

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/11/2026
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents have the right to dignified existence, self-determination for 1 of 6 residents (Resident #20) reviewed for dignity. RN V failed to knock, identify themselves before entering Resident #20's room. This failure could cause loss of privacy, decreased sense of safety for residents, and potential psychosocial harm. Findings included: Record review of Resident #20's admission record revealed a [AGE] year-old female who admitted into the facility on [DATE]. Her diagnoses included anxiety disorder, pneumonia, need for assistance with personal care, muscle weakness and pain. Record review of Resident #20's Care Plan initiated on 06/01/2026 read. requires assistance with her physical needs. She enjoys independent leisure activities, word puzzles, movies/tv, groups, exercise class, and 1:1 social visits. We will provide materials for individualized activities as desired and accommodate wants/needs accordingly. The interventions/tasks read. All staff to converse with Resident #20 while providing care. Record review of Resident #20's Initial MDS assessment dated [DATE] revealed a BIMS score of 14 out 15 which indicated she was oriented and able to recall information appropriately with no significant memory or thinking impairment detected based off testing. Resident #20 required substantial/maximal assistance with lower body dressing. During an interview and observation on 06/09/2026 at 10:06 a.m., Resident #20 stated, I hate it here and she felt staff do not treat her with respect or dignity. Resident #20 stated when she asked for assistance, staff respond with an attitude, often saying what do you want in a tone that was rude and dismissive. She stated staff do not knock before entering her room, which made her feel disrespected and as if her privacy was not valued. She stated staff made her feel like she was a bother when she requested help. Resident #20 stated the interactions made her feel unwelcome, uncomfortable, and unhappy living in the facility. Resident #20 asked if she could be assisted with the room temperature and was asked to use the call light button. It was observed RN V to walk into Resident #20's room without knocking or identifying herself before asking Resident #20 what she needed. During an interview on 06/09/2026 at 10:12 a.m., RN V stated the expectation for answering call lights was for staff to enter the resident's room, ask what the resident needs, and then turn the call light off. She stated that, for dignity, staff are expected to knock before entering any resident room, regardless of whether the door was open or closed. RN V stated the risk of not knocking and identifying oneself was that the residents may not know who entered the room, which could affect their sense of safety and dignity. RN V stated she did not realize that she did not knock before entering the room or identifying herself, she was just focused on answering the call light. During an interview on 06/10/2026 at 1:12 p.m., the DON stated the expectation for dignity was for staff to introduce themselves, explain what they were going to do, and respect the resident preferences, including the right to refuse care. She stated staff were expected to knock and identify themselves before entering a resident's room. She stated the risk of not doing so as the resident not knowing who entered the room, which could cause the resident to feel scared, startled, or unsure of the situation. Record review of the facility's policy for 'Resident Rights' revised 08/2024 read. Policy Statement 1. Federal and state laws guarantee certain basic rights to all residents of this facility. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to prevent complications for 1 (Resident #4) of 2 resident reviewed for gastrostomy tubes (a surgically implanted tube into the stomach to provide delivery of nutrition).RN A failed to check for placement of gastrostomy tube (g-tube) prior to administering medication.This failure could place residents with g-tubes at risk of complications such as aspiration, abdominal injury, tube dislodgement and hospitalization. Findings included:Record review of Resident #4's face sheet dated 06/11/26 revealed a [AGE] year-old first admitted to the facility on [DATE] and initially admitted on [DATE]. Diagnoses included cerebral infarction (death of brain tissue), gastrostomy status (a surgically implanted tube to allow provision of nutritional support), Dysphagia (swallowing disorder), malnutrition, Aphasia (language disorder caused by damage in a specific area of the brain) Hemiplegia (one sided paralysis or severe loss of strength on one side), Dementia (a decline in cognitive function), and Diabetes (a chronic condition that occurs when the body cannot properly use blood sugars).Record review of Resident #4's quarterly MDS dated [DATE] revealed she had short term and long-term memory problems. She had severely impaired cognitive skills for daily decision making. She had lower extremity limitations in range of motion. She was dependent on staff assistance for oral hygiene, toileting needs, bathing, dressing, personal hygiene and mobility. She required a feeding tube for delivery of nutritional support.Record review of Resident #4's undated care plan revealed: Focus - Resident #4 was NPO, on tube feeding for inadequate oral intake r/t decreased appetite AEB need for Gastrostomy-tube. Goal - Resident #4 will remain free of side effects or complications r/t to tube feeding through review date, target date 07/25/26. Interventions included - check for tube placement and gastric contents/residual volume per facility protocol and record. Monitor/document/report PRN any s/sx of Aspiration: fever, SOB, tube dislodged, self-estuation, tube dysfunction or malfunction.Record review of Resident #4's active physician orders as of 6/10/26 revealed the following:*enteral feed order every shift: check tube placement before initiation of formula, medication administration and flushing tube or at least every 8 hours, start date was 11/13/25. *Aspiration precaution: monitor for choking, teary eyes, nasal drip, coughing-notify MD with change in condition every shift, start date 11/3/25. *Buspirone HCL oral tablet 5mg: give 2 tablets twice a day for restlessness and anxiety.During an observation on 6/10/26 at 8:00 AM, Resident #4 was alert, on her back in bed with the HOB raised, the tube feeding was turned on and delivering formula to the resident through the gastrostomy tube. RN A had crushed and prepared the medication Buspirone 5mg tablets x 2 tablets. RN A added 20 ml of water to the crushed medication. RN A performed hand washing, put on a disposable gown and clean gloves. RN A paused the TF pump, disconnected the tubing from the G-tube, attached the barrel of the 60 ml syringe to the G-tube and poured 30 ml of water into the barrel. The water was not infusing by gravity. RN A attached the plunger to the barrel and pushed until the water infused into the resident. RN A did not check for placement of the G-tube. RN A poured the medication that dissolved in 20 ml of water into the barrel of the syringe as it infused into the resident. RN A poured 30 ml of water into the barrel of the syringe as it infused into the resident then attached the tubing to the pump. RN A then turned the pump on. Resident #4 remained alert and in no distress.In an interview on 6/10/26 at 8:15 AM, RN A stated he did check for placement of Resident #4's G-tube by attaching the barrel of the syringe and observing backup of formula into the syringe, when he was satisfied then he poured the water into the barrel of the syringe. RN A stated the risk when pushing too hard with the syringe would be injury to the abdomen, but he pushed only gently. RN A stated another risk could be the internal balloon could pop and dislodge the G-tube. RN A stated he did receive training on G-tube medication administration during orientation 7 months ago.In an interview on 6/10/26 at 4:27 PM, the DON stated when administering (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication via G-tube she would make sure the tube was patent (open and free of obstruction) by attaching a syringe to the G-tube and pulling back to check for residual. The DON stated she would then check for placement by injecting some air using the syringe and listening to the air using a stethoscope placed over the abdomen. The DON stated checking for placement was done to make sure medications do not go into the wrong space and the risk to the resident would be aspiration. The DON stated if fluid was not infusing her expectation would be that the nurse milk the tubing to break up any formula that was stuck in the tubing. The DON stated pushing fluid into the G-tube either forcibly or gently should not be done because it may cause discomfort for the resident. The DON stated checking for placement and residual should be done every single time prior to medication administration or prior to starting tube feeding or administration of a bolus of feeding. Record review of the facility policy and procedure for Administering Medications through an Enteral Tube (feeding tube), revised on 08/2024 read in part: .The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. General Guidelines.3. Administer each medication separately and flush between medications. The following equipment and supplies will be necessary when performing this procedure.12. Stethoscope.6. Verify placement of feeding tube: a. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. 7. Stop feeding and flush tubing with at least 15ml warm purified water (or prescribed amount).9. Dilute medication:.b. Dilute crushed (powdered) medication with at least 30 ml purified water (or prescribed amount).11. Reattach syringe (without the plunger) to the end of the tubing. 12. Administer medication by gravity flow: a. Pout diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. B. open the clamp and deliver medication slowly. c. Begin flush before the tubing drains completely.14. When the last of the medication begins to drain from the tubing, flush the tubing with 15ml of warm purified water(or prescribed amount). 15. Quickly clamp the tubing when the flush is complete. Remove syringe.		