

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Winnie L Ltc Partners Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2104 N Karnes Cameron, TX 76520	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 3 (Resident #24, Resident #11 and Resident #18) of 9 residents reviewed for accommodation of needs.</p> <p>1.</p> <p>The facility failed to ensure that Residents #24's call light was within reach.</p> <p>2.</p> <p>The facility failed to ensure that Resident #11's call light was within reach.</p> <p>3.</p> <p>The facility failed to ensure that Resident #18's call light was within reach.</p> <p>These failures placed residents at risk of not being able to call for assistance and have their needs met.</p> <p>Findings included:</p> <p>1.</p> <p>Record review of Resident #24's undated Face Sheet reflected she was a an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) late onset, difficulty in walking and cognitive communication deficit (communication is impaired due to problems with attention, memory and reasoning rather than with language or speech itself).</p> <p>Record review of Resident #24's Comprehensive MDS dated [DATE] reflected she was unable to complete a BIMS assessment.</p> <p>Record review of Resident #24's Care Plan dated 05/29/2024 and revised on 12/11/2024 reflected Focus: has a communication problem related to Dementia, sometimes understands, sometimes understood. Goal: Anticipate and meet needs. Ensure/provide a safe environment. Call light in reach.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 05/20/2025 at 10:08 AM revealed Resident #24 was in her bed and her call light was not in reach. Resident #24 was not interviewable.</p> <p>2.</p> <p>Record review of Resident #11's undated Face Sheet reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions) late onset, and a history of falling.</p> <p>Record review of Resident #11's Quarterly MDS dated [DATE] reflected she was unable to complete a BIMS assessment.</p> <p>Record review of Resident #11's Care Plan dated 09/30 /2024 reflected Focus: The resident has a communication problem with Alzheimer's. She is mostly non-verbal. Interventions/Tasks: Ensure/provide a safe environment: Call light in reach.</p> <p>Observation on 05/20/2025 at 10:29 AM revealed Resident #11 was sitting in a reclining wheelchair in her room. There was no call light in reach. The resident was not interviewable.</p> <p>3.</p> <p>Record review of Resident #18's undated Face Sheet reflected she was an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Unspecified Dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) without behavioral disturbance, Cognitive Communication Deficit (communication is impaired due to problems with attention, memory and reasoning rather than with language or speech itself) and history of falling.</p> <p>Record review of Resident #18's Quarterly MDS dated [DATE] reflected she was unable to complete a BIMS assessment.</p> <p>Record review of Resident #18's Care Plan dated 08/22/2024 and revised on 03/10/2025 reflected Focus: The resident has a communication problem r/t advanced Alzheimer's disease, Cognitive Communication Deficit, age-related cognitive decline r/t Alzheimer's progression. Goal: the resident will be able to make basic needs known on a daily basis through the next review date. Interventions/Tasks: Anticipate and meet needs. Ensure/provide a safe environment: Call light in reach.</p> <p>Observation on 05/20/2025 at 2:32 PM revealed Resident #18 was sitting in her wheelchair in her room. Resident #18's call light was on her bed and not in reach. Resident #18 stated I need help. The surveyor asked the resident if they could push her call light and she stated yes.</p> <p>During observation and interview on 05/20/2025 at 2:35 PM the Social Worker came into Resident #18's room to see what she needed. She stated she helped the nursing staff to answer call lights. She stated the resident needed to have her call light in reach. She further stated by not having her call light in reach, the resident could have fallen and could have gotten hurt.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/22/2025 at 7:35 AM CNA D stated call lights should have been kept in reach of all residents and all staff were responsible. She stated if the call lights were not kept in reach for the residents Something bad could happen to the resident. She stated she had not received any in-services regarding call light placement.</p> <p>In an interview on 05/22/2025 at 7:26 AM LVN B stated she had worked at the facility since April 7th, 2025. She stated she made rounds on 500 Hall about three times a day and she did check for call light placement. She stated the potential risk if a resident could not reach their call light would be a delay in the resident receiving care. She stated they could fall.</p> <p>In an interview on 05/22/2025 at 11:35 AM the DON stated her expectations would be for every resident to have their call lights always in reach whether they were in the bed or a wheelchair. She stated they could need anything such as the bathroom, food, drink or even just want to get out of the room. She further stated if the call light was not in reach, they could potentially fall trying to reach the call light. She stated they could hurt themselves, get a skin tear or even a fracture.</p> <p>In an interview on 05/22/2025 at 12:24 PM the ADM stated any staff that entered a resident room should make sure their call light was in reach. She stated if they took a resident back to their room or did rounds, they should ensure the call light was in reach. She further stated the potential risk to the resident was that their needs would not be met. She stated the resident could fall and be injured if their call light was not in reach.</p> <p>In an interview on 05/22/2025 at 12:24 PM the ADM stated there was no specific policy regarding call light placement.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 good grooming and personal hygiene for 1 of 6 residents (Resident #6) reviewed for ADLs.</p> <p>The facility failed to ensure that assistance was provided to Resident #6 to remove all BM from hands and face before the lunch meal on 05/20/2025.</p> <p>This failure could place residents at risk of cross contamination and not being provided care and assistance when needed.</p> <p>Findings include:</p> <p>Review of Face Sheet for Resident #6 reflected an [AGE] year-old female admitted on [DATE]. Diagnoses included Alzheimer's Disease (dementia disorder related to protein formation in the brain), Acquired Absence of Left Upper Limb Above Elbow, and Need for Assistance with Personal care.</p> <p>Review of MDS for Resident #6 dated 02/12/2025 reflected a BIMS score of 2 (severe cognitive impairment). Section G0110 for Activities of Daily Living Assistance indicated that Resident #6 required Supervision of one assistance person with eating and Extensive Assistance from one to two staff for Bed Mobility, Transfers, and Toilet Use.</p> <p>Review of Care Plan for Resident #6 reflected a Focus Area stating the resident, has bladder and bowel incontinence r/t ALZHEIMER'S DISEASE. Date Initiated: 08/11/2023 with an intervention to, PERFORM INCONTINENT CARE AFTER EACH INCONTINENT EPISODE. Date Initiated: 01/21/2025. There was a Focus Area stating the Resident, has an ADL Self Care Performance Deficit r/t ALZHEIMER'S DISEASE and Left Arm Above Elbow Amputation. Date Initiated: 08/30/2023 with an intervention of, TOILET USE: [Resident #6] requires ASSIST with 1 staff participation to use toilet and has occasional bowel and bladder incontinence which requires staff assist with incontinent care. Date Initiated: 08/30/2023.</p> <p>Observation and interview on 05/20/25 at 10:23 AM with Resident #6 revealed resident lying in bed on her right side. There was a smear of brown substance across her right cheek approximately 1.5 inches long. She stated she has no concerns regarding her care at the facility.</p> <p>Observation on 05/20/25 at 12:10PM of Resident #6 revealed resident sitting at a dining table, waiting for lunch. Her right hand had a brown substance under all the nails with a smear across her thumb and her right cheek. Resident had an amputation to her left arm above the elbow. Resident smelled of BM. The resident stated that she likes her nails longer. Resident stated that there was nothing under her nails.</p> <p>Observation on 05/20/2025 at 12:45PM revealed Resident #6 sitting at the table, eating her meal with her right hand using a spoon and her fingers to eat. The brown substance remained under her nails and the brown smear was still on her right cheek. Resident took a bite of her chicken and licked the fingers of her right hand.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/20/2025 at 01:03PM CNA E stated that she cleaned Resident #6's hands with a wipe before the meal. She stated she did not see the brown residue under her nails and on her face before it was brought to her attention by surveyor. She stated that she did not know what the brown substance was. She stated she would take the resident back to the room to clean her up. She stated that the resident could get an infection if her hands were soiled with BM while she was eating a meal.</p> <p>In an interview on 05/20/2025 at 01:20PM CNA E stated that it was BM under Resident #6's nails when she took the resident back to clean her up. She stated that she cleaned the Resident's face and nails.</p> <p>Observation on 05/22/2025 at 08:52AM revealed CNA F assisting Resident #6 with her meal tray and positioning her for comfort in her bed. Resident #6 nails were clipped short. Her hands, face, and all visible person and clothing were clean.</p> <p>In an interview on 05/22/2025 at 08:52AM Resident #6 stated she was doing fine. Resident denied any upset stomach.</p> <p>In an interview on 05/22/2025 at 11:08AM, LVN B stated that the CNAs and charge nurses work together to ensure good hygiene for Resident #6 and all other residents. She stated that she did not see the soiled hands, nails, and face for Resident #6 before someone brought it up. She stated that if the staff did not assist the resident with hand hygiene when residents are soiled and prior to meals she could get sick.</p> <p>In an interview on 05/22/2025 at 11:17AM, CNA F stated that Resident #6 has a behavior of scratching her skin and handling her brief sometimes. She stated that she assists the Resident to wipe her hands after providing incontinent care, before meals, and as needed, including removing any debris from under her nails. She stated that if staff do not assist residents with hand hygiene and ADL care when it is needed, the residents could get an infection.</p> <p>In an interview on 05/22/2025 at 01:50 PM, the Regional Compliance Nurse stated the facility had no specific policy and procedure for ADL care. She stated the only related policy they had was for Infection Control.</p> <p>In an interview on 05/22/2025 at 02:40 PM, the Administrator stated that if a CNA or a nurse saw that a resident was not clean, then it was her expectation that staff assist them with cleaning themselves if they are not able. She stated that her expectation was that staff assist all residents with hand hygiene prior to meals. She stated that the potential impact to the resident if staff do not assist with hand hygiene prior to meals, is that they could get sick.</p> <p>In an interview on 05/22/2025 at 02:53PM DON stated that it was the responsibility of all staff to monitor the residents and ensure cleanliness of their clothing and their person. She stated that all staff assisting with dining, especially CNAs and nurses were to assist residents with hand hygiene especially before meals and as needed. She stated that a resident could get sick from having nails and hands soiled with BM while they are eating. She stated it could also be embarrassing for the resident. She stated that she has in-serviced staff on hand hygiene and ADL care and educated staff to ensure that they are aware of the expectations.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy for Infection Control (No Date) reflected: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Residents #15) reviewed for accidents hazards and supervision:</p> <p>The facility failed to ensure Resident #15 had a fall mat in place and the bed was in the low position on 05/20/2025 while in bed.</p> <p>This failure could place the residents at risk for falls with the possibility of injury, including fractures.</p> <p>Findings include:</p> <p>Review of Face Sheet for Resident #15 reflected a [AGE] year-old man admitted on [DATE]. Diagnoses included: Dementia, Bipolar Disorder (a mental illness that causes extreme mood swings), Aphasia (difficulty using or comprehending language), and Deaf.</p> <p>Review of MDS for Resident #15 dated 05/02/2025 reflected a BIMS score of 1 (severe cognitive impairment). Section G0110 for Activities of Daily Living Assistance reflected the resident requires Extensive Assistance of Two or more persons with bed mobility and transfers.</p> <p>Review of Care plan for Resident #15 reflected a Focus area stating the resident, has a communication problem r/t aphasia and he is also deaf. Date initiated 04/28/2025 with an intervention to keep the bed in the lowest position. Further review reflected a Focus area stating the resident, is risk for falls r/t Gait/balance problems, Unaware of safety needs, hearing problems, Date Initiated: 04/28/2025, with interventions to Anticipate and meet the resident's needs. Date initiated 04/28/2025 and Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. Date Initiated: 05/01/2025</p> <p>Review of Event Nurse's Note for Resident #15 with date of 04/26/2025 reflected resident was found on the floor by the bedside.</p> <p>Review of Progress Notes for Resident #15 reflected a note on 05/09/2025 stating, Resident had a fall. Location: Resident Room .Fall information: Unwitnessed, Discovered on floor, . Next to bed.</p> <p>Cognition / Behavior at Time of Event: Oriented / no problem, Agitated, Restless, Refuses to call for assistance Nurse walking down & noticed resident on floor in his room. Charge nurse immediately started head to toe assessment. resident able to [NAME] upper & lower without difficulty, no rotation noted to lower extremities, able to straighten both legs without hesitation v/s 148/70, 72, 20, 97.5,</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>98% neuros initiated resident non verbal, communicates with writing- example dry erase board, also able to nod head yes or no if you write down questions, hard of hearing No Pain. Initial Treatment/New Orders: floor mat beside bed</p> <p>Review of Physician Orders for Resident #15 reflected no orders for fall mat prior to 05/22/2025.</p> <p>Observation on 05/20/2025 at 02:45PM reflected Resident #15 was lying in bed. The bed was not in the low position and there was no fall mat on the floor beside the bed. No fall mat was observed in the room.</p> <p>Observation on 05/22/2025 at 09:09AM revealed Resident #15 was sitting in his WC. No fall mat was in the room.</p> <p>In an interview on 05/22/2025 at 10:00AM CNA F stated that Resident #15 did not have a fall mat in his room. She stated she was not sure of the circumstances for Resident #15's falls but was aware Resident #15 had fallen in the past.</p> <p>In an interview on 05/22/2025 at 10:15AM, the DOR stated that he was familiar with Resident #15. He stated that he screens the residents after falls. He stated they review residents after falls to screen for their ability and for the source of the falls. He stated that Resident #15 did have a fall out of bed. He stated that a fall mat would be a good temporary intervention to attempt to prevent major injury with falls for Resident #15. He stated that he recommended a defined perimeter mattress, which is similar to a scoop mattress, but less restrictive for the resident. He stated that it would be a better approach than a fall mat. He stated that he did not have any defined perimeter mattresses to his knowledge at the time. He stated that he was not aware that the Resident did not have a fall mat. He stated that if the Resident had a fall out of bed without a fall mat it could contribute to fractures.</p> <p>In an interview on 05/22/2025 at 11:15 AM, LVN B stated that she was aware that Resident had a history of falls. She stated that her fall interventions for Resident #15 included watching him closely, especially during smoke breaks. She stated that he should have a fall mat, a low bed, and staff should ensure the call light is in reach. She confirmed that Resident#15 does not currently have a fall mat in his room. She stated that it is everyone's responsibility to help with fall prevention. She stated all the care staff are responsible to ensure the fall interventions are in place. She stated that everyone should be monitoring for appropriate fall interventions. She stated that if the resident did not have the appropriate interventions in place for falls, like a fall mat, that the resident could hit is head and possibly have a brain bleed.</p> <p>In an interview on 05/22/2025 at 1100 AM, DOR stated he found a defined perimeter mattress cover and applied it to the bed.</p> <p>Observation on 05/22/2025 at 1100 AM revealed that a new mattress topper was applied to Resident #15's mattress. It has raised edges on the top and bottom and a more gradual raised edge in the middle of the mattress. The bed was in the low position.</p> <p>In an interview on 05/22/2025 at 02:53 PM, the DON stated that she agreed with the DOR and was comfortable with the mattress topper as an adequate intervention for falls for Resident #15. She stated that she would update the care plan and the records to reflect the change and remove the fall mat.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy of Fall Prevention, revised 10/02/2016, reflected:</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. The facility will complete a fall risk assessment on each resident at the time of admission to the facility. The Fall Assessment Tool will be used to assess the resident's risk of falls until completion of the comprehensive MDS assessment. 2. The comprehensive MDS assessment will assist in identifying those residents as risk for falls. 3. Residents at risk will be care planned for fall prevention. 4. After risk is assessed, individualized nursing care plans will be implemented to prevent falls. The resident and family members will be educated on methods to prevent falls. Interventions will focus on manipulating the environment, educating the resident/family, implementing rehabilitation programs to improve functional ability, and care monitoring of medication side effects. <p>Incident Reporting: Reported falls will be thoroughly investigated to assess fall risk factors and contributing factors in order to provide a safe environment for the resident(s).</p> <p>Environment: Keep bed in low position. Keep the bed wheels locked. Use mobility handles or $\frac{1}{4}$ rails in bed, low bed, scoop mattress, bolsters, or any combination of the previous. Place the call light and other objects within easy reach. Use bed/chair alarm systems to monitor unsafe activity as needed. Maintain adequate illumination in bedrooms and bathrooms. Maintain non-slip floor surface. Keep hallway clear. Provide grab bars and toilet risers in the bathroom.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for one of one medication storage rooms in the facility and one of three medication carts reviewed for medication safety.</p> <p>A.</p> <p>The facility failed to ensure expired supplies and/or medications were removed from the nurse's medication cart for the secure unit.</p> <p>B.</p> <p>The facility failed to ensure expired/discontinued supplies and/or medications were removed from the medication storage room.</p> <p>This failure could place residents at risk of not receiving the intended therapeutic benefits of their medications.</p> <p>Findings included:</p> <p>A.</p> <p>During an observation on 05/21/2025 at 10:25 AM of the medication cart for the secure unit with LVN B there were two insulin pens that were beyond the use dates of 28 days after opening for Resident #14. A Lantus Solostar Subcutaneous Solution Pen injector had an open date of 4/17/25, expired on 05/15/2025. An Insulin Lispro Subcutaneous Pen Injector had an open date of 4/4/25, expired on 05/02/2025. Pens were removed from the medication cart and discarded by LVN B.</p> <p>B.</p> <p>During an observation on 05/21/2025 at 10:53AM of the medication storage room with DON there were eight bottles of Jevity 1.2K tube feeding formula with an expiration date of 04/01/2025. Eight bottles of expired product were removed from medication storage by DON to be discarded.</p> <p>In an interview with LVN B on 5/21/25 at 10:25 AM, LVN B stated that the insulin pens expire after 28 days from opening. She stated that she should have checked the expiration date and discarded the pens. She stated it was the responsibility of the nurse administering the medication to check the expiration date prior to administering the medication. She stated that the impact to the resident for receiving expired insulin was that the medication might not work to lower blood sugar as intended.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/21/25 at 02:20PM, the DON stated that it was the nurse's responsibility to check expiration dates on medications and products for residents prior to administration. She stated that a pharmacy consultant comes to review the medication storage and carts, but she has not been here in a few weeks to catch the expired products found during review. She stated that her expectation was that the staff discard any expired medications or products and reorder them, if needed. She stated that the risk to the resident with receiving expired tube feeding formula was the possibility of gastrointestinal upset, diarrhea, and vomiting. She stated there were no residents in the facility at this time requiring the tube feeding formula that was expired. She stated that the risk to the resident regarding the expired insulin was that the product may not work to lower the blood sugar of the resident and put them at risk for DKA (an emergency situation due to increased blood sugar levels in the body).</p> <p>In an interview with ADM on 05/21/25 at 02:35 PM, ADM stated that removing expired products should be a shared responsibility between nurses, medication aides, DON, and pharmacy consultant. She stated the products should have been removed from stock on the day of expiration and disposed of properly. She stated that she would prefer to defer to the clinical judgement of her DON regarding the risks for the resident with the expired products.</p> <p>Review of Facility policy on Recommended Medication Storage, revised 07/2012 reflected, Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that it is clear when the medication was opened. Below is a list of medications that require a date when opening and the recommended time frame the medication should be used. This is not an all-inclusive list and the manufacturer recommendations will supersede this list.</p> <p>INSULINS (Vials, Cartridge, Pens)</p> <p>Insulin Glargine (Lantus)</p> <p>Review of [Medication Brand] Prescribing information for Lantus Solostar subcutaneous pen reflected that the Pen should be discarded after 28 days from opening.</p> <p>Review of [Medication Brand] Complete instructions for non-branded Insulin Lispro pen reflected, Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary drugs for one (Resident #32) of five residents reviewed for adequate monitoring of medication.</p> <p>The facility failed to discontinue an order for antipsychotic medication when ordered by the Medical Director with Medication Regimen Review with a Review date of 02/19/2025.</p> <p>This failure could place residents at risk of receiving discontinued and unnecessary antipsychotic medications.</p> <p>Findings included:</p> <p>Review of Face Sheet for Resident #32 reflected an [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses included Dementia, Moderate, with other behavioral disturbance; Hypertension (high blood pressure), and Vitamin D Deficiency.</p> <p>Review of Care Plan for Resident #32 reflected a Focus Area stating The resident is risk for falls r/t Confusion, Deconditioning, Gait/balance problems, Psychoactive drug use, Unaware of safety needs, Wandering with a date initiated of 10/15/2024. There was a Focus Area stating The resident requires anti-psychotic medication for dx of behaviors and for agitation with a date initiated of 10/15/2024 with an intervention, Administer medications as ordered. Monitor/document for side effects and effectiveness with the same start date.</p> <p>Review of MDS for Resident #32 dated 04/22/2025 reflected a BIMS score of 7 (severe cognitive impairment). Section J1800 indicated that Resident has had no falls since admission/entry/or reentry to facility. Section N0415 for High Risk Drug Classes, indicated use of Antipsychotic medications for Resident #32.</p> <p>Review of Physician Orders for Resident #32 reflected an order for Olanzapine Oral Tablet 2.5 mg: Give one tablet by mouth two times a day related to Unspecified Dementia, Moderate, with other Behavioral Disturbance AND Give 1 tablet by mouth every 6 hours as needed for agitation with a start date of 02/12/2025.</p> <p>Review of Medication Regimen Review for Resident #32 dated 02/19/2025 reflected a recommendation from Pharmacy for Olanzapine Oral Tablet 2.5 mg: Give one tablet by mouth every 6 hours as needed for agitation with a check mark in the Response section indicating to Discontinue the medication. The form was signed by the Medical Director. No date next to signature line.</p> <p>Review of Medication Administration Record for Resident #32 for May 2025 reflected a dose of Olanzapine oral tablet 2.5 mg: Give by mouth every 6 hours as needed for agitation was given on 05/12/2025 and 05/13/2025.</p> <p>Review of Progress Notes for Resident #32 from 02/19/2025 to 05/22/2025 reflected that no other as needed doses of Olanzapine Oral Tablet 2.5 mg were administered to Resident.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/22/2025 at 01:20PM, the Regional Compliance Nurse stated that she did not know why the as needed order for Olanzapine was not discontinued after MD A signed the order to discontinue the medication. The Regional Nurse called MD A and notified her of the error and received a new order to discontinue the as needed order for Olanzapine 2.5 mg for Resident #32. Regional Compliance Nurse stated that although her name is attached to the order when it is viewed in the resident record, she was not the one who ordered the medication on that date. She stated that it was because she updated the times for the scheduled dose on the day listed under the modification. She stated she did not participate in the pharmacy review for the facility that month. She stated that would have been the former DON for February 2025. She stated that it was the responsibility of the Charge Nurse or DON who received the pharmacy review for that month to ensure that all orders are initiated and executed at the time they are received. She stated that the impact to the resident for not discontinuing the as needed order for olanzapine would be that the Resident could receive unnecessary medications.</p> <p>Phone interview with MD A attempted on 05/22/2025 at 01:58PM. Left a message. Did not receive call back from physician prior to exit.</p> <p>In an interview on 05/22/2025 at 02:40PM, the Administrator stated that she was learning to do the Pharmacy review currently. She stated she has not yet reviewed any of the recommendations for the facility. She stated that her expectation was that the physician orders are executed and followed. She stated that she would refer to her DON for the clinical impact to Resident #32 of receiving doses of olanzapine after it was discontinued. She stated that it was the responsibility of the DON and the Pharmacy to ensure that the orders from the pharmacy review are executed and followed.</p> <p>In an interview on 05/22/2025 at 02:53PM, the DON stated the staff member that reviewed the pharmacy recommendations was responsible for initiating the orders from the doctor. She stated that for the month of February 2025 the staff member responsible for the pharmacy review was the former DON. She stated that to her knowledge there were no other recommendations in the pharmacy review for the months of March and April of 2025 to discontinue the as needed order for Olanzapine for Resident #32. She stated she completed the last review with the Regional Nurse.</p> <p>In an interview on 05/22/2025 at 03:39PM, the Pharmacy Consultant stated that she received notification that the February letter from the physician was approved to discontinue the as needed Olanzapine dose for Resident #32. She stated it was a shared responsibility between the pharmacist, nursing, and the physician to review medications for the appropriate dose and appropriate orders. She stated that the as needed dose of Olanzapine did come up for pharmacy review for the months of March and April. She stated there were no recommendations listed from her pharmacy review for the as needed Olanzapine order in March and April. She stated she was not sure what her thought process was at the time. She stated that generally the pharmacy tries to only adjust one medication at a time. She stated that when the scheduled dose of Olanzapine triggered for a GDR (gradual dose reduction) in the April pharmacy review, she only addressed that change. She stated that the impact to the resident was that receiving additional doses of Olanzapine could potentially contribute to falls. She stated that the Resident has been on the medication prior to February and the facility monitors for side effects. She stated that she did not know of any decline in function for the Resident.</p> <p>Review of Facility Policy for Physician Orders (No Date) reflected: Written Orders by the Physician or Nurse Practitioner</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Nurse will review the order and if needed contact the prescriber for any clarifications 2. The nurse will enter the order into PCC [PointClickCare electronic medical health record] for the resident and select prescriber written 3. If the order requires documentation, it will be directed to the proper electronic administration record once the order is completed. 4. The receiving nurse will contact any other department or external facilities as required, i.e. dietary department, pharmacy, lab provider, x-ray provider, etc. Review of Facility Policy for Psychotropic Drugs, revised 10/25/17, reflected, The facility must will ensure that- <ol style="list-style-type: none"> 1. Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; 2. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; (Refer to Medication Review policy and behavior management policy) 3. Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record 4. PRN orders for psychotropic drugs are limited to 14 days. Except as provided in &sect;483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. 5. (continued on next page)

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p>