STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676035	A. Building B. Wing	11/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingsland Hills Care Center	3727 W Ranch Rd 1431 Kingsland, TX 78639

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 5 residents (Resident #1) reviewed for resident rights. The facility failed in notifying Resident #1's physician right away when the resident had a significant change in condition. Resident #1 had was bleeding from skin tears on 09/13/25.) This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition. Findings included:Record review of Resident #1's face sheet dated 10/08/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included shortness of breath, Alzheimer's disease, muscle weakness, chronic pain, hypertension and other abnormalities of gait and mobility. Record review of Resident #1's quarterly MDS dated [DATE] revealed that a BIMS interview could not be conducted as she rarely/never understood the interview questions. Record review of Resident #1's Care Plan dated 06/08/25 revealed Resident #1 had potential for impaired skin integrity and was at risk of bleeding. The relevant intervention was evaluating skin for integrity and impaired coagulation (Bruising, petechia (pinpoint red spots on skin from bleeding from capillaries) , bleeding from orifices) Record review of Resident #1's MAR of September 25 revealed Resident#1 was not blood thinners. Record review of the wound assessment profile revealed substantial improvement in healing. The dimensions of the wound during the assessment on 09/15/25 was 4cm L x 0.5cms W x 0.1cm D and on 10/06/25 it was 0.9cm L x 0.4cm W x UTD A phone call made to LVN A on 10/08/25 at 11:20am and left to VM to call back. No return call was received as on 10/08/25 at 5:00pm.During an interview on 10/08/25 at 12:30pm the RP stated she visited Resident #1 almost every day. She said Resident #1 was on prednisone (An anti-inflammatory drug) for a very long time and due to that she had very vulnerable skin (as side effect of prednisone medication) with bilateral edema (swelling on both legs). The RP said Resident #1's skin was prone to skin tears very easily . The RP reported on 09/13/25 early in the morning CNAs who took care of Resident #1 noticed she was bleeding from newly developed skin tears on her left leg. The RP said CNA B who noticed the bleeding threw a towel on the wound to stop the bleeding and reported to LVN A however she did not do any interventions and let Resident #1 bleed until a nurse from the next shift came and fixed it. She said LVN A left the facility without even look at Resident#1 to see what was going on. The RP stated Resident #1's condition is stable currently and there was no further complication from the wound and bleeding. During an observation on 10/08/25 at 1:15pm she was in her room in her wheelchair napping. She appeared calm and relaxed without any distress. The wound was covered by dressing. She could not answer any of the interview questions and responded with unrelated answers.During a phone interview on 10/08/25 at 1:33pm CNA B stated she was the night CNA who worked on the night shift on 09/12/25 and finished the next day at 7:00am. CNA B stated, on 09/13/25 at about 5:10am she and CNA E were changing Resident #1 and getting her for the day. She said, while separating Resident #1's crossed legs, a skin tear occurred on her right lower leg from rubbing her left leg on the other leg, as her skin was sensitive even to mild pressure. CNA B stated Resident #1 was bleeding from the skin tears. She said as the bleeding was not stopping, she reported immediately to LVN A who was in the same hall administering medications. CNA B reported that LVN A told her that she was busy with administering medications and would go and assess Resident #1 once she completed administering medications to the residents in the hall. CNA B said she returned to Resident #1 and wrapped a towel around the wound to minimize further damage until LVN A's visit and intervention. CNA B stated she clocked out at about 7:20am and went home thinking Resident #1's bleeding was taken care of by LVN A. She said, at around noon she received a phone call at her home from LVN A asking her how severe Resident #1's wound was and stated she got busy with administering medications and had forgotten to take care of Resident #1's bleeding. CNA B stated on 09/15/25 she attended Inservice on abuse and neglect, reporting to the oncoming nursing team and competent nursing. A phone call made to RN C on 10/08/25 at 2:05pm and left a VM to call back and she returned the call on 10/10/25 at 11:06am. RN C stated on 09/13/25 she worked in the day shift. She said, at about 7:20am CNA D reported to her that Resident #1 was bleeding profusely in her bed. RN C stated she rushed to Resident #1's room to take care of her bleeding. RN C stated on arrival she noticed Resident #1 was bleeding heavily from 3 skin tears on her right lower leg from knee to ankle and the bed sheet was visibly wet with blood. RN C stated she had to

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that a resident receives treatment and care in accordance with professional standards of practice for 1 of 2 nurses (LVN A) reviewed for nursing services. The facility failed to ensure LVN A assessed and performed necessary interventions to stop Resident #1 from bleeding from skin tears on 09/13/25.This failure could place residents with wounds at risk for bleeding related complications.Findings included: Record review of Resident #1's face sheet dated 10/08/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included shortness of breath, Alzheimer's disease, muscle weakness, chronic pain, hypertension and other abnormalities of gait and mobility. Record review of Resident #1's quarterly MDS dated [DATE] revealed that a BIMS interview could not be conducted as she rarely/never understood the interview questions. Record review of Resident #1's Care Plan dated 06/08/25 revealed Resident #1 had potential for impaired skin integrity and was at risk of bleeding. The relevant intervention was evaluating skin for integrity and impaired coagulation (Bruising, petechia (pinpoint red spots on skin from bleeding from capillaries) , bleeding from orifices) Record review of Resident #1's MAR of September 25 revealed Resident#1 was not blood thinners. Record review of physician's order reflected: Skin Tear to Right Distal Lower Leg: Cleanse with wound cleanser, dry, apply Xeroform, ABD pad, and wrap with Kerlixdaily and PRN. Everyday shift. Record review of the wound assessment profile revealed substantial improvement in healing. The dimensions of the wound during the assessment on 09/15/25 was 4cm L x 0.5cms W x 0.1cm D and on 10/06/25 it was 0.9cm L x 0.4cm W x UTD A phone call made to LVN A on 10/08/25 at 11:20am and left to VM to call back. No return call was received as on 10/08/25 at 5:00pm. During an interview on 10/08/25 at 12:30pm the RP stated she visited Resident #1 almost every day. She said Resident #1 was on prednisone (An anti-inflammatory drug) for a very long time and due to that she had very vulnerable skin (as side effect of prednisone medication) with bilateral edema (swelling on both legs). The RP said Resident #1's skin was prone to skin tears very easily . The RP reported on 09/13/25 early in the morning CNAs who took care of Resident #1 noticed she was bleeding from newly developed skin tears on her left leg. The RP said CNA B who noticed the bleeding threw a towel on the wound to stop the bleeding and reported to LVN A however she did not do any interventions and let Resident #1 bleed until a nurse from the next shift came and fixed it. She said LVN A left the facility without even look at Resident#1 to see what was going on. The RP stated Resident #1's condition is stable currently and there was no further complication from the wound and bleeding. During an observation on 10/08/25 at 1:15pm she was in her room in her wheelchair and napping. She appeared calm and relaxed without any distress. The wound was covered by dressing. She could not answer any of the interview questions and responded with unrelated answers. During a phone interview on 10/08/25 at 1:33pm CNA B stated she was the night CNA who worked on the night shift on 09/12/25 and finished the next day at 7:00am. CNA B stated, on 09/13/25 at about 5:10am she and CNA E were changing Resident #1 and getting her for the day. She said, while separating Resident #1's crossed legs, a skin tear occurred on her right lower leg from rubbing her left leg on the other leg, as her skin was sensitive even to mild pressure. CNA B stated Resident #1 was bleeding from the skin tears. She said as the bleeding was not stopping, she reported immediately to LVN A who was in the same hall administering medications. CNA B reported that LVN A told her that she was busy with administering medications and would go and assess Resident #1 once she completed administering medications to the residents in the hall. CNA B said she returned to Resident #1 and wrapped a towel around the wound to minimize further damage until LVN A's visit and intervention. CNA B stated she clocked out at about 7:20am and went home thinking Resident #1's bleeding was taken care of by LVN A. She said, at around noon she received a phone call at her home from LVN A asking her how severe Resident #1's wound was and stated she got busy with administering medications and had forgotten to take care of Resident #1's bleeding. CNA B stated on 09/15/25 she attended Inservice on abuse and neglect, reporting to the oncoming nursing team and competent nursing. A phone call made to CNA E on 10/08/25 at 2:15pm and left a VM to call back. She returned the call on 10/10/25 at 3: 13pm. CNA E stated, on 09/13/25 early in the morning, she was helping CNA B in changing Resident #1. She stated since Resident #1 had contracted legs it was very difficult to change her. She stated in the process of separating her legs she had seen Resident#1 bleeding from her right leg. CNA E said, CNA B rushed out of the room to report it to LVN A. She stated they wrapped a towel around Resident #1's leg to put some

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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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed make sure that drugs are stored properly and only authorized persons have access for 2 of 3 medication carts (MC #1, and TC #2) reviewed for drug storage and labeling.The facility failed to ensure MC #1, and TC #2 were locked, medications secured, and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications. Findings included: During an observation on 11/10/2025 at 8:03a.m., revealed MC #1, was near the nurses' station, and unlocked. There were no nurses around MC #1. MC #1 contained residents' prescription drugs, over the counter medications, and narcotics in a locked box in the medication cart.During an observation on 11/10/2025 at 8:10a.m., revealed TC #2, was near the nurses' station and unlocked. No staff were in sight of TC #2. TC #2 had residents' prescription creams in the top drawer. During an interview with LVN A on 11/10/2025 at 10:53a.m., revealed that he had been trained on medication storage. He said the policy for the medication carts was the medication cart must always be locked when not around it. He said whoever is on the medication cart was responsible for ensuring the cart was locked, when not using the medication cart. He said if the medication cart was left unlocked and unattended someone or a resident could get into the cart. He said all staff monitored to ensure the medication carts were locked. He said staff monitored the medication carts by observations. He said he had to go into the medication room to get some medications and did not lock the cart. He said he should have locked the medication cart when he walked away. During an interview with TN on 11/10/2025 at 11:02a.m., revealed she had been trained on medication storage. She said the policy for the medication carts was the medication cart was to be locked any time staff were away from it. She said the nurses and other staff walking by were responsible for ensuring the medication carts were locked. She said the medication carts were to be locked at all times when not in use. She said if a medication cart was left unlocked and unattended a resident could get into the medication cart and take medications they are not supposed to have. She said nurses and all administrative staff monitored to ensure staff were locking the medication carts. She said the nurses and administrative staff monitored by observations. She said she did not know why the treatment cart was unlocked. She said she had not been to the cart by the time the surveyor saw it was unlocked. She said she did not know who used the cart last or who left the cart unlocked. During an interview with the DON on 11/10/2025 at 2:38p.m., revealed she had been trained on medication storage. She said the policy for the medication cart was that it needed to be locked and only nurses and medication aides were to have access to it. She also said if the cart is not within the nurses' eyesight it should be locked. She said if the medication was left unlocked and unattended someone who was not authorized to be in the medication cart could take something out. She said leadership monitors to ensure staff are locking the medication carts. She said when leadership sees a medication cart unlocked when they go by the cart leadership will tell the nurse or medication aid to lock the medication cart. She said she did not know why the medication cart and the treatment cart were unlocked. During an interview with the ADM on 11/10/2025 at 2:44p.m., revealed that he had not been formally trained on medication storage. He said from experience he knew the medication storage policy was the medication cart had to be locked. He said the medication cart should be locked when the nurse or treatment nurse and medication aide was not actively using the cart. He said if the mediation cart was left unlocked or unattended someone could take something from the cart that someone should not have. He said that the administrative team and peer to peer monitored to ensure the carts are locked. He said the administrative staff monitor through observation. Said that he did not have a good explanation as to why the medication cart and treatment cart were unlocked. Record review of Medication Labeling and Storage Policy dated 2/2023, revealed The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.