STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676452	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegiant Wellness and Rehab	724 W. Rendon Crowley Road Crowley, TX 76036

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177 Based on interview and record review, the facility failed to provide adequate supervision and assistance to prevent accidents and/or injury for 1 of 3 residents (Resident #1) reviewed for accidents and supervision. CNA A and RN B failed to ensure that Resident #1 did not receive a solid food tray, as Resident #1 was an NPO (no food by mouth) resident, with a G-Tube. As a result, Resident #1 consumed approximately 50% of the tray food given to her by CNA A. This failure could place residents at risk of aspiration (the accidental inhalation of food, liquid, saliva, or stomach contents into the airway and lungs, potentially leading to complications like pneumonia) causing serious injury or death. Findings included: Record review of Resident #1's Face Sheet dated 3-11-2025, conveyed a [AGE] year-old female who admitted to the facility on [DATE] with a primary diagnosis of Metabolic Encephalopathy (a brain dysfunction caused by underlying systemic illnesses or metabolic imbalances, resulting in altered mental status or consciousness, ranging from confusion to coma) and secondary diagnoses of Type 2 diabetes with neuropathy (a condition where the body's inability to use insulin correctly leads to high blood sugar, causing nerve damage (neuropathy) without a specific type of neuropathy being identified), Morbid Obesity (a severe form of obesity characterized by a high body mass index (BMI) and significant health risks), and Acute Respiratory Failure with Hypoxia (a condition where the lungs fail to adequately deliver oxygen to the blood, leading to dangerously low oxygen levels). Record review of Resident #1's transfer orders from the hospital dated 2-6-2025 revealed Resident #1 was assessed as being a NPO patient. Record review of Resident #1's Care Plan dated 2-9-2025 revealed she required tube feeding related to Dysphagia (having difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage) with interventions to monitor Resident #1 for Aspiration. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Nursing Home PPS (Prospective Payment System) (NP - Nurse Practitioner) MDS (Minimum Data Set) dated 2-13-2025 revealed Resident #1 had a BIMS score of 1, indicating severe cognitive impairment. The MDS indicated in the Swallowing/Nutritional Status section that Resident #1 had a swallowing disorder of Coughing or choking during meals or when swallowing medications, Holding food in mouth/cheeks or residual food in mouth after meals, and Complaints of difficulty or pain with swallowing. Record review of Resident #1's Order Summary dated 2-13-2025 indicated the facility's dietician listed Resident #1 as an NPO. Record review of Resident #1's doctor orders dated 2-13-2025 indicated Resident #1 was on an NPO Diet. Record review of Resident #1's Progress Notes by RN B, dated 2-26-2025, stated This nurse entered patient room noted tray present with food eaten. Sign above bed that says NPO. Feeding pump present in room. This nurse asked CNA if she gave patient a tray she stated, yes. CNA educated that she is supposed to ask a nurse about patient diet. Never assume. Kitchen did not send patient a tray for a reason. Patient is sitting up in wheelchair no coughing or respiratory distress noted. Dr. A notified waiting for response, DON notified. Resident #1's Progress Note dated 2-26-2025 at 3:09 PM stated RN B contacted Resident #1's [family member] saying . informed her that CNA did give [Resident #1] a [food] tray and she did eat some of the food .informed Resident [family member] that Resident #1 was a .nothing by mouth [and] we are concerned about aspiration of food going into the lungs, so we are going to get a chest x-ray. Record review of the facility's in-services on the topic of NPO residents and food trays revealed they were conducted on 2-26-2025. The in-services included NPO training for CNA A with a one-on-one session with the DON, all the kitchen staff, and facility wide for staff members indicating that NPO residents do not get a food tray. Record review of Resident #1's Radiology Note dated 3-1-2025 at 6:42 PM, indicated a chest x-ray was completed showing Resident #1's lungs were clear showing no signs of aspiration. Record review of Resident #1's Progress Note dated 3-4-2025 at 5:00 AM revealed Resident #1 had a change in condition due to vomiting and shortness of breath. Resident #1 was sent out to the hospital via ambulance on 3-4-2025 at 7:00 AM. In an interview on 3-11-2025 at 12:50 PM, it was revealed RN B worked at the facility on 2-26-2025, entered Resident #1's room after lunch was served, saw a food tray next to Resident #1's bed, and saw food had been eaten. RN B conveyed she asked CNA A why Resident #1 had a food tray in her room and CNA A stated that the kitchen did not make a meal ticket for Resident #1, so she retrieved one and gave it to Resident #1. RN B stated she informed CNA A that Resident #1 does not get food trays because Resident #1 was a tube fed patient with a NPO sign above her bed. RN B said CNA A was surprised to learn Resident #1 was a NPO. RN B said CNA A should know this. RN B said a nurse should be responsible to make sure a CNA knows a patient is an NPO. RN B said the risk to Resident #1 eating food from a food tray was aspiration into the lungs and could be very dangerous to the patient. RN B said the facility did in-services on NPO and tube feeding after this incident on 2-26-2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Therapy (DOT) on 3-11-2025 at 5:00 PM it was revealed she was also the facility's speech therapist and had worked at the facility since 2018. The DOT stated she screens for swallowing issues on every resident who admits into the facility. The DOT stated when Resident #1 admitted into the facility Resident #1 had a swallow test performed at the hospital prior to admission. The DOT said Resident #1 was a NPO from the beginning of her admittance into the facility and Resident #1 was not supposed to have received a food tray on 2-26-2025. The DOT said the risk to Resident #1 receiving a food tray and consuming food was that Resident #1 could aspirate and cause her to be hospitalized . In an interview with CNA A on 3-11-2025 at 3:00 PM, it was revealed CNA A has been a CNA for over 7 years, has worked at the facility since 12-2023, and usually works the 2:00 PM-10:00 PM shift. CNA A said she was working at the facility on 2-26-2025 in the hallway where Resident #1 was residing. CNA A said she did not usually work the hallway where Resident #1 was residing and was not familiar with Resident #1. CNA A said she did not see the NPO sign above Resident #1's bed but noticed she did not have a food tray. CNA A said she retrieved a food tray for Resident #1 and brought it to her in her room to eat. CNA A said she made a mistake. CNA A stated she was in-serviced by the facility on NPO residents and food trays after the incident with the DON. CNA A said the facility went over NPO training when she was orientated back in 12-2023. In an interview on 3-12-2025 at 4:28 PM, it was revealed that the Facility's Dietitian stated Resident #1 was the facility's only G-Tube patient and the only NPO patient. The Facility's Dietician said Resident #1 was not supposed to receive a food tray on 2-26-2025 as Resident #1 was not supposed to receive any food by mouth. The Facility's Dietician said her expectation was for the facility staff to not give Resident #1 a food tray as eating tray food could cause Resident #1 aspirate. In an interview on 3-14-2025 at 12:30 PM it was revealed from RN B that Resident #1 ate approximately 50% of the tray food that was given to her on 2-26-2025. Record review of Resident #1's current hospital record dated 3-6-2025 revealed Resident #1's reason for admission was a Bilateral acute on chronic Subdural Hematoma and did not have aspiration (a condition where a new bleeding episode (acute) occurs on top of a pre-existing, older hematoma (chronic) in the subdural space, affecting both sides of the brain) and not aspiration. Record review of the facility's policy called Enteral Nutrition dated 2001 and revised on 1-2014 stated: .11. The Nurse will confirm that there are appropriate orders for oral (PO) intake or restrictions for nothing by mouth (NPO), as appropriate. .13. Staff caring for residents with feeding tubes will be trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as: a. Aspiration . 15. Risk of aspiration will be assessed by the Nurse and Physician and addressed in the individual care plan .