STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676233	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bandera Nursing & Rehabilitation	222 Fm 1077 Bandera, TX 78003

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for accuracy of records, in that: The facility failed to ensure the medication administration record (MAR) for Resident #1 accurately reflected urine sample was not collected on the January 2024 MAR on the 3rd, 4th, and 5th. The facility failed to document or provide a rationale from a medical provider in January of 2024 when the order for collection of a urine sample for a urinalysis for Resident #1 was canceled on January 11th of 2024 by the DON. This failure could put residents at risk of an untreated urinary tract infection due to inaccurate documentation and lead to missed or delayed diagnosis and treatment. The findings were: Record review of Resident #1's Admission Record (face sheet), dated 02/20/2025, revealed an [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses which included nontraumatic subarachnoid hemorrhage (condition where blood leaks into the subarachnoid space, which is the area between the brain and the membranes that cover it), aphasia following cerebral infarction (Language disorder that affects your ability to communicate. It's most often caused by strokes in the left side of the brain that control speech and language.), contracture of right hand (condition that causes one or more fingers to bend toward the palm of the hand), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain), cognitive communication deficit, and hemiplegia and hemiparesis (weakness or loss of strength of one side of the body) of right side. A diagnosis of urinary tract infection was not documented on the admission record. Record review of Resident #1's MDS, a Quarterly assessment dated [DATE], revealed her cognition was severely impaired; and she was always incontinent of bowel and bladder. (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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NAME OF PROVIDER OR SUPPLIER: Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 222 Fm 1077 Bandera, TX 78003	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan, dated 02/20/2025, for infection or recurrent/chronic infection related to compromised medical condition: UTI, revealed under interventions was to 1. Report changes in condition to MD as clinically indicated. 2. Administer medication and/or antibiotic as clinically indicated. 3. Monitor vital signs as indicated. with a start date of 11/11/23. Educated RP that frequent bladder catheterization for UA as requested potentially allows bacteria to enter your body. This can cause an infection in the urethra, bladder, or the kidneys, initiated on 11/11/2023, and revised 03/19/2024. Record review of Resident #1's care plan, dated 02/20/2025, revealed to obtain urinalysis via in and out catheter every 3 months due to history of chronic UTIs created on 03/19/2024 and revised on 08/29/2024. Record review of Resident #1's new order form, dated 09/29/2022, revealed the urologist ordered a urinalysis reflex to culture (a process where the laboratory performs a chemical urinalysis (UA) to detect abnormalities such as blood, protein, glucose, and indicators of bacterial infection) if positive on the 1st of each month for UTI. Record review of Resident #1's urology clinical notes, dated 10/26/2023, revealed the resident was seen for multiple UTIs, a diagnosis for urinary tract infection debilitated, in a facility. Monthly UAs due to hx decomp events. Record review of Resident #1's Physician's Order Listing Report, dated 02/20/2025, revealed the following orders: -May obtain urinalysis via in and out cath every 3 months for urinalysis and culture if indicated with a start date of 03/19/2024, reflected as active, and a no end date. -Urinalysis with culture on 1st of each month Dx: UTI reoccurrence with a start date of 09/30/2022 and discontinued 11/11/2023. -Urinalysis with culture on 1st of each month Dx: UTI reoccurrence every night shift starting on the 1st and ending on the 5th every month collect per in and cath for lab pick with a start date of 06/15/2023 and a discontinue date of 01/11/2024. Record review of a document titled Discontinued Order for Resident #1, dated 01/11/2024 revealed an order summary for Urinalysis with culture on 1st of each month Dx: UTI reoccurrence every night shift starting on the 1st and ending on the 5th every month COLLECT PER IN AND CATH FOR LAB PICK was created on 01/11/2024 by the DON at 9:34 a.m. and discontinued at 9:43 a.m., and was signed by NP D on 02/06/2024 at 10:52 a.m. The reason for the order being discontinued was blank. The order was not reflected in Resident #1's physician orders listing report dated 02/20/2025. Record review of Resident #1's January 2024 MAR revealed a urinalysis with culture on the 1st of each month starting on the 1st and ending on the 5th was documented as refused on 01/01/2024 by LVN A; documented as refused on 01/02/2024 by LVN A; documented as administered on 01/03/2024 by LVN B; documented as administered on 01/04/2024 by LVN B; and blank on 01/05/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of document titled 1/11/2024 Report, revealed .HAS MONTHLY UA BEEN COLLECTED??? Reinstated order for p/u on Friday morning (1-12-24) Was cancelled on 1-3/24 per lab receipts .MONTHLY ORDER DISCONTINUED DO NOT COLLECT . Record review of Resident #1's lab results report dated 02/20/2025 revealed there were no lab results collected in January of 2024 for a urinalysis. Record review of Resident #1's progress notes dated 02/20/25, revealed: -12/05/2023 at 7:47 p.m. by NP D reflected follow-up urine from 12/01/2023 ua is negative .plan: . Will fax monthly urine culture to nephrologist whom ordered lab for management. Will follow up with recommendations. Exam stable . -01/02/2024 at 5:29 a.m. LVN A reflected attempted to perform I/O cath, resident refused. Will try again tomorrow night. At 5:30 a.m. Urinalysis with culture on 1st of each month Dx: UTI reoccurrence every night shift starting on the 1st and ending on the 5th every month COLLECT PER IN AND CATH FOR LAB PICK will attempt again on night shift 1/2/2024 -01/03/2024 at 4:51 a.m. by LVN A reflected Urinalysis with culture on 1st of each month Dx: UTI reoccurrence every night shift starting on the 1st and ending on the 5th every month COLLECT PER IN AND CATH FOR LAB PICK resident refused, became very combative. will try again on Thursday evening. -01/11/2024 at 3:51 p.m. by LVN C reflected Received in bed responsive to verbal stimuli. Family visits often and are very supportive of her care.UA to be collected tonight. -01/22/2024 at 6:18 p.m. by NP D reflected follow-up monthly regulatory assessment. no acute issues noted. medications and labs reviewed . -02/29/2024 at 8:43 a.m. by NP D reflected follow-up, continues with aphasia (a disorder that results from damage to the parts of the brain responsible for language, typically affecting the left hemisphere. It can impact a person's ability to communicate, including difficulties in speaking, understanding speech, reading, and writing.), no new issues, called and spoke with [family member] in regards to no medical reason for continued ua's, will monitor q 3 months and prn . -03/14/2024 at 3:00 p.m. by the DON reflected This nurse called [Urologist] office to verify if [Urologist] will be managing the urinalysis reflux to culture and sensitivity when positive every monthly for 12 months per prescription dated 3/5/24. Staff stated will return call after verifying with [Urologist]. -03/14/2024 at 3:16 p.m. by LVN E reflected [Staff] from [Urologist] office called regarding resident's recent UA C&S and requested the results be sent to his office (once sensitivity is available) wherein which [Staff] informed this nurse that she would be calling resident's RP thereafter to inform her that [Urologist] office will not be recommending a monthly UA. In an interview on 02/20/25 at 5:30 p.m. LVN C stated the resident was known to be uncooperative with UA collections and she would chart the resident refused in the MAR and add a progress note. LVN C stated on 1/11/24 she notated they planned to collect a UA from Resident #1 on the night shift because there was an order. LVN C stated she would have noted if there was an order to cancel the UA. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/20/25 at 4:25 p.m. the DON stated most resident orders were in the EMR. The DON stated if an order was not in the EMR it was because it was a brand-new order, or the resident had just returned from a medical appointment, and it had not been entered yet. The DON stated if there was an order to discontinue an order, she would DC in the EMR. The DON stated sometimes the nurses would add a note as to why and the provider would sign the order. The DON stated in January of 2024 she recalled having a phone conversation with NP D to discontinue to monthly UA order because the family member of Resident #1 wanted it done monthly but the facility doctor wanted it done every 3 months. The DON stated the rationale was not documented in January 2024 in the EMR however she provided an order to discontinue the monthly UA, signed by NP D on 02/06/2024. The DON stated she was unsure which the medical provider originally ordered a monthly UA or if the order came from the urologist. The DON stated the urologist stopped practicing in 2024 and was not treating Resident #1 any longer. The DON stated she needed a doctor's order to DC an order. The DON stated she was not a doctor and did not know why they ordered a monthly UA on Resident #1. The DON stated the UA was ordered monthly at the time of the January 2024 MAR and they gave staff opportunities on the 1st-5th to collect the urine sample because the resident would refuse often. The DON stated staff should document if the resident refused, let the provider know, and use the code in the EMR for refused. The DON stated the check marks on the MAR meant the UA order was done which was improper documentation. The DON stated if staff had collected the urine sample for the UA they should have discontinued the order for the rest of that month or document it was already collected. When asked if there was a risk to the resident when staff incorrectly documented a sample was collected, the DON stated staff would document in the 24-hour report they had already collected the sample so other staff would not try to collect the sample again. Record review of the facility's policy Medical Records, dated 02/2017, revised January 2023, stated Compliance Guidelines: A medical record is maintained for every person admitted to a community in accordance with accepted professional standards and practices. The administrator has ultimate responsibility for the maintenance of medical records but may delegate this responsibility to another team member. The medical record consists of but not limited to the following: o information to identify the resident o a record of the resident's assessments o the plan of care and services provided o the results of any preadmission screening conducted by the state and progress notes .