

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER The Shoal		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 Mainland Center Dr Texas City, TX 77591	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident had the right to be treated with respect and dignity for 1 (Resident #84) of 5 residents reviewed for respect and dignity .</p> <p>The facility failed to provide Resident #84 privacy when providing incontinence care on 4/23/25 as the door to the room was open and the privacy curtains were not pulled.</p> <p>The failure could place residents at risk of emotional distress, embarrassment, and lower self-esteem.</p> <p>Findings included:</p> <p>Record review of Resident #84's face sheet dated 4/24/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Epilepsy (seizure disorder) and Cognitive Communication Deficit (difficulty communicating).</p> <p>Record review of Resident #84's quarterly MDS dated [DATE] revealed a BIMS score of 10 that suggested moderate cognitive impairment.</p> <p>Record review of facility's Sign In Sheet for 4/22/25 revealed CNA K and CNA L worked 10 p.m. to 6 a.m. and LPN B worked 6 p.m. to 6 a.m. on the #100 Hallway where Resident #84 resided.</p> <p>Record review of Employee Inservice/Training for Ensuring Privacy during Residents Care was completed on 4/26/25.</p> <p>Observation of video on 4/23/25 at 2:35 a.m. revealed CNA K provided incontinence care to Resident #84 and left the door to the hallway open and privacy curtains were left open.</p> <p>On 4/23/25 at 12:33 p.m., surveyor attempted to contact CNA K via phone but received message that wireless customer was not available.</p> <p>On 4/23/25 at 12:47 p.m., surveyor called LPN B via phone and left a message with request to call surveyor, but no call back received prior to survey exit.</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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/25 at 10:33 a.m., the Administrator said the curtains and door should be closed when providing care. The Administrator said training regarding privacy was through online training and in-services that was completed upon hire, annually and as needed if issues. The Administrator said to monitor for resident privacy that they did daily rounds. The Administrator said if a resident did not have privacy, then a negative effect on the resident would be due to resident dignity. The Administrator said CNA K had been dismissed.</p> <p>On 4/25/25 at 10:33 a.m., the DON said residents' curtains and door should be closed when providing care. The DON said training regarding privacy was through online training and in-services that was completed upon hire, annually and as needed if there were issues. The DON said if a resident did not have privacy, it could have a negative effect on the resident due to resident dignity.</p> <p>On 4/25/25 at 11:26 a.m., ADON A said the expectation regarding resident privacy was that the door will be closed. and curtain pulled when providing care. ADON A said she monitored for privacy when she was out on the unit. ADON A said that failing to provide privacy for a resident was a dignity issue and the resident could feel like no care if privacy was not provided.</p> <p>Record review of Personnel Disciplinary Record dated 4/24/25 for CNA K revealed dismissal with reason termination due to abuse allegation. The Personnel Disciplinary Record was not signed by CNA K with note staff member not returning call.</p> <p>Record review of facility's policy Perineal Care revised 8/2024 revealed Avoid unnecessary exposure of the resident's body.</p> <p>Record review of facility's policy Confidentiality of Information and Personal Privacy revised October 2017 revealed the facility will strive to protect the resident's privacy regarding personal care.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents had the right to be free from abuse for 1 (Resident #84) of 5 residents reviewed for abuse.</p> <p>The facility failed to ensure that Resident #84 from was free from mental abuse, verbal abuse, and deprivation of services by staff when CNA K verbally abused Resident #84 on 4/23/25 and placed his call light out of his reach.</p> <p>The failure could place residents at risk of mental abuse, verbal abuse, and deprivation of services by staff.</p> <p>Findings included:</p> <p>Record review of Resident #84's face sheet dated 4/24/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Epilepsy (seizure disorder) and Cognitive Communication Deficit (difficulty communicating).</p> <p>Record review of Resident #84's quarterly MDS dated [DATE] revealed a BIMS score of 10 that suggested moderate cognitive impairment and a functional abilities code of 01 for toileting hygiene indicating he was dependent for others to complete.</p> <p>Record review of care plan follow up for Resident #84 dated 4/22/25 revealed in-service to be conducted due to concern related to staff putting call light on the floor.</p> <p>Record review of facility's Sign In Sheet for 4/22/25 revealed CNA K and CNA L worked 10 p.m. to 6 a.m. and LPN B worked 6 p.m. to 6 a.m. on the #100 Hallway where Resident #84 resided.</p> <p>Record review of Resident #84's Care Plan Report printed 4/24/25 revealed Resident #84 was dependent on staff for meeting physical needs. Interventions included staff will approach Resident #84 in a calm, non-threatening manner when interacting with him, encourage to use bell to call for assistance, and caregivers to provide opportunity for positive interactions.</p> <p>Record review of Employee Inservice/Training for Abuse/Neglect revealed training was completed on 4/23/25.</p> <p>Record review of Suspected Verbal Abuse Questionnaire revealed trainings completed on 4/23-5/5/25.</p> <p>Record review of Employee Inservice/Training for Abuse, Neglect & Exploitation, Resident Rights, and Ensuring call [NAME] in reach of Residents revealed trainings were completed on 4/26/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of video recorded on 4/23/25 at 2:32 a.m. revealed CNA K entered Resident #84's room. At 2:33 a.m. CNA K said, Shame on you [Resident #84] and Shame on you for trying to make everybody else's night awful. At 2:34 a.m. CNA K said I bet you won't get it back while she was holding the call light and leaves the call light on the floor. At 2:34 a.m. CNA K also said that ain't got nothing to do with why you are acting a fool. CNA K provided incontinence care to Resident #84 at 2:36 a.m. and exited the room [ROOM NUMBER]:38 a.m. At 2:38 a.m. the call light could be seen on the floor near the curtain in the middle of the room.</p> <p>During interview on 4/23/25 at 10:07 a.m., Resident #84's family member said there was an incident around 2 a.m. on 4/23/25 and they had a video of the incident. Surveyor viewed the video with time stamp that started on 4/23/25 at 2:25 a.m. on Resident #84's family member's phone. Resident #84's family member said CNA K member was saying you are not going to mess up our night and you are messing everybody else's night up and the surveyor was shown sections of the video where Resident #84's family member said this was occurring. At the time the surveyor viewed in the video CNA K was also seen placing the call light near the curtain in the middle of the room and saying, I bet you won't get that back.</p> <p>Observation on 4/23/25 at 10:07 a.m., Resident #84 was tearing up while his family member was showing the surveyor the video of the incident on 4/23/25 at 2:25 a.m.</p> <p>During interview on 4/23/25 at 10:58 a.m., when Resident #84 was asked how he felt last night when CNA K came into the room he said, they don't care. When asked if staff does not speak to him nicely, Resident #84 shook his head yes. When asked if he was afraid last night, Resident #84 shook his head yes.</p> <p>During interview on 4/23/25 at 10:58 a.m., Resident #84's family member said they did not know the names of the staff members in the video that started on 4/23/25 at 2:25 a.m. Surveyor requested Resident #84's family member to provide a copy of the video as soon as possible. Resident #84's family member said that they were not going to show the video to anyone at the facility before leaving and they would send a copy to the administration this afternoon when they send the other videos.</p> <p>On 4/23/25 at 12:33 p.m., surveyor attempted to contact CNA K via phone but received message that wireless customer was not available.</p> <p>On 4/23/25 at 12:44 p.m., surveyor called CNA L via phone and a male voice answered but was disconnected. Surveyor called CNA L back immediately and left a message with request to call surveyor, but no call back received prior to survey exit.</p> <p>On 4/23/25 at 12:47 p.m., surveyor called LPN B via phone and left a message with request to call surveyor, but no call back received prior to survey exit.</p> <p>On 4/23/25 at 1:24 p.m., surveyor notified Administrator and DON regarding Resident #84's family member showing video to surveyor with concerns of female staff member telling Resident #84 you are not going to mess up our night, you are messing everybody else's night up and I bet you won't get this back in regarding to the resident's call light.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 4/23/25 at 1:24 p.m., the Administrator and DON said they were unaware of any reports of abuse regarding Resident #84. The Administrator and DON said the allegations in the video from Resident #84's family member was not acceptable practices for the CNA to act and they would be upset with these actions. The Administrator said she considered these actions to be abuse and would be reportable. The Administrator said she would suspend the staff right away and start an investigation.</p> <p>During interview on 4/23/25 at 3:46 p.m., the Administrator and DON denied any concerns told to them regarding staff from the overnight shift. The Administrator said she had completed the self-report and was starting the investigation. The Administrator said she had not received any videos from Resident #84's family member.</p> <p>During interview on 4/23/25 at 5:18 p.m., the Administrator said that both CNAs from the video were suspended pending the investigation and CNA L had provided a statement. The Administrator said she had tried to call Resident #84's family member and they did not answer but she would attempt to reach out again this evening.</p> <p>Record review of Personnel Disciplinary Record dated 4/23/25 for CNA K revealed suspension with reason on suspension pending investigation.</p> <p>During interview on 4/24/25 at 11:19 a.m., the DON said they had already started in-servicing staff regarding call lights.</p> <p>Record review of written statement from LPN B dated 4/23/25 revealed they had made sure the call light was within easy reach of Resident #84. LPN B said they had never had any negative reports from residents regarding CNAs and had not received any messages from Resident #84's family with any concerns from the night of 4/22/25.</p> <p>Record review of email dated 4/24/25 at 3:10 p.m. revealed Resident #84's family member had provided a copy of the video regarding the incident that occurred on 4/23/25 to the surveyor.</p> <p>During interview on 4/24/25 at 11:19 a.m., the DON said they have abuse training quite often and have abuse in-services when they did a self-report and annually through their online in-service system. The DON said she monitored for abuse by talking to the residents and that the residents were open. The DON said she also watched interactions between residents and staff and stood outside the rooms to listen to conversations. The DON said she also looked at resident's skin assessments and looked for bruises.</p> <p>Record review of Personnel Disciplinary Record dated 4/24/25 for CNA K revealed dismissal with reason termination due to abuse allegation. The Personnel Disciplinary Record was not signed by CNA K with note staff member not returning call.</p> <p>During interview on 4/25/24 at 8:21 a.m., ADON A said staff had in-services monthly for abuse and neglect or when something happened. ADON A denied seeing any abuse or neglect at the facility or residents/family members reporting abuse to her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/25/25 at 10:33 a.m., the Administrator said an adverse effect of verbal abuse was the resident could be scared to ask for help, become isolated, their health could decline, or the resident could be afraid the same person could come back in and speak to them in the same manner. The Administrator said if a resident could not reach their call light, then their care would be affected or the staff's ability to meet the resident's needs. The administrator said she sat in on resident council meetings and reviewed resident rights and talked about abuse. The Administrator said they monitored for signs of abuse or neglect and did life satisfaction rounds randomly. The Administrator said they did abuse trainings at least quarterly. The Administrator said she would do more monitoring of the facility including life satisfaction surveys and town halls and that everyone would be responsible. The Administrator said CNA K had been dismissed.</p> <p>On 4/25/25 at 10:33 a.m., the DON said an adverse effect of verbal abuse was the resident could be scared to ask for help, be afraid that the same person could come back in and speak to them in the same manner, the resident's health could decline, or the resident could become isolated. The DON said if a resident cannot reach their call light, then the resident could have a delay in care.</p> <p>Record review of CNA K's personnel file on 4/25/25 at 12:16 p.m. revealed New Hire Application Checklist dated 4/30/24 and current nurse aide license to expire 4/9/2026. CNA K was not listed on the Employee Misconduct Registry dated 4/30/24. No disciplinary actions noted in CNA K's personnel file.</p> <p>During Interview on 4/25/25 at 2:05 p.m., the Administrator said she did not think CNA K had any prior disciplinary actions. The Administrator said she believed disciplinary actions would be in the employee's file, but human resources was on vacation this week and she was unsure if they kept the disciplinary actions in another place.</p> <p>Record review of CNA K's User Learning dated 4/25/25 revealed she had completed Communicating Effectively on 3/4/25, Abuse, Neglect, and Exploitation on 12/8/24 and Elder Abuse: The Elder Justice Act on 12/7/24.</p> <p>Record review of facility's policy Perineal Care revised 8/2024 revealed that after providing incontinence care staff should place the call light within easy reach of the resident.</p> <p>Record review of facility's policy Abuse Prevention Program revised December 2016 revealed residents have the right to be free from abuse that includes but was not limited to verbal and mental abuse.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48315</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure the MDS assessment accurately reflected resident's status for 1 (Resident #22) of the 6 residents reviewed for accuracy of assessments.</p> <p>Resident # 22's assessment did reflect her hearing loss on section B0200 hearing inadequate on, quarterly, and annual assessment since admitted [DATE] and readmitted [DATE]</p> <p>This deficient practice could affect residents at the facility by contributing to inadequate care based on inaccurate assessments.</p> <p>The findings included:</p> <p>Record review of Resident # 22 face sheet revealed resident is an [AGE] year-old female and was admitted [DATE] with a diagnosis of upper respiratory tract, depression disorder, pain, hyperkalemia (high potassium), dementia, bipolar disorder, and diabetes type II.</p> <p>Record review of Residents #22 5-day admitted d 9/27/2017 section B category B0200. Hearing ability to hear was code 0 Adequate - no difficulty in normal conversation, social interaction, listening to TV. Section B0300 of Resident's #22 MDS dated [DATE] revealed the following: Hearing Aid Enter Code, 0 Hearing aid or other hearing appliance used in completing B0200.</p> <p>Record review of Resident #22's Quarterly MDS revealed Resident #22 had a BIMS of 14 which indicates moderate cognitive impairment.</p> <p>Record review of Resident #22 physicians' orders and care plan revealed no documentation pertaining to hearing aids.</p> <p>Interview and observation with Resident #22 on 4/22/25 at 9:45AM, Resident expressed she was unable to hear the questions being asked of her and that surveyor would have to speak up and to speak loudly, close to her ear. Even speaking up Resident #22 had difficulty understanding the surveyor. Resident #22 said I cannot hear good I am hard of hearing, and I don't know where my hearing aides are. Resident #22 said I told the nurse, and the people up front I cannot hear and wanted to see a doctor. Resident #22 said I had hearing aid when I came here a while back, I guess they are lost. Observation of Resident #22 on 4/22/25 at 10:00AM revealed no hearing aid present, resident was moving close to roommate to see if she would be able to tell her what was being said.</p> <p>Interview with CNA #2 on 4/22/2025 at 10:00AM, she reported that she had never seen hearing aids for Resident #22. I just speak loudly when I assisted her so she can hear and understand me. I do know she needs them because we have to yell in her ear, and she is able to respond to us that way. CNA #2 reported it is our responsibility to make sure we report to nurse or the upper management that a resident is having trouble hearing. CNA #2 reported if a resident cannot hear us talking to them than they may not understand what is going on and they may not be able to tell us what is going on or answer the questions right.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/22/2025 at 10:15AM, CNA #5 stated I remember Resident #22 having hearing aids. I just speak loudly when I am talking to her.</p> <p>Interview with LVN #1 on 4/22/2025 at 10:25AM, she reported that she was unaware of Resident #22 having an issue with hearing, I notice her roommate would answer the questions for her, but I thought it was because they have been roommates for so long and they just knew each other like that. LVN #1 stated if she (Resident #22) had a hearing problem I would let the social worker know and she will take it from there. I would also tell the doctor and family. If Resident #22 lost her hearing that will affect her overall care as well.</p> <p>Interview with SW on 4/22/2025 at 11:00AM, SW stated I send residents out to UTMB for hearing, and she was not one of them. I do sections CDE of MDS and the MDS nurse does the coding for hearing, vision. I was not told Resident #22 had issues with hearing. I do know I had to talk loudly to her sometimes. I believe she had some hearing aids when she was admitted. I will get her on the list for UTMB to be seen today.</p> <p>Interview on 4/22/2025 at 11:30AM, the MDS nurse said I do sections B, sometimes I do all the sections of the MDS. Yes, I coded Resident #22 MDS quarterly and annual that she had no issues with hearing and no hearing aid was present. I did interview her. MDS nurse confirmed that Resident #22 MDS all of them were inaccurate and that could lead to her not getting or receiving the proper care she needed. MDS section B should have reflected she had hearing aids and inadequate hearing.</p> <p>Review of facility policy, Resident Assessment reviewed on 4/22/2025, read in part it is the policy of this facility to ensure that the assessment accurately reflect the resident's status.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48315</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure that residents receive proper treatment and assistive devices to maintain hearing abilities, for 1 (Resident #22) of the 6 residents reviewed for the use of assistive device in that-</p> <p>Resident #22 was not assessed and did not receive care for her hearing deficit.</p> <p>This failure could place residents at risk of not receiving appropriate care and services needed to maintain their health and quality of life.</p> <p>The findings included:</p> <p>Record review of Resident # 22 face sheet revealed resident is an [AGE] year-old female and was admitted [DATE] with a diagnosis of upper respiratory tract, depression disorder, pain, hyperkalemia (a condition characterized by abnormally high levels of potassium in the blood), dementia, bipolar disorder, and diabetes type II.</p> <p>Record review of Residents #22 5-day admitted d 9/27/2017 section B category B0200. Hearing ability to hear was code 0 Adequate - no difficulty in normal conversation, social interaction, listening to TV. Section B0300 of Resident's #22 MDS dated [DATE] revealed the following: Hearing Aid Enter Code, 0 Hearing aid or other hearing appliance used in completing B0200.</p> <p>Record review of Resident #22's Quarterly MDS revealed Resident #22 had a BIMS of 14 which indicates moderate cognitive impairment.</p> <p>Record review of Resident #22 physicians' orders and care plan revealed no documentation pertaining to hearing aids.</p> <p>Interview and observation with Resident #22 on 4/22/25 at 9:45AM, Resident expressed she was unable to hear the questions being asked of her and that surveyor would have to speak up and to speak loudly, close to her ear. Even speaking up Resident #22 had difficulty understanding the surveyor. Resident #22 said I cannot hear good I am hard of hearing, and I don't know where my hearing aides are. Resident #22 said I told the nurse, and the people up front I cannot hear and wanted to see a doctor. Resident #22 said I had hearing aid when I came here a while back, I guess they are lost. Observation of Resident #22 on 4/22/25 at 10:00AM revealed no hearing aid present, resident was moving close to roommate to see if she would be able to tell her what was being said.</p> <p>Interview with CNA #2 on 4/22/2025 at 10:00AM, she reported that she had never seen hearing aids for Resident #22. I just speak loudly when I assisted her so she can hear and understand me. I do know she needs them because we have to yell in her ear and she is able to respond to us that way. CNA #2 reported it is our responsibility to make sure we report to nurse or the upper management that a resident is having trouble hearing. CNA #2 reported if a resident cannot hear us talking to them than they may not understand what is going on and they may not be able to tell us what is going on or answer the questions right.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/22/2025 at 10:15AM, CNA #5 stated I remember Resident #22 having hearing aids. I just speak loudly when I am talking to her.</p> <p>Interview with LVN #1 on 4/22/2025 at 10:25AM, she reported that she was unaware of Resident #22 having an issue with hearing, I notice her roommate would answer the questions for her, but I thought it was because they have been roommates for so long and they just knew each other like that. LVN #1 stated if she (Resident #22) had a hearing problem I would let the social worker know and she will take it from there. I would also tell the doctor and family. If Resident #22 lost her hearing that will affect her overall care as well.</p> <p>Interview with SW on 4/22/2025 at 11:00AM, SW stated I send residents out to University of Texas Medical Branch (UTMB) for hearing, and she was not one of them. I do sections CDE of MDS and the MDS nurse does the coding for hearing, vision. I was not told Resident #22 had issues with hearing. I do know I had to talk loudly to her sometimes. I believe she had some hearing aids when she was admitted. I will get her on the list for UTMB to be seen today.</p> <p>Interview on 4/22/2025 at 11:30AM, the MDS nurse said I do sections B, sometimes I do all the sections of the MDS. Yes, I coded Resident #22 MDS quarterly and annual that she had no issues with hearing and no hearing aid was present. I did interview her. MDS nurse confirmed that Resident #22 MDS all of them were inaccurate and that could lead to her not getting or receiving the proper care she needed. MDS section B should have reflected she had hearing aids and inadequate hearing.</p> <p>Review of facility policy, Resident Assessment reviewed on 4/22/2025, read in part it is the policy of this facility to ensure that the assessment accurately reflect the resident's status.</p>		

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NAME OF PROVIDER OR SUPPLIER The Shoal		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 Mainland Center Dr Texas City, TX 77591	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036</p> <p>Based on observation, interview and record review, the facility failed to ensure that all drugs and biologicals used in the facility must include the expiration date when applicable for one (#100 Hallway medication aide medication cart) out of four medications carts reviewed for labeling of drugs.</p> <p>The facility failed to ensure that Latanoprost eye drops (Latanoprost is used to treat certain types of Glaucoma (eye condition that damages the optic nerve) and other causes of high pressure inside the eye) were labeled with expiration date on all medication carts.</p> <p>This failure could place residents at risk of not receiving the intended therapeutic effects of prescribed medications or receiving potentially harmful side effects from prescribed medications.</p> <p>Findings included:</p> <p>Record review of Resident #42's face sheet dated 4/24/2025, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (high blood sugar) without Complications and unspecified Open-Angle Glaucoma (eye condition that damages the optic nerve).</p> <p>Record review of Resident #42's quarterly MDS dated [DATE] revealed a BIMS score of 13 that suggested cognition was intact (13-15).</p> <p>Record review of Resident #42's Order Summary Report dated 4/24/25 revealed Latanoprost Ophthalmic Solution 0.005% with instructions to instill 1 drop in both eyes at bedtime for Open Angle Glaucoma with order date of 8/2/2024.</p> <p>Record review of Resident #42's April MAR printed 4/24/25 revealed Latanoprost Ophthalmic Solution 0.005% with instructions to instill 1 drop in both eyes at bedtime with administration dates from 4/1-4/23/25.</p> <p>Record review of Resident #42's Care Plan Report printed 4/24/25 revealed Resident #42 had impaired visual function related to Glaucoma (eye condition that damages the optic nerve) with Latanoprost drops daily.</p> <p>Observation on 4/23/25 at 9:15 a.m. revealed Latanoprost 0.005% eye drops for Resident #42 with no open date documented found on the #100 Hallway medication aide medication cart.</p> <p>During interview on 4/23/25 at 9:20 a.m., MA G said eye drops should be dated when they were opened. MA G said if a resident is given eye drops past the use by date the resident could get an eye infection and if the eye drops were not dated when they were opened then they would not be able to know when to dispose of the eye drops.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 4/24/25 at 11:19 a.m., the DON said the medication aides and nurses were responsible for checking their medication carts. The DON said the DON and ADON audited the medication carts weekly, and the pharmacist also checked medication carts monthly. The DON said if a medication was given past the use by date, then there could be decreased effectiveness of the medication or adverse reactions depending on the medication.</p> <p>During interview on 4/25/24 at 8:21 a.m., ADON A said the medication aides were responsible for checking the medication carts. ADON A said the DON and ADONs spot checked the medication carts weekly. The ADON A said that the Pharmacist comes to the facility monthly and checked the medication carts. The ADON A said if a medication had a use by recommendation and no open date is documented then the resident could get an eye infection. The ADON A said if a medication that had a used by recommendation and no open date was documented then staff would not know when to dispose of the medication and they would need to get a new medication. ADON A said staff had in-services or trainings at least monthly related to medications.</p> <p>During interview on 4/25/24 at 8:40 a.m., the Pharmacist said they tell staff to date everything when opened to be on the safe side. The Pharmacist said Latanoprost 0.005% needs to be disposed of after six weeks from opening. The Pharmacist said they come to the facility monthly and performed spot checks of medication carts. The Pharmacist said if they saw a problem then they will do one on one training of the staff. The Pharmacist said an adverse reaction that a resident could experience if it unknown how long a medication had been opened for and used past the recommendations was the medication could be less effective.</p> <p>Record review of facility's policy Medication Storage dated 1/25 revealed outdated, contaminated, discontinued, or deteriorated medications are immediately removed from stock. Record review also revealed medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51036</p> <p>Based on observation, interview and record review, the facility failed to establish and 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 (Resident #84) of 5 residents that were reviewed for infection control practices.</p> <p>The facility failed to ensure that CNA K followed proper infection control while providing care to Resident #84 on 4/23/25.</p> <p>The failure could place residents at risk of infection, decline in health, or cross contamination.</p> <p>Findings included:</p> <p>Record review of Resident #84's face sheet dated 4/24/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Epilepsy (seizure disorder) and Cognitive Communication Deficit (difficulty communicating).</p> <p>Record review of Resident #84's annual/quarterly MDS dated [DATE] revealed a BIMS score of 10 that suggested moderate cognitive impairment.</p> <p>Record review of Resident #84's Care Plan Report printed 4/24/25 revealed focus of bladder incontinence with intervention to clean peri-area with each incontinence episode.</p> <p>Record review of facility's Sign In Sheet for 4/22/25 revealed CNA K and CNA L worked 10 p.m. to 6 a.m. and LPN B worked 6 p.m. to 6 a.m. on the #100 Hallway where Resident #84 resided.</p> <p>Observation of video on 4/23/25 at 2:32 a.m. revealed CNA K entered Resident #84's room. At 2:33 a.m. CNA K reached into her right scrub pocket with her right hand and pulled a bag out and ate from the bag using her right hand to place food in her mouth. CNA K picked up a pillow from the floor using her right hand and placed it on the bed. At 2:34 a.m. CNA K put food in her mouth twice using her hands, touched the curtain and picked up the call light from the right side of the bed while holding a bag of food in her left hand. At 2:34 a.m. CNA K put food in her mouth using her right hand. CNA K then touched Resident #84's right arm, pulled down his sheet and touched his diaper with her right hand. At 2:35 a.m. CNA K poured food in her left hand and ate the food putting her hand to her mouth. At 2:35 a.m. CNA K picked up a box of gloves with her left hand, a brief with her right hand and put on a pair of gloves. At 2:36 a.m. CNA K wiped Resident #84's bottom using the dirty diaper and did not use wipes during incontinence care. At 2:36 a.m. CNA K threw the dirty diaper on the floor knocking the clean diaper on the floor which she picked up and placed on Resident #84. At 2:37 a.m. CNA K placed Resident #84's blankets over him while wearing the gloves she used to change his dirty diaper and then picked up the dirty diaper off the floor and placed in the trash. Then CNA K removed her gloves and placed them in the trashcan. At 2:38 a.m., CNA K exited the room and shut the door. CNA K was not observed entering or exiting restroom or using hand sanitizer during the time she was in Resident 84's room during the video .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 4/23/25 at 10:07 a.m., Resident #84's family member showed surveyor the video from 4/23/25 that started at 2:25 a.m. At 10:58 a.m. Resident #84's family member said they were not going to speak to anyone at the facility regarding the video prior to leaving the facility. Resident #84's family member said they would send the video from 4/23/25 to the administrator when she sends other videos that she was sending to the administrator. Surveyor received copy of the video on 4/24/25 at 3:10 p.m. from Resident #84's family member.</p> <p>On 4/23/25 at 12:33 p.m., surveyor attempted to contact CNA K via phone but received message that wireless customer was not available.</p> <p>On 4/23/25 at 12:47 p.m., surveyor called LPN B from via phone and left a message with request to call surveyor, but no call back received prior to survey exit .</p> <p>During interview on 4/25/25 at 8:21 a.m., ADON A said the Infection Control Preventionist was who monitored for infection control . ADON A said staff should wash their hands if they touch anything soiled, before and after providing resident care. ADON A said staff should use hand sanitizer between each resident interaction. ADON A said staff should wear gloves when staff had direct contact. ADON A said staff had in-services when something new comes out regarding infection control of if they see high infection rates.</p> <p>On 4/25/25 at 10:33 a.m., the Administrator said it was an expectation for staff to follow the regulations regarding infection control and nursing was who monitored for infection control. The Administrator said if staff did not use proper infection control practices like washing hands and using hand sanitizer then the resident could get a possible infection. The Administrator said she monitored for infection control when making daily rounds. The Administrator said CNA K had been dismissed.</p> <p>On 4/25/25 at 10:33 a.m., the DON said she did daily rounds and throughout the day multiple times a day to monitor for infection control. The DON said staff should use gloves when providing care especially for incontinence care, wound care, touching food on the trays and showers. The DON said staff should wash their hands before and after applying gloves. The DON said staff had annual training and training as needed regarding infection control. The DON said if Infection Control saw any trends, then she would do trainings as needed. The DON said if staff did not use proper infection control practices like washing hand and using hand sanitizer then the resident could get a possible infection.</p> <p>On 4/25/25 at 11:32 a.m., Infection Control said expectations was staff was following standard precautions and washing hands before and after using gloves. Infection Control said they did in-services and trainings regarding infection control and that online trainings were monthly and was unsure how often infection control trainings were completed but probably quarterly. Infection Control said she did pop up inspections about 3-4 times a week to make sure staff were following infection control. Infection Control said a staff member should not be eating in a resident's room and had not seen any staff eating in resident rooms. Infection Control said if staff did not use proper infection control, then an infection could pass from one resident to another.</p> <p>Record review of facility's Employee Inservice/Training form dated 4/25/25 revealed training for staff to remove gloves after being soiled, no eating in resident rooms and to wash hands with hand sanitizer or soap and water after removing globes.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of CNA K's User Learning dated 4/25/25 revealed she completed About Infection Control and Prevention on 12/8/24, Bloodborne Pathogens and the Use of Standard Precautions on 3/6/25, Hand Hygiene Basics on 11/24/24 and Infection Control: Basic Concepts on 11/24/24.</p> <p>Record review of Personnel Disciplinary Record dated 4/24/25 for CNA K revealed dismissal with reason termination due to abuse allegation. The Personnel Disciplinary Record was not signed by CNA K with note staff member not returning call.</p> <p>Record review of facility's policy Perineal Care revised 8/2024 revealed staff should wash and dry hands thoroughly prior to starting and after providing care. Record review also revealed that perineal and rectal/buttocks area should be washed using wet washcloth and soap or skin cleansing agent.</p> <p>Record review of facility's policy Infection Control - Standard Precautions revised October 2018 revealed that hands are washed with soap and water after removing gloves and before eating. Record review also revealed that hand hygiene (handwashing with soap or use of alcohol-based rub) was to be performed before and after contact with the resident, after contact with items in the resident's room and after removing personal protective equipment. Record review also revealed gloves are removed promptly after use and before touching non-contaminated items and environmental surfaces. Record review also revealed that hands are to be washed immediately after gloves are removed to avoid the transfer of microorganisms to other residents or environments.</p>		