| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676000 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Pine Ridge Health Care LLP | 1620 US 59 N<br>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) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 2 residents with IV (intravenous) lines (Resident #75) and 1 of 2 staff performing fingerstick blood sugar checks (RN F) reviewed for infection control. *The facility did not initiate Enhanced Barrier Precautions (EBP) and ensure staff wore appropriate PPE when providing care on Resident #75 with a midline IV. *The facility did not ensure glucometers were disinfected with the appropriate EPA approved disinfectant by RN F. This failure could place residents at risk for cross contamination and the spread of infection. Findings included: 1. Record review of Physician Orders for May 2026 indicated Resident #75 was a [AGE] year-old male admitted on [DATE]. His diagnoses included chronic obstructive pyelonephritis (a condition where the kidneys become inflamed due to repeated urinary tract infections leading to scarring of the kidneys and symptoms like fever and pain in the back) and urinary tract infection (UTI) (an infection in the kidneys, ureters, bladder, or urethra). Resident #75 had an order on 05/14/26 for Ertapenem Sodium Injection Solution Reconstituted 1Gm intravenously every 24 hours related to UTI until 05/21/26. There was no order for Enhanced Barrier Precautions. Record review of the May 2026 MAR indicated Resident #75's Ertapenem Sodium Injection Solution Reconstituted 1Gm intravenously was initiated on 05/14/26. There was no indication of Enhanced Barrier Precautions. During an observation on 05/18/26 at 10:52 a.m., Resident #75 was in bed. Resident #75 had an IV PICC line (a long, thin tube inserted through a vein in the arm to allow access to the upper large central vein near the heart) to RUE with dressing dated 05/12/26. There was no EBP sign or set up outside of the resident's room. During an observation and interview on 05/19/26 at 8:20 a.m., there was no EBP sign or set up outside of Resident #75's room. CNA G observed entering the room to provide direct patient care to Resident #75 but no PPE was applied. CNA G said Resident #75 was not in any isolation. During an observation on 05/19/26 at 04:40 p.m., RN F provided IV antibiotic administration on Resident #75 who had a PICC line IV. There was no EBP sign or set up outside the resident's door. RN F did not put on PPE except gloves when administering the antibiotic through the IV. RN F said Resident #75 actually had a midline IV (inserted into peripheral veins of the upper arm with the tip located near the armpit) and not a PICC line. She said she would not have done anything different. During an interview on 05/20/26 at 08:50 a.m. LVN H said EBP signage and set up were to be put into place for residents with indwelling devices. She said a resident with a PICC line or midline IV should have EBP set up. She said Resident #75 should have EBP set up because he had a midline IV. During an interview on 05/20/26 at 10:30 a.m., the Administrator and DON said EBP signage and set up was to be put into place with residents who had a PICC line or midline IV. The DON said it must have been overlooked on Resident #75. They said any resident with an indwelling medical device should have EBP in place due to them being at higher risk for exposure to infections. Record review of an Enhanced Barrier Precautions policy revised 12/2024 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<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | sign to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.Policy Explanation and Compliance Guidelines:.2. Initiation of Enhanced Barrier Precautions: .b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO.10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 2. Record review of the Physician Orders for May 2026 indicated Resident #10 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). Resident #10 had an order dated 04/03/26 to check blood sugar before meals and at bedtime. During an observation and interview on 05/19/26 at 04:54 p.m. RN F conducted finger stick blood sugar on Resident #10. No insulin was required. RN F then cleaned the glucometer with alcohol pads. She said she could use the alcohol wipes and clean for 2 minutes. She said the alcohol pads were a disinfectant. During an interview on 05/19/26 at 05:20 p.m., the DON said alcohol pads were not an approved disinfectant to use on the glucometers. She said they could be used to clean the glucometers but then the disinfectant wipes provided should be used to disinfect the glucometers, She said if the glucometers were not cleaned and disinfected appropriately blood borne pathogens could be transmitted to another resident. During an interview on 05/20/26 at 10:30 a.m., the Administrator said she expected nurses to clean/disinfect the equipment with the appropriate wipes. Record review of a Glucometer Disinfection policy revised 05/20/26 indicated Policy: The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Definitions:.Disinfection is a process that eliminates many or all pathogenic microorganisms, except bacterial spores on inanimate objects. Policy Explanation and Compliance Guidelines: 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use for multi-resident use. 2. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C, and Hepatitis B virus. 3. Glucometers will be cleaned and disinfected after each use and according to regardless of whether they are intended for single resident or multiple resident use. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep all essential equipment working safely.<br><br>Based on observation, interview, and record review, the facility failed to maintain all mechanical and electrical equipment in safe operating condition for 1 of 1 facility kitchen. The vegetable freezer had accumulation of ice build-up with damaged and worn freezer door seals. This failure had the potential to affect residents by placing them at risk for food borne illness.Findings An observation of the vegetable freezer and interview on 05/18/2026 at 9:45 a.m., indicated the temperature was 20 degrees Fahrenheit. The vegetable freezer had excessive amount of ice built-up around the bottoms of door 1 and door 2 and both door seals were worn and torn. The vegetable freezer contained 1 bag of vegetable blend garden on the right top shelf which was soft to touch (defrosting - not frozen solid) and 1 bag of creamy tomato soup which was soft (defrosting - not frozen solid) and a package of buns (soft - not frozen solid). There was a 1/8 inch thick, 6-inches long sheet of ice at the bottom of both freezer doors and on the ceiling of the freezer were multiple frozen water drops. The vegetable freezer had a signage Make sure the doors close after opening. The vegetable freezer had water dripping down the front from around door 1 and 2 bottom seals. The DM said he reported to the maintenance department about a month ago that the vegetable freezer's door seals needed to be replaced but did not have any evidence that a requisition had been made for the repairs needed. During an observation of the vegetable freezer and interview on 05/18/2026 at 11:15 a.m., the temperature was 20 degrees Fahrenheit. The vegetable freezer had excessive amount of ice built-up around the bottoms of door 1 and door 2 and both door seals were worn and torn. The vegetable freezer contained 1 bag of vegetable blend garden on right top shelf which was soft to touch (defrosting - not frozen solid) and 1 bag of creamy tomato soup which was soft (defrosting - not frozen solid) and a package of buns (soft - not frozen solid). There was a 1/8 inch thick, 6-inches long sheet of ice at the bottom of both freezer doors and on the ceiling of the freezer were multiple frozen water drops. The vegetable freezer had a signage Make sure the doors close after opening. The vegetable freezer had water dripping down the front from around door 1 and 2 bottom seals. The DM said he thinks the freezer door may have been left ajar causing the ice build-up and defrosting - not frozen solid foods. During an observation of the vegetable freezer and interview on 05/18/2026 at 2:30 p.m., the temperature was 20 degrees Fahrenheit. The vegetable freezer had excessive amount of ice built-up around the bottoms of door 1 and door 2 and both door seals were worn and torn. There was a 1/8 inch thick, 6-inches long sheet of ice at the bottom of both freezer doors and on the ceiling of the freezer were multiple frozen water drops. The vegetable freezer had water dripping down the front from around door 1 and 2 bottom seals. The MS said he was not aware that the freezer door seals on the vegetable freezer were needing to be replaced. The MS said the water dripping from the door seal was the freezer cycling through a defrost cycle causing the dripping water. The MS said the ice buildup and defrosting food could be related to the damaged door seals and he would replace them. The MS said he replaced the other vegetable freezer door seal about a month ago for a similar concern. During an interview on 05/18/2026 at 4:30 p.m., the DM said that his boss came and toured the kitchen and assessed the vegetable freezer and instructed him to dispose of all the foods that were not frozen solid, so he disposed of approximately $2,000 worth of frozen foods. The DM said if the residents consumed the defrosted or freezer burnt foods it could cause them to become sick. During an interview on 05/18/2026 at 4:45 p.m., the Administrator said that when the DM informed her the vegetable freezer had ice accumulation, defrosting vegetables, and worn and torn door seals, she toured and assessed the vegetable freezer and instructed the DM to dispose of all the foods in the vegetable freezer that were not frozen solid to prevent residents from becoming sick from consuming foods that were defrosted improperly or freezer burnt. She said if the residents consumed the freezer burnt or improperly defrosted food it could cause a widespread facility sickness, so she had the DM dispose of all the food in the vegetable freezer that was not frozen solid. She said she would rather replace the food than have a facility wide sickness. During an observation of the vegetable freezer<br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and interview on 05/19/2026 at 11:45 a.m., the temperature was -2 degrees. No bagged vegetables, soup or buns were observed in the vegetable freezer. The vegetable freezer had no ice buildup noted at door seals and no leaking water observed from the lower door seals. The DM said he removed, disposed of affected vegetable, cleaned the freezer and the MS had replaced the door seals and the temperature was below freezing and no new ice accumulation had been observed. The DM said he would be monitoring the vegetable freezer for temperature control and ice accumulation. Record reviews of the maintenance logs for April and May 2026 indicated no entry to service the vegetable freezer or replace the door seals. Review of the facility's policy Preventive maintenance program dated 05/18/2026 indicated: Policy: A preventive maintenance program shall be developed and implemented to ensure the provision of a safe functional sanitary and comfortable environment for residents, staff, and the public. Policy explanation and compliance guidance: 1. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 2. The Maintenance Director shall assess all aspects of the physical plant to determine if Preventive Management (PM) is required. Required PM may be determined from manufacturers' recommendations, maintenance requests, grand rounds, life safety requirements, or experience. 3. If preventive maintenance is required, the Maintenance Director shall decide what tasks need to be completed and how often to complete them. 4. The Maintenance Director shall develop a calendar to assist with keeping track of all tasks. 5. Maintenance requests (for building, equipment, pest, life safety, grounds of facility, other issues) must be communicated in the maintenance book (located at nurse station). Maintenance books have tabs labels to find the area that needs maintenance. 6. Documentation shall be completed for all tasks and kept in the Maintenance Director's office. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the services provided met professional standards of quality, for 1 of 2 residents (Resident #76) reviewed for PICC line/midline. *The facility did not ensure LVN B used the appropriate size syringe for the Heparin flush to flush Resident #76's midline. This failure could place residents at risk of increased pressure in the PICC line/midline which can cause catheter damage. Findings included: Record review of a face sheet dated 05/20/26 indicated Resident #76 was a [AGE] year-old male admitted on [DATE]. His diagnoses included cellulitis (bacterial infection of the skin) of left lower leg, chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), hypertensive heart disease (heart problems that arise due to prolonged high blood pressure), and hyperlipidemia (abnormally high levels of fats (lipids) in the blood). Record review of Physician Orders for May 2026 indicated Resident #76 had an order dated 05/15/26 to flush midline (IV inserted into veins of the upper arm with the tip located near the armpit) with SASH (saline flush, antibiotic administration, saline flush, heparin flush (a small amount of a blood thinner used to keep an IV line open so it won't get blocked by blood clots) every shift and as needed; an order dated 05/14/26 for Zosyn Intravenous Solution 3-0.375 Gm/50 ml (Piperacillin Sodium-Tazobactam Sodium in Dextrose) intravenously three times a day; and an order dated 05/19/26 for Vancomycin in Normal Saline Intravenous Solution 1.5-0.9 Gm/250 ml (Vancomycin-Sodium Chloride) intravenously one time a day. Record review of the admission MDS dated [DATE] indicated Resident #76's was still in process.Record review of the Care Plan dated 05/20/26 indicated Resident #76 received IV therapy with goal of will have not have any complications related to IV therapy through the review.During an observation on 05/19/26 at 09:58 a.m., LVN B was removing Resident #76's completed IV antibiotic. LVN B flushed the midline with saline in a 10 ml syringe. LVN B then had a Heparin lock flush 10 U/5 ml in a 5 ml syringe. During an observation and interview on 05/19/26 at 05:00 p.m., RN F was removing a completed IV antibiotic. RN F was using a Heparin lock flush 10 U/5 ml in a 10 ml syringe. RN F said Heparin in a 10ml syringe was always to be used to flush a PICC line, midline, or central line IV. RN F said if a smaller syringe was used it could cause the tip of the catheter to rupture and could release small pieces of the catheter into the blood vessel. RN F said since the end of the catheter was near the heart the pieces could go into the heart and cause complications such as infection. During an interview on 05/19/26 at 05:20 p.m., the DON said she did not realize they had the Heparin flush in a 5 ml syringe for the midline IV lines. She said the tip could rupture and go into the heart. During an interview on 05/20/26 at 01:18 p.m., LVN B said she should have used a 10 ml syringe with the heparin. She said not using a 10 ml could cause the tip of the line to blow out. She said she received training on IVs last year. Record review of a Certificate of Successful Completion indicated LVN B received Management of Central Lines: Current Standards of Practice 4.0 contact hours on 06/27/25. Record review of the Central Venous Access Catheter Flushing, Locking, Removal policy revised 03/27/25 indicated Policy: It is the policy of this facility to ensure central venous access catheters are flushed, locked, and removed with current standards of practice.Compliance Guidelines:.8. Syringes no smaller than 10 ml should be used when assessing patency (the condition of being open) to avoid catheter damage. According to the Texas Board of Nursing Rules 22 TAC S217.11, Standards of Nursing Practice accessed on 05/20/26 at https://www.bon.texas.gov/:Two standards applicable in all practice scenarios include: S217.11(1)(B) Implement measures to promote a safe environment for clients andothers, and S217.11(1)(T) Accept only those nursing assignments that take into considerationclient safety and that are commensurate with the nurse's educational preparation,experience, knowledge, and physical and emotional ability.Additional standards in 22 TAC S217.11 that may be applicable when an LVN chooses to engage in an IV therapy related task include (but are not limited to): (1)(C) Know the rationale for and the effects of medications and treatments andcorrectly administer the same. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer parenteral fluids consistent in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, for 1 of 2 (Resident #76) residents reviewed for IV (intravenous: administering fluids or medications directly into a vein) fluids. *The facility did not ensure LVN B used the appropriate size syringe for the Heparin flush to flush Resident #76's midline. This failure could place residents at risk of increased pressure in the PICC line/midline which can cause catheter damage. Findings included: Record review of a face sheet dated 05/20/26 indicated Resident #76 was a [AGE] year-old male admitted on [DATE]. His diagnoses included cellulitis (bacterial infection of the skin) of left lower leg, chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), hypertensive heart disease (heart problems that arise due to prolonged high blood pressure), and hyperlipidemia (abnormally high levels of fats (lipids) in the blood). Record review of Physician Orders for May 2026 indicated Resident #76 had an order dated 05/15/26 to flush midline (IV inserted into veins of the upper arm with the tip located near the armpit) with SASH (saline flush, antibiotic administration, saline flush, heparin flush (a small amount of a blood thinner used to keep an IV line open so it won't get blocked by blood clots) every shift and as needed; an order dated 05/14/26 for Zosyn Intravenous Solution 3-0.375 Gm/50 ml (Piperacillin Sodium-Tazobactam Sodium in Dextrose) intravenously three times a day; and an order dated 05/19/26 for Vancomycin in Normal Saline Intravenous Solution 1.5-0.9 Gm/250 ml (Vancomycin-Sodium Chloride) intravenously one time a day. Record review of the admission MDS dated [DATE] indicated Resident #76's was still in process. Record review of the Care Plan dated 05/20/26 indicated Resident #76 received IV therapy with goal of will have not have any complications related to IV therapy through the review. During an observation on 05/19/26 at 09:58 a.m., LVN B was removing Resident #76's completed IV antibiotic. LVN B flushed the midline with saline in a 10 ml syringe. LVN B then had a Heparin lock flush 10 U/5 ml in a 5 ml syringe. During an observation and interview on 05/19/26 at 05:00 p.m., RN F was removing a completed IV antibiotic. RN F was using a Heparin lock flush 10 U/5 ml in a 10 ml syringe. RN F said Heparin in a 10ml syringe was always to be used to flush a PICC line, midline, or central line IV. RN F said if a smaller syringe was used it could cause the tip of the catheter to rupture and could release small pieces of the catheter into the blood vessel. RN F said since the end of the catheter was near the heart the pieces could go into the heart and cause complications such as infection. During an interview on 05/19/26 at 05:20 p.m., the DON said she did not realize they had the Heparin flush in a 5 ml syringe for the midline IV lines. She said the tip could rupture and go into the heart. During an interview on 05/20/26 at 01:18 p.m., LVN B said she should have used a 10 ml syringe with the heparin. She said not using a 10 ml could cause the tip of the line to blow out. She said she received training on IVs last year. Record review of a Certificate of Successful Completion indicated LVN B received Management of Central Lines: Current Standards of Practice 4.0 contact hours on 06/27/25. Record review of the Central Venous Access Catheter Flushing, Locking, Removal policy revised 03/27/25 indicated Policy: It is the policy of this facility to ensure central venous access catheters are flushed, locked, and removed with current standards of practice.Compliance Guidelines:.8. Syringes no smaller than 10 ml should be used when assessing patency (the condition of being open) to avoid catheter damage. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 7 residents (Resident #46) reviewed for respiratory therapy. The facility failed to keep the oxygen concentrator filter clean for Resident #46. This failure could place residents at risk of receiving incorrect or inadequate oxygen support which could result in a decline in health. Findings included: 1. Record review of Resident #46's face sheet dated 05/18/2026, indicated she was a [AGE] year-old female readmitted on [DATE] with a diagnosis of chronic obstructive pulmonary disease (group of progressive lung disease that cause restricted airflow and breathing difficulties) and heart failure (condition in which the heart does not pump blood as well as it should). Record review of Resident #46's most recent significant change MDS assessment dated [DATE] indicated she had a BIMS score of 13 which indicated intact cognition. The assessment indicated medical diagnoses of chronic obstructive pulmonary disease and heart failure and received oxygen therapy while a resident of this facility and within the last 14 days of the look back period. Record review of Resident #46's care plan with a target date of 06/19/2026 indicated she had altered respiratory status related to chronic obstructive pulmonary disease and oxygen therapy with interventions including oxygen therapy, give oxygen as ordered by the physician. Record review of Resident #46's Physicians Order Summary dated 05/18/2026 indicated she was prescribed *oxygen at 2 liters per nasal canula (a thin flexible tube that delivers supplemental oxygen through your nose) for shortness of breath with a start date of 12/17/2025 and change oxygen tubing weekly and check filter every week wash/ replace as needed every Sunday night shift with a start date of 04/23/2026. Record review of Resident #46's Medication Administration Record dated 05/19/2026 indicated change oxygen tubing weekly and check filter weekly, wash/ replace as needed with a start date of 04/22/2025 and initiated as checked by RN E on 05/17/2026. During an observation and interview on 05/18/2026 at 10:45 a.m., Resident #46 was lying in bed with oxygen per nasal canula set at 2 liters/minute to an oxygen concentrator with a black filter on the side soiled with a thick grayish/ white powdery substance. Resident #46 said she wore her oxygen all the time. During an observation and interview on 05/19/2026 at 4:30 p.m., Resident #46 was lying in bed with oxygen per nasal canula set at 2 liters/minute to an oxygen concentrator with a black filter on the side soiled with a thick grayish/ white powdery substance. Resident #46 said she wore her oxygen all the time and the staff changed the oxygen tubing at night sometimes and probably cleaned the filters then. During an observation and interview on 05/19/2026 at 4:32 p.m., with LVN C she said she was providing care for Resident #46 today (05/19/2026). She checked Resident #46's oxygen concentrator filter and removed it. She said it should have been cleaned before now. LVN C said the night shift nurses were responsible for ensuring the oxygen concentrator filters were clean when they changed the oxygen concentrator tubing. She said the day shift nurses were the back up to double check and ensure the oxygen concentrator filters were cleaned. LVN C said she did not check the oxygen concentrator filters but would from now on. She said the oxygen concentrator filter was overlooked. LVN C said she was educated on hire to check the oxygen concentrator filters and ensure they were cleaned. She said the potential resident risk was infection. During an interview on 5/19/2026 at 4:44 p.m., the ADON said the nurses that worked Sunday nights were responsible for ensuring the oxygen concentrator filters were cleaned, and the DON and ADON did spot checks on Monday mornings to ensure the filters were clean. She said Resident #46's oxygen concentrator filter was overlooked. The ADON said all staff were educated to ensure the oxygen concentrator filters were cleaned. She said resident risk was potentially not getting the correct air flow for the oxygen concentrator to work properly. During an interview on 5/19/2026 at 4:48 p.m., the DON said the nurses that worked Sunday nights were responsible for<br>(continued on next page) |

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| Pine Ridge Health Care LLP | 1620 US 59 N<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | ensuring the oxygen concentrator filters were cleaned, and the UM, ADON and DON spot check to ensure the oxygen concentrator filters were clean. She said she changed all the oxygen concentrators' filters out a month ago. The DON said Resident #46's oxygen concentrator filter was overlooked. She said the staff were educated to ensure all oxygen concentrator filters were cleaned as needed. The DON said the resident risk of soiled oxygen concentrator filters was the resident potentially not getting the correct oxygen concentration. The DON said her expectation was all oxygen concentrator filters cleaned weekly on Sunday nights with the oxygen tubing changes. During an interview on 5/19/2026 at 5:00 p.m., the Administrator said the night nurses were responsible for ensuring all concentrator filters were cleaned weekly and the UM, ADON, and DON did random checks to ensure the concentrator filters were cleaned. She said the nurses were educated to ensure the oxygen concentrator filters were cleaned. The Administrator said the resident risk was minimal; a soiled oxygen concentrator filter could potentially decrease air flow to the oxygen concentrator. She said her expectation was all oxygen concentrators were inspected, cleaned and filters replaced timely. During an interview on 5/20/2026 at 7:55 a.m., RN E said she worked Sunday night (05/17/2026) and was responsible for cleaning Resident #46's oxygen concentrator filter. She said the night was very busy and she overlooked it. RN E said the UM, ADON, and DON were the back up to ensure all oxygen concentrator filters were cleaned. She said she was educated to ensure the oxygen concentrator filters were cleaned Sunday night along with oxygen tubing changes. RN E said the potential resident risk of a soiled oxygen concentrator filter was infection or breathing difficulty.<br>During an interview on 5/20/2026 at 10:09 a.m., the UM said the nurse that worked Sunday night was responsible for changing the oxygen tubing and cleaning oxygen concentrator filters. She said all the nurses were educated on cleaning oxygen concentrator filters. The UM said herself, the ADON, and DON did spot checks to ensure the oxygen concentrator filters were cleaned. She said Resident #46's oxygen concentrator filter was overlooked. The UM said the potential resident risk of a soiled oxygen concentrator filter was that the resident may not get the accurate flow of concentrated oxygen.<br>Record Review of a facility policy dated 03/28/2025, titled, Oxygen Concentrator indicated, . 1. Staff responsible for the use and care of oxygen concentrators receive training on oxygen safety and the functionality of the device.a. Follow manufacturer recommendations for the frequency of cleaning filters and servicing the device. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676000 | A. Building<br>B. Wing | 05/20/2026 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications for 1 of 23 residents (Resident #57) reviewed for unnecessary medications. The facility did not monitor Resident #57's Eliquis (blood thinner) medication for side effects. This failure could place residents at risk for unintended, harmful events attributed to the use of medication without monitoring for side effects.Findings included: Record review of a face sheet dated 05/18/2026 indicated Resident #57 was an [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Her diagnoses included chronic embolism (a piece of a clot breaks off and travels and lodges in a different vessel) and thrombosis of deep veins (formation of blood clots within a vessel) and peripheral vascular disease (slow and progressive circulation disorder causing narrowing, blockage or spasm in the blood vessels). Record review of a physician order for Resident #57 dated 05/18/2026 indicated she was prescribed Eliquis 5 mg two times a day for peripheral vascular disease with a start date of 08/05/25. Record review of Resident #57's quarterly MDS assessment dated [DATE] indicated she was severely impaired of cognition with diagnosis of chronic embolism and thrombosis of deep veins and peripheral vascular disease. The assessment indicated she was taking an anticoagulation medication during the lookback period. Record review of the electronic record of Resident #57 from 01/30/2026 to 05/19/2026 did not indicate monitoring for side effects of the anticoagulant medication Eliquis. Record review of the Medication Administration Record of Resident #57 dated 05/19/2026 indicated she received Eliquis 5 mg two times a day for peripheral vascular disease with a start date of 08/04/2025. Record review of Resident #57's care plan with a target date of 09/04/2026 indicated she had a high-risk drug use of anticoagulant medication with interventions including observation for bleeding, and side effects of Eliquis. During an observation on 05/18/2026 at 11:20 a.m., Resident #57 was sitting in a wheelchair confused and unable to answer questions. She had no observed bruising or bleeding. During an interview on 05/20/26 at 9:30 a.m., LVN B said she was providing care for Resident #57 today (05/20/2026). She said Resident #57 received Eliquis twice a day that was given by MA D and should be monitored for side effects. LVN B said Resident #57 was not being monitored in the computer system for side effects of her anticoagulant medication but would add it immediately. She said the nurse putting the order in the system was responsible for adding side effect monitoring and the DON, ADON and UM were the back up to ensure all anticoagulant medications were monitored for side effects in the computer system. She said Resident #57's anticoagulant was overlooked. LVN B said the nurses and MAs were educated to monitor anticoagulant medication for side effects. She said the resident risk of side effects not monitored in the computer system for anticoagulant medication was potential side effects including bleeding. During an interview on 05/20/26 at 9:45 a.m., the ADON said the nurse receiving the order for an anticoagulant medication was responsible for adding the monitoring into the computer system. During the care plan meeting the MDS nurse with the ADON, UM or DON depending on the resident status would check the charts and ensure monitoring was added into the computer system during the chart audit. She said a month or so ago the facility changed the monitoring for side effects out of the Task system and added monitoring into the Medication Administration Record for monitoring and Resident #57's side effect monitoring was removed from the task system but not added into the medication administration record part of the computer system, and it was overlooked. The ADON said nurses and MAs were educated to ensure all anticoagulant medications were monitored for side effects. She said the resident risk of the side effect monitoring not being completed was potential for bruising. During an interview on 05/20/26 at 10:08 a.m., MA D said she gave Resident #57 her Eliquis this morning and she did not have any bleeding side effects. She said the computer does not ask her about side effects of anticoagulants but if she sees a side effect she reports it to the nurse. MA D said the nurses were responsible for documenting side effects<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | in the computer system. She said she was educated to monitor residents on anticoagulant medication for side effects. MA D said the resident risk of not monitoring a resident on anticoagulant medication was the potential for bleeding. During an interview on 05/20/26 at 10:14 a.m., the UM said the nurse admitting the resident was responsible for adding the monitoring to the computer system. She said she was responsible for auditing all new admission and readmission charts to ensure monitoring for side effects was added to the computer system. The UM said Resident #57's side effect monitoring was overlooked during changeover of monitoring out of the TASK area into the other system that added it to the Medication Administration Record for monitoring. She said the nurses and MAs were educated to monitor anticoagulants for side effects and document it. The UM said the resident risk of not monitoring of side effects for anti-coagulant medication was a potential for bleeding. During an interview on 05/20/26 at 10:18 a.m., MDS nurse A said the nurses were responsible for adding monitoring for side effects into the computer system and during the care plan meeting the UM, ADON and DON go over the chart and ensure monitoring was added for all anticoagulant medication. She said Resident #57 was overlooked. MDS Nurse A said the resident risk of not monitoring for side effects in the computer system was potential for increased bruising or bleeding. During an interview on 05/20/26 at 10:25 a.m., the DON said the nurse receiving the order for an anticoagulant medication was responsible for adding side effect monitoring into the computer system and UM checked all new admissions to ensure the side effect monitoring was added. She said during the care plan meeting the MDS nurse, ADON, UM and DON spot checked the orders to ensure side effect monitoring was added into the computer system. The DON said the monitoring was originally under the TASK section of the computer system but was recently removed from TASK and moved into the other section that came out in the Medication Administration Record section. She said Resident #57's monitoring was overlooked. The DON said the nurses were educated to ensure monitoring of side effects was added to the computer system for all anticoagulants. She said the resident risk of not adding side effect monitoring for anticoagulant medications into the computer system was potential for increased bleeding. The DON said her expectation was all anticoagulant medications monitored for side effects and documented in orders. She said Resident #57 should have been monitored for side effects but was care planned for monitoring of side effects. During an interview on 05/20/26 at 10:30 a.m., the Administrator said the nurses were responsible for adding monitoring for side effects into the computer system and the UM, ADON and DON were the back up to ensure the anticoagulant medication was monitored for side effects. She said the nurses were educated to add monitoring into the computer system for anticoagulant medication. The Administrator said Resident #57's anticoagulant medication monitoring for side effects was overlooked during the changeover of monitoring documented under TASK section to monitoring being documented into the Medication Administration Record section of the computer system. She said the resident risk was minimal, a resident could have a side effect. The Administrator said her expectation was all medication needing monitoring to be monitored. Review of a facility policy titled High Risk Medications - Anticoagulants revised 03/20/2025 indicated the following. This facility recognizes that medications, including anticoagulants, are associated with greater risk of adverse consequences than other medications. This policy addresses the facility's collaborative, systematic approach to managing anticoagulant therapy for efficacy and safety.4. The resident's plan of care shall alert staff to monitor for adverse consequences/ Risk associated with anticoagulants include: a. Bleeding and hemorrhage . |