STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676372	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines North Nursing and Rehabilitation Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676372	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines North Nursing and Rehabilitation Center	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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 4 residents (Resident #1 and Resident #4), reviewed for the ADL of showers/bathing. 1. Resident #1 did not receive showers/bathing for the period 11/18/25 to 11/29/25 (11 days). 2.Resident #4 did not receive showers/bathing for the period 12/01/25 to 12/15/25 (14 days). This failure could result in residents experiencing infections, skin breakdown, and a diminished quality of life.The findings include: 1. Record review of Resident #1's face sheet, dated 12/27/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged home on [DATE]. Resident #1 had diagnoses which included: HTN (hypertension), kidney disease, a UTI (urinary tract infection at admissions), and a history of stroke. The RP was listed as: a family member. Record review of Resident #1's admissions MDS, dated [DATE], reflected a BIMS score of 15, indicative of no impairment in cognition. The ADLs for: B/B were incontinent for some episodes; and Transfer and Mobility was set up. ROM reflected: left side impairment. Toileting was assisted by one staff member. The resident's assistive device was a walker. Record review of Resident # 1's Care Plan, undated, revealed, the goals and interventions included: ADLs: showers X1. The interventions included self-determination, participation during care, and staff to give explanation. The CP also reflected that resident was resistive to care related to adjustment to NF, anxiety, and refusals of baths. Record review of Resident #1's physician orders, dated December 2025 reflected: no orders for infections at exit. A UTI was treated in the hospital. There were no orders for a rash or itching. Record review of Resident#1's Customer Service assessment, dated 12/3/25 and authored by corporate staff, revealed: the family (RP) expressed concern that the resident was not showered, and the family member stated the resident refused showers at times. Resident #1 was showered on 12/3/25. Record review of Resident #1's Skin Assessments revealed: Admissions (dated 11/17/25) bruise to hand. Last skin assessment, dated 12/1/25, revealed his skin was intact. Record review of Resident #1's daily charting for skin assessment reflected no skin findings for 12/3 and 12/4/2025. Record review of Resident #1's POC for showers/bathing revealed the scheduled days were Tuesday, Thursday, and Saturday. Further review of the PPC revealed, in reference to showers/bathing:-11/18/25-not documented-11/20/25-not documented-11/22/25-not documented-11/25/25-refused-11/27/25-refused-11/29/25-not documented-12/2/25-received-12/4/25-received Record review of Resident #1's Nurse Notes from 11/17/25 to 12/4/25 reflected no nurse documentation of resident refusing showers. During a telephone interview on 12/18/25 at 10:08 AM, LVN A stated he had provided nursing care to Resident #1. LVN A stated Resident #1 refused showers a lot. LVN A stated the resident would accept showers from family members and at times refused the showers from family members. LVN A stated the OT [name not given] attempted to encourage the resident to accept showers and the resident would still refuse. LVN A stated he did not call the MD to get guidance or get new orders to deal with the resident's refusals of showers. LVN A stated there were no negative outcomes from the resident's refusals of showers and the resident did not reveal body odors. LVN A stated the CNAs [names not given] would inform him about the shower refusals. During a telephone interview on 12/18/25 at 10:25 AM CNA B stated Resident #1 had refused showers 1 or 2 times and she informed the charge nurse LVN A. CNA B stated she had been employed in the facility for 2 months. The CNA stated she documented refusals in the POC. CNA B stated she saw no skin breakdown or smelled odors when providing ADL care to the resident. During a telephone interview on 12/18/25 at 4:14 PM, the RP stated she visited the resident daily and would inquire about the need for Resident #1 to be showered. The RP stated she complained every day for 15 days and was given excuses or told the resident would be showered. The RP stated the resident was showered only on 12/3/25 and 12/4/25. During a telephone interview on 12/8/25 at 4:20 PM, Resident #1 stated he did not refuse showers and asked for a shower daily from the CNA [name not given] staff. Resident #1 stated the CNAs [names not given] would state he would be given a shower but did not return to give him a shower. Resident #1 stated the CNAs would make excuses why he missed or was not given a shower. The resident stated it was frustrating to get a shower, but showers were given on 12/3/25 and 12/4/25. 2.Observation and interview on 12/17/25 at 3:21 PM, Resident #4 was in bed watching TV; There were no injuries, skin tears or bruises present. W/C present. Disposition was one of neutrality. The resident was alert and oriented X3. The residents stated her showers day were M

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676372	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines North Nursing and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676372	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines North Nursing and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records that were complete and accurately documented for 2 of 4 (Residents #1 and #4) residents reviewed for accuracy of clinical records. There were no Nurse Notes in the EMR documenting that Resident #1's and Resident #4's missed or refused showers/bathing. This failure could result in inadequate care due to incomplete and inaccurate medical records. The findings include: 1.Record review of Resident #1's face sheet, dated 12/27/25, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and discharged home on [DATE]. Resident #1 had diagnoses which included: HTN (hypertension), kidney disease, a UTI (urinary tract infection at admissions), and a history of stroke. The RP was listed as: a family member. Record review of Resident #1's admissions MDS, dated [DATE], reflected a BIMS score of 15, indicative of no impairment in cognition. The ADLs for: B/B were incontinent for some episodes Transfer and Mobility was set up. ROM: was left side impairment. Toileting was assisted by one staff member. Resident's assistive device was walker. Record review of Resident #1's Care Plan, undated, revealed, the goals and interventions included: ADLs: showers X1. G Interventions included-self-determination, participation during care, and staff to give explanation. CP also reflected that residents were resistive to care related to adjustment to NF, anxiety, and refusals of baths. Record review of Resident #1's Customer Service assessment, dated 12/3/25 and authored by corporate staff, revealed: the family (RP) expressed concern that the resident was not showered, and the family member stated the resident refused showers at time. Resident was showered on 12/3/25. Record review of Resident #1's POC for showers/bathing revealed: the scheduled days were Tuesday, Thursday, and Saturday. Further review of the POC revealed, in reference to showers/bathing:-11/18/25-not documented-11/20/25-not documented-11/22/25-not documented-11/25/25-refused-11/27/25-refused-11/29/25-not documented-12/2/25-received-12/4/25-received Record review of Resident #1's Nurse Notes from 11/17/25 to 12/4/25 revealed no nurse documentation of resident refusing or missing showers. During an interview on 12/17/25 at 4:39 PM, the MDS Nurse stated she had no explanation for nurse notes not containing any documentation involving Resident #1 refusing or missing showers. The MDS Nurse stated the DON or Administrator was responsible for the accuracy of the clinical record. During a telephone interview on 12/18/25 at 10:25 AM CNA B stated Resident #1 had refused showers 1 or 2 times and she informed the charge nurse, LVN A. CNA B stated she documented refusals in the POC. During a telephone interview on 12/18/25 at 4:14 PM, the RP stated she visited the resident daily and would inquire about the need for Resident #1 to be showered. The RP stated she complained every day for 15 days and was given excuses or told the resident would be showered. The RP stated the resident was showered only on 12/3 and 12/4/25. During a telephone interview on 12/8/25 at 4:20 PM, Resident #1 stated he did not refuse showers and asked for a shower daily from the CNA [name not given] staff. Resident #1 stated the CNAs [names not given] would state he would be given a shower but did not return to give him a shower. Resident #1 stated the CNAs would make excuses why he missed or was not given a shower. The resident stated it was frustrating to get a shower, but showers were given on 12/3/25 and 12/4/25. 2.Observation and interview on 12/17/25 at 3:21 PM, Resident #4 was in bed watching TV; There were no injuries, skin tears or bruises present. W/C present. Disposition was one of neutrality. The resident was alert and oriented X3. The residents stated her showers day were M, W, and F. The resident stated, I have not had a shower in the past week.missed many days.they say (we will see about a shower) .my family has complained about showering. The Resident stated she was not sure about any skin breakdown due to lack of showers. The resident stated she gets angry when not showered. Record review of Resident #4 's face sheet, dated 12/17/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included inflammation of the intestine, lack of coordination, and gait abnormality. The RP was listed as a family member. Record review of Resident #4's quarterly MDS, dated [DATE], reflected a BIMS score of 12, indicative of moderate impairment in cognition. The resident's ADLs for showers/bathing were documented as supervision with one staff assistance. B/B was listed as incontinent X1; transfer and mobility X1. Resident's assistive device was a W/C. Record review of Resident #4's KARDEX (nurse form for listing of ADLs) dated 12/17/25 reflected one person assistance for bathing. Record review of Resident #4's POC reflected her shower days were M, W, and F. Further review of documentation