

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2025
NAME OF PROVIDER OR SUPPLIER Twin Pines North Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 Mallette Drive Victoria, TX 77904	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which are complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for documentation. LVN B inaccurately documented on Resident #1's TAR that his BiPAP was removed on 9/16/25 in the morning. This failure could place residents at risk for inaccurately documented interventions, monitoring, and information provided to the interdisciplinary team. The findings were: Record review of Resident #1 's face sheet, dated 9/18/25, reflected the resident was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: acute and chronic respiratory failure with hypercapnia (too much CO2 (carbon) in the bloodstream) [primary], congestive heart failure, obesity, end stage renal disease, hypertensive heart disease, sleep apnea (sleep disorder where breathing stops and starts), and COPD (lung disease). Record review of Resident#1's admissions MDS, dated [DATE], reflected a BIMS score of 9, indicative of moderate impairment in cognition. Record review of Resident#1's Physician' Orders, dated August 2025 revealed: connect resident to BiPAP machine when sleeping and napping; and Remove BIPAP upon waking up. Record review of Resident #1's TAR dated September 2025 reflected the BiPAP machine was removed every morning upon the resident waking up for the period September 1 to September 16, 2025. On 9/16/25, LVN B documented the removal of Resident #1's BiPAP in the AM. Record review of Resident #1's Care Plan, undated revealed, the goal of respiratory care. The CP stated the resident required the BiPAP related to sleep apnea, morbid obesity with hypoventilation. Further review revealed the care plan noted, resident removes BIPAP per personal preference, and nursing staff were required to monitor saturation as ordered and the resident was to use the BiPAP as ordered. Record review of Resident#1's Nurse Note, dated 9/15/25 at 11:09 PM authored by LVN B, reflected: resident was upset, refused his medications, broke his cane, and threw his BiPAP machine to the floor. LVN B documented the BiPAP machine would not turn on, and the resident remained on continuous O2 through the nasal cannula. LVN B further documented that the resident was alert and oriented. During an interview with LVN A on 9/18/25 at 11:32 AM, LVN A stated, based on the nurse note dated 9/15/25 at 11:09 PM authored by LVN B, the resident threw the BiPAP on the floor and went to sleep without a BiPAP. LVN A stated per the nurse note revealed the resident was on continuous O2. LVN A stated the TAR documented by LVN B reflected removal of the resident's BiPAP in the morning. LVN A stated the resident claimed the BiPAP was not present the night of 9/15/25 but the TAR reflected the BiPAP was removed in the morning. Attempted interview on 9/18/25 at 2:03 PM with Resident #1 was unsuccessful. During an interview with the DON on 9/18/25 at 3:46 PM, the DON stated the nurse note dated 9/15/25 at 11:09 PM authored by LVN B reflected Resident #1 threw his BiPAP on the floor and refused to put it on. The DON stated, LVN B inaccurately documented on the TAR that the BiPAP was removed in the morning. The DON stated she could not explain the inaccurate documentation of the TAR by LVN B. During an interview with LVN B on 9/19/25 at 10:18 AM, LVN B stated she was the night nurse for Resident #1 on 9/15/25. LVN B stated on 9/15/25 around 11:00 PM the resident got upset and threw his BiPAP on the floor. LVN B stated the BiPAP was not re-connected to the resident and continuous O2 remained in place on the resident through a nasal cannula the entire time. LVN B stated she inaccurately charted on Resident #1's TAR that she removed the resident's BiPAP in the morning on 9/16/25. LVN B stated that she should have charted removing Resident #1's nasal canula and replacing it. During an interview with the DON on 9/19/25 at 11:18 AM, The DON stated the TAR for Resident #1 should document per MD order when the BiPAP was removed when the resident was awakened. The DON confirmed LVN B inaccurately documented in the TAR the removal of Resident #1's BiPAP in the morning on 9/16/25. The DON stated she trusted that nurses accurately documented in the clinical record and by exception would check when inaccurate documentation was noted in the clinical record. During an interview with the Administrator on 9/19/25 at 11:35 AM, the Administrator stated resident records needed to be accurate to reflect care and services given. Record review of the facility's policy titled, Documentation, undated, revealed, The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.</p>		