STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676303	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirador	5857 Timbergate Dr Corpus Christi, TX 78414

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50969 Based on observation, interview, and record review the facility failed to develop and implement a person-centered comprehensive care plan to include measurable objectives and timeframes to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being for 2 of 5 (Resident #1 and #2) residents reviewed for comprehensive care plans in that: The facility failed to revise or update Resident #1's care plan to reflect the need and order for Enhanced Barrier Precautions (EBP). The facility failed to revise or update Resident #2's care plan to reflect the need and order for Contact Precautions. This failure could affect the residents by placing them at risk for not receiving appropriate interventions or care to meet their current needs. The findings included: Record review of Resident #1' s face sheet dated 04/29/25 revealed an [AGE] year-old male with an admitted [DATE]. Record review of Resident #1' s care plan initiated 03/27/25 revealed a care plan for an indwelling foley catheter, but no care plan or interventions for EBP. Record review of Resident #1's physician orders dated 04/28/25 revealed an order for EBP. In an observation on 04/29/25 at 9:35 AM it was revealed Resident #1's room had an EBP sign outside of the door. Record review of Resident #2' s face sheet dated 04/29/25 revealed a [AGE] year-old female with an original admitted [DATE], and a current admitted [DATE]. Record review of Resident #2' s care plan initiated 02/03/23 revealed no care plan for C. Diff (Clostridium Difficile is an infection in the colon caused by bacteria), and no care plan or interventions for Contact Precautions. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's physician orders dated 04/21/25 revealed an order for Contact Precautions for C. Diff. In an observation on 04/29/25 at 9:42 AM it was revealed Resident #2's room had a Contact Isolation sign outside of the door. In an interview with CNA-A, on 04/29/25 at 9:35 AM, she stated residents were on EBP or contact precautions to help prevent cross contamination and infections, and the signs helped them know what to wear when providing care to the residents. She also stated the CNAs did not use the care plans, and care plans were something the nurses used to keep updated information about the residents. In an interview with RN-B, on 04/29/25 at 9:44 AM, she stated residents were on EBP or contact precautions so the staff knew the proper PPE to wear and to prevent cross contamination and possible infection. She also stated she had not known how to access the care plan to check for precautions because the floor nurses did not really use the care plan. She agreed that the nurses working on the floor should have known how to access and use the care plan. After searching, she stated she could not find Resident #1's EBP care plan or Resident #2's Contact Precautions care plan, but it was definitely something that should have been care planned so the nurses and staff were aware of any precautions, changes, or updates with these residents. In an interview with the DON on 04/29/25 at 10:00 AM, she stated the types of residents that were placed on EBP included residents with C. Diff, foley catheters, Gastrostomy tubes, and/or open wounds. The DON stated if a resident had a foley catheter or C. Diff, it should have been care planned. After searching, the DON was unable to find an EBP care plan for Resident #1 or a Contact Isolation care plan for Resident #2. She stated care plans were supposed to be used as a communication tool for the staff and nurses, as well as to ensure residents received the best possible care. She stated the nurses did not use the care plans though because this was real life, and the nurses were too busy and did not have time to read resident care plans. The DON also stated that was why they had other tools such as the Kardex and other forms to keep the nurses updated on each resident. She also stated that even though they did not really use the care plans, they should have known how to access them and how to use them, and if the nurses were not properly aware of a resident's isolation status, cross-contamination and infection could occur. The DON stated the MDS nurse was the one who updated the clinical care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the MDS nurse on 04/29/25 at 11:15 AM, she stated she was aware that some of the care plans were missing, and she had been doing an audit today with her supervisor that double checked any residents that had an issue that qualified for EBP or Contact Precautions was care planned. She stated the IDT team met once per week, usually on Wednesdays, and went over any updates or changes that needed to be made to the care plans, as well as any updates and changes regarding infection control between meetings got relayed to her by the infection control nurse. Infection control relayed the information when she placed a resident on precautions, and then the MDS nurse updated the care plans. She stated she was aware of the precautions, but she forgot to update the care plans. The MDS nurse stated the nurses on the floor should have known how to use the care plans, but they were too busy on the floor most of the time, so anytime there was something new added to the care plan, she actually went to the nurses and updated them. She also stated these care plans just got overlooked on Resident #1 and Resident #2 because there had been a GI outbreak, and a lot going on, and that was the reason these two care plans got overlooked. The MDS nurse stated if the care plan was not updated appropriately, nurses or other staff could have provided care to a resident without having known the proper precautions to take or proper PPE to wear, and cross-contamination could have occurred. Record review of the Care Plan Goals and Objectives policy, revised April 2009, revealed Policy Statement: Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Policy Interpretation and Implementation 4. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. Record review of the Care Planning - Interdisciplinary Team policy, revised March 2022, revealed Policy Statement The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT).