STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676443	A. Building B. Wing	11/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center at Grande	3219 East Grande Boulevard Tyler, TX 75707

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify the resident's physician when there was a need to alter treatment for 1 of 4 residents reviewed for physician notification. (Resident #1) The facility failed to immediately notify the physician on 9/24/25 when they were unable to draw the blood successfully on Resident #1 for labs. This failure could place residents at risk for delayed diagnosis or altered medical management.Findings included: Record review of an admission record, dated 9/30/25, indicated Resident #1 was a 68 year female who admitted on [DATE] and discharged home with home health services on 9/28/25 with diagnoses including acute kidney failure (when the kidneys suddenly stop functioning, leading to a build-up of waste products in the blood), arthropathic psoriasis (a form of inflammatory arthritis that can affect people with psoriasis, causing joint pain, swelling, stiffness, and fatigue), congestive heart failure (a condition where the heart muscle is damaged and cannot pump blood efficiently to meet the body's needs), anemia (a condition where the body lacks enough healthy red blood cells or hemoglobin, which can cause symptoms like fatigue, weakness, and shortness of breath), hypertension (or high blood pressure, a condition where the force of blood against artery walls is consistently too high), and hypothyroidism (a common condition where the thyroid gland in your neck does not make enough hormones). Record review of an active orders summary report, dated 9/16/25, indicated Resident #1 had admission Labs CBC, CMP, TSH, Vit.D one time only for one week post admission for two days follow up with results with an order date of 9/16/25, start date of 9/23/25, and end date of 9/25/25. Record review of Physician order detail report, dated 9/16/25, and completed by LVN B, indicated Resident #1 had verbal orders for admission labs: CBC, CMP on admission and one week post admission: CBC, CMP, TSH, Vit.D. This order was signed by Resident #1's Physician and dated 9/17/25. Record review of admission MDS assessment, dated 9/20/25, indicated Resident #1 had clear speech, was able to make her self-understood by expressing ideas and wants; had clear comprehension. She had a BIMS score of 12 out of 15 indicating she had moderate cognitive impairment with thinking and memory. She required supervision or moderate assistance with most ADLs. Record review of Resident #1's undated revised care plan indicated the following:-Focus (initiated 9/16/25): [Resident #1] respiratory risk related to respiratory conditions. Goal: Respiratory risks related to pulmonary conditions/function will be minimized with interventions. Intervention (initiated 9/24/25): Notify physician of change in status. -Focus (initiated 9/24/25): [Resident #1] was at risk for cardiac complications due to Hypertension. Goal: will have no cardiac complications through review date. Interventions: and monitor lab work as ordered by physician and report results.-Focus (initiated 9/24/25): [Resident #1] had potential for complications from chronic kidney disease. Goal: [Resident #1] will have minimized risk for progression of comorbidities due to CKD. Intervention: Monitor lab values per physician's orders.-Focus (initiated 9/24/25): [Resident #1] at risk for complications r/t Hypothyroidism (under active thyroid). Goal: No complications related to hypothyroidism over the next 90 days. Interventions: Monitor lab results per physician's orders and report results to physicians.-Focus (initiated 9/24/25) [Resident #1] had blood pressure. Goal: No complications related to high blood pressure over the next 90 days. Interventions: Obtain and monitor lab work as ordered by physician. Notify physician of any change in condition. Record review of Resident #1's clinical records from 9/16/25 to 9/28/25 reflected no one week post admission: CBC, CMP, TSH, Vit.D. documentation or results. Record review of a handwritten statement, dated 9/29/25, provided by the facility, completed by Staff C indicated the following: On September 24, 2025, I [Staff C] attempted to draw blood from [Resident #1] for her one-week labs. Unfortunately, [Staff C] was unsuccessful after two attempts. So, on the next day [Staff C] went to [LVN D] that worked on the 2nd floor who had helped [Staff C] before on several occasions. However, [LVN D] was also unable to draw the blood successfully. At the next attempt to draw blood [Resident #1] refused because of so many failed attempts. Record review of education/in-service record, date 9/29/25, and signed by the DON and Staff C, indicated the following: If [Staff C] was unable to obtain blood from the patient, [Staff C] must immediately notify the charge nurse and either DON. During an interview on 11/16/25 at 4:00 p.m. the DON said the one-week post admission labs for CBC, CMP, TSH, and Vit.D. were a mistake made by the staff when entering the order. During an interview on 11/16/25 at 5:23 p. m. the DON said Resident #1's one week post admission CBC, CMP, TSH, Vit.D labs were not done. The DON said she was not aware of what [Staff C] did until after [Resident #1] discharged . The DON said Staff C and LVN D should have told her or the resident's doctor. The DON said they did not have a system in place