not following physician orders for SASH was a resident's IV line could potentially become occluded, and the line could go bad and cause pain to the resident by having to have a new IV line inserted. The DON said the expectation was for nurses to follow facility policy by obtaining physician orders for SASH and input IV SASH orders in the computer. Record Review of the facility's Physician's Orders policy dated January 2020 indicated, It is the policy of this facility that physician orders are maintained per state and federal regulations. 6. Medications, diets, therapy, or any treatment may not be administered to the patient without a written order from the attending physician. Record Review of the facility's Midline Catheter Flushing, Locking, Removal policy dated March 2025 indicated, Policy: It is the policy of this facility to ensure that midline catheters are flushed, locked, and removed consistent with current standards of practice . 1. The nurse will obtain and/or verify the physician's order for the type of IV solution or medication .3. Midline catheters will be flushed and aspirated for blood return prior to each infusion to assess catheter functionality and prevent complications .4. Midline catheters will be flushed after each infusion to clear infused medication from the lumen. 5. The catheter will be locked after the final flush to prevent catheter occlusion if used intermittently .7. The facility will use a flush such as a heparin flush solution or preservative-free normal saline solution to lock the catheter .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based observations, interviews, 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 diseases and infections for 1 of 18 (Resident #16) residents observed for infection control. The facility failed to ensure LVN B and LVN C followed the EBP (enhanced barrier precautions) for Resident #16. This failure could place the residents at risk of cross-contamination and the development of infection. Findings included: Record review of the face sheet dated 03/25/25 indicated Resident #16 was admitted on [DATE] and was an [AGE] year-old female with diagnoses of heart failure and peripheral vascular disease (blood flow to arms and legs is reduced). Record review of the admission MDS assessment dated [DATE] indicated Resident #16's BIMS score was 15, which demonstrated she was cognitively intact. She had 4 pressure ulcers and was receiving pressure ulcer/injury care. Record review of care plan dated 02/27/25 indicated Resident #16 had a pressure ulcer on 2 of her toes on her right foot. She had stage IV (full skin and tissue loss, exposing muscle, tendon cartilage, and high risk of infection) on the back of her right lower leg and the back of the left lower leg. During an observation on 03/25/25 at 10:00 a.m. to 10:20 a.m., there was an EBP sign on Resident #16's room door indicating Resident #16 was on EBP. LVN B performed treatment and LVN C assisted. LVN B and LVN C did not wear gowns while providing treatments to the back of Resident#16's legs. During an interview 03/25/25 at 10:21 a.m., LVN B and LVN C said they should have worn gowns and had been trained on EBP. They said we were nervous and just forgot. They said the gowns would have prevented spreading infections or soiling their own clothes. During an interview on 03/26/25 at 7:45 a.m., the DON said her expectation was for staff to wear gowns when in close contact with residents who were on EBP. She said when providing wound care to wounds, staff should use gowns and gloves for EBP to prevent spread of infections. During an interview on 03/26/25 at 8:26 a.m., the Administrator said she expected the staff to follow policy and regulations about EBP to decrease infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Enhanced Barrier Precautions dated 12/24 indicated Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 33460 Based on observations, interviews, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 laundry room reviewed for essential equipment. The facility did not ensure 1 of 2 washing machines (right washing machine) and 2 of 3 dryers (middle and right dryer) were in safe operating condition. This failure could place the residents at risk of a fire and not receiving their clothes in a timely manner. Findings included: During an observation of the laundry room on 03/26/25 at 12:00 p.m., the washers were washing clothes. One of the 2 washers were missing the cover which left the wiring exposed by the handle of the door. Laundry Staff D said the cover was on top of the washer since it was fixed about a year ago. Two of the 3 dryers had the top cover propped open which exposed the pilot light and the gas burner. The dryers were drying clothes. Laundry Staff D stated, We opened to get heat in the laundry room because it was cold, and the middle dryer needed extra air to keep working. She said the cover should be closed to prevent possible fires. During observation and interview on 03/26/25 at 12:15 p.m., the Laundry Supervisor said she expected the dryer covers up top to be closed to prevent possible accidents. She said the laundry staff should make sure service panels stay closed. During observation and interview on 03/26/25 at 12:25 p.m., the Maintenance Supervisor said the equipment in the laundry should have the covers on and it had been a while since the washer cover plate off. He said he was responsible to put plate back if repair man left it off. He said if the laundry staff was too cold, they can adjust temperature. The Maintenance Supervisor pointed towards the wall in the laundry room at the thermostat and said it is right here. During an interview on 03/26/25 at 12:30 p.m., the Administrator said she was not sure why the service panels were open, and the washer cover was off. She wanted the services covers to be on and closed. She said to prevent accidents, and no accidents had happened yet. Record review of the policy titled Risks of Hazards dated 10/2024 indicated Policy: It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 2. Maintain all essential mechanical, electrical and patient care equipment in safe operating condition.