

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676452	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Allegiant Wellness and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store food in accordance with professional standards for food service safety in the facility's kitchen, reviewed for food safety1. The facility failed to correctly label and date 6 storage bags of pudding mix, 1 bag of scalloped potatoes, 4 packages of biscuit mix and 1 bag of strawberry gelatin. 2. The facility failed to correctly label a cart of water and juice stored in the reach-in refrigerator.3. The facility failed to discard a salad with a creation date of 07/17/2025 and was labeled discard by 2nd shift. 4. The facility failed to securely store a box of frozen green peas/mixed vegetables leaving it exposed to air. These failures could place residents at risk for food-borne illness and cross contamination.Findings included:Observation of the kitchen on 07/22/2025 at 9:15 a.m., revealed in the dry storage area, 6 storage bags containing pudding mix were observed with a date of 7/15 marked on the bag with no use by date, and no information describing the contents. There were bags of scalloped potatoes, strawberry gelatin mix, 4 bags of biscuit mix with only a singular date marked on the package. Observation of the reach-in refrigerator on 07/22/2025 at 9:30 am., revealed a tray with prepared beverages including water and juice with no date or description of the items on the tray. Observation of the walk-in freezer on 07/22/2025 at 9:32 am., revealed a large box with frozen green peas was observed in the freezer. The box was partially open and the bag inside containing the green peas/mixed vegetables was open to the air. Observation of the walk-in cooler on 07/22/2025 at 9:36 am a bag with a premade salad was observed with a 07/17/2025 date and discard by 2nd shift written on the package. A bag containing yellow cheese was observed with no use by date on the bag. In an interview with the Dietary Manager on 07/23/2025 at 11:55 a.m., revealed that he recently started the position in the past few weeks and he has not had the opportunity to go through all of products. He stated that they just received a truck before the initial kitchen observation. Surveyor explained those items would not be included as the boxes were sealed and stacked. He revealed that he noticed some things but had not caught the dates on the storage bags. He stated that he has a small staff but was in the process of training them. The dietary manager stated the facility does have a food storage policy and he will retrieve the policy. Note (Policy not provided before exit from the facility.) Interview with the Cook, on 07/23/2025 at 11:50 a.m., revealed he just started and was primarily cooking food and has not reviewed the storage policy of the facility. Interview with administrator on 07/23/2025 at 1:25 pm reveal the facility policy is the Texas Food Establishment Rules, and he does not provide a copy. Record review of the Texas Food Handler's guide taken from the DSHS webpage. 1. What are the regulations and guidelines for storing food in a commercial kitchen in Texas?In Texas, the regulations and guidelines for storing food in a commercial kitchen are primarily outlined by the Texas Department of State Health Services (DSHS) and the Texas Food Establishment Rules (TFER). Here are key regulations and guidelines that food handlers and operators in Texas must adhere to when storing food in a commercial kitchen: 3. Labeling and Dating: All food items should be properly labeled and dated to ensure proper rotation and prevent spoilage. Labels should include the name of the product, the date it was prepared or received, and the use-by or expiration date. 2. How should perishable foods be stored in a refrigerator to prevent spoilage? 3. Packaging: Store perishable foods in airtight containers or sealed bags to prevent (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cross-contamination and to maintain freshness. Findings included: Observation of the kitchen on 07/22/2025 at 9:15 a.m., revealed in the dry storage area, 6 storage bags containing pudding mix were observed with a date of 7/15 marked on the bag with no use by date, and no information describing the contents. There were bags of scalloped potatoes, strawberry gelatin mix, 4 bags of biscuit mix with only a singular date marked on the package. Observation of the reach-in refrigerator on 07/22/2025 at 9:30 a.m., revealed a tray with prepared beverages including water and juice with no date or description of the items on the tray. Observation of the walk-in freezer on 07/22/2025 at 9:32 a.m., revealed a large box with frozen green peas was observed in the freezer. The box was partially open and the bag inside containing the green peas/mixed vegetables was open to the air. Observation of the walk-in cooler on 07/22/2025 at 9:36 am a bag with a premade salad was observed with a 07/17/2025 date and discard by 2nd shift written on the package. A bag containing yellow cheese was observed with no use by date on the bag. In an interview with the Dietary Manager on 07/23/2025 at 11:55 a.m., revealed that he recently started the position in the past few weeks and he has not had the opportunity to go through all of products. He stated that they just received a truck before the initial kitchen observation. Surveyor explained those items would not be included as the boxes were sealed and stacked. He revealed that he noticed some things but had not caught the dates on the storage bags. He stated that he has a small staff but was in the process of training them. The dietary manager stated the facility does have a food storage policy and he will retrieve the policy. Note (Policy not provided before exit from the facility.) Interview with the Cook, on 07/23/2025 at 11:50 a.m., revealed he just started and was primarily cooking food and has not reviewed the storage policy of the facility. Interview with administrator on 07/23/2025 at 1:25 pm reveal the facility policy is the Texas Food Establishment Rules, and he does not provide a copy. Record review of the Texas Food Handler's guide taken from the DSHS webpage. 1. What are the regulations and guidelines for storing food in a commercial kitchen in Texas? In Texas, the regulations and guidelines for storing food in a commercial kitchen are primarily outlined by the Texas Department of State Health Services (DSHS) and the Texas Food Establishment Rules (TFER). Here are key regulations and guidelines that food handlers and operators in Texas must adhere to when storing food in a commercial kitchen: 3. Labeling and Dating: All food items should be properly labeled and dated to ensure proper rotation and prevent spoilage. Labels should include the name of the product, the date it was prepared or received, and the use-by or expiration date. 2. How should perishable foods be stored in a refrigerator to prevent spoilage? 3. Packaging: Store perishable foods in airtight containers or sealed bags to prevent cross-contamination and to maintain freshness.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for four of eight (CNA A, LVN B, LVN C, and MA) staff members and ten of ten residents (Resident #3, #4, #11, #16, #25, #37, #39, #57, #63 & #64) reviewed for infection control procedures. 1) LVN C failed to disinfect the blood pressure machine in between vital sign checks for Residents #63, #57, and #25. 2) MA D failed to cleanse the key used to open Lidocaine packages before and after usage when administering lidocaine patches to Resident #25 and #3. 3) CNA A failed to perform hand hygiene after direct contact with residents #4, #16, and #39 while serving meals trays in the common dining area. CNA A failed to perform hand hygiene after direct contact with residents #11, #7, and #65 while serving trays on Hall 100. 4) LVN B failed to cleanse the scissors before and after usage when performing wound care on Resident #3. LVN B removed the scissors from the treatment cart drawer and used them to open treatment packages and then placed them back into the drawer of the treatment cart. LVN B failed to change gloves and disinfect hands while providing wound care for Resident #3. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #63's 5-day admission MDS assessment, dated 07/23/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #63 had diagnoses which included: hypertension (high blood pressure), coronary artery disease (clogged arteries) and heart failure (heart does not pump blood like it should). Resident #63 was severely cognitively impaired and unable to make decisions and required assistance of two staff for activities of daily living. Record review of Resident #57's in progress 5-day admission MDS Assessment, dated 07/22/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #57 had diagnoses which included: heart failure (inability for the heart to work properly), and hypertension (high blood pressure), and dementia (forgetfulness and confusion). Resident #57's was severely cognitively impaired and unable to make decisions and required one staff for assistance with activities of daily living. Record review of Resident #25's quarterly MDS Assessment, dated 07/11/2025, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #25 had diagnoses which included: hypertension (high blood pressure), renal insufficiency (kidneys not working well) and spinal stenosis (compressing the spine). Resident #15 was cognitive and able to make decisions and required one staff for assistance with activities of daily living. Record review of Resident #3's admission MDS Assessment, dated 06/30/2024, revealed an [AGE] year-old male who admitted to the facility on [DATE]. Resident #3 had diagnoses which included: coronary artery disease (clogged arteries), chronic obstructive pulmonary disease (short of breath), and non-pressure chronic ulcer of skin (wounds to toes and ankle). Resident #3 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #4's 5-day admission MDS Assessment, dated 06/27/2025, revealed a [AGE] year-old male who admitted to the facility on [DATE]. Resident #4 had diagnoses which included: diabetes (high blood sugar), cerebral vascular accident (stroke), and hypertension (high blood pressure). Resident #4 was alert and oriented and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #16's 5-day MDS Assessment, dated 07/17/2025, revealed an [AGE] year-old female who admitted to the facility on [DATE]. Resident #16 had diagnoses which included: seizure disorder (convulsions), hypertension (high blood pressure), and mild protein calorie malnutrition (skinny). Resident #16 was cognitively able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #39's annual MDS Assessment, dated 07/15/2025, revealed an [AGE] year-old female who admitted to the facility on [DATE]. Resident #39 had diagnoses which included: diabetes (high blood sugar), (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hypertension (high blood pressure), and dementia (thyroid slow to function). Resident #39 was severely cognitively impaired unable to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #11's 5-day MDS Assessment, dated 07/21/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #11 had diagnoses which included: acute respiratory failure (stopped breathing), hypertension (high blood pressure), and diabetes (high blood sugar). Resident #11 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #37's 5-day MDS Assessment, dated 07/02/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #37 had diagnoses which included: cerebral vascular accident (stroke), hypertension (high blood pressure), and diabetes (high blood sugar). Resident #37 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #64's [SP1] 5-day MDS Assessment, dated 07/27/2025, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #65 had diagnoses which included: atrial fib (irregular heartbeat), heart failure (weak heart), and left hip fracture (broken left hip). Resident #65 was cognitive and able to make decisions and required assistance of one staff for activities of daily living. Observation on 07/22/2025 at 9:10 am revealed LVN C taking the blood pressure machine into Residents #63 and Resident #57's room. LVN C did not disinfect the blood pressure machine prior to taking it in the room. LVN C performed vital sign checks on both residents without disinfecting the blood pressure machine between each usage. LVN C came out of the room and proceed into Resident # 25's room, checking the resident's vital signs without disinfecting prior of after usage. LVN C walked down the hallway, plugging the blood pressure machine in, not disinfecting the machine. In an interview on 07/22/2025 at 11:00 a.m., LVN C stated she did not clean the blood pressure machine, but she used hand sanitizer following each usage[SP2] , (this had not been observed by the surveyor) The LVN stated had attended in-services concerning infection control, but she did not recall anything mentioned about cleaning equipment. LVN C stated she guessed this could cause the spread of infections. Observation on 07/22/2025 at 9:15 a.m., revealed MA D during medication pass went to the medication cart and started preparing to perform medication administration for Resident #3. MA D took the Lidocaine Patch from the medication cart, looked for the scissors on the cart, finding no scissors. MA D took key out of her pocket and slashed through the Lidocaine Patch packet. MA D did not clean the key before or after usage, placing the key back in her pocket. MA D gathered the patch and entered Resident #3's room. MA D placed the patch on Resident #3's back. MA D left the room went back to the medication cart removed her gloves, used hand sanitizer, documented on the resident's clinical record and began to prepare for the next medication pass. Observation and interview on 07/22/2025 at 9:30 a.m., revealed MA D during medication pass went to the medication cart and started preparing to perform medication administration for Resident #25. [SP3] MA D took the Lidocaine Patch from the medication cart, looked for the scissors on the cart, finding no scissors. MA D took key out of her pocket and slashed through the Lidocaine Patch packet. MA D did not clean the key before or after usage, placing the key back in her pocket. MA D gathered the patch and entered Resident #25's room. MA D placed the patch on Resident #25's back. MA D left the room went back to the medication cart removed her gloves, used hand sanitizer, documented on the resident's clinical record and began to prepare for the next medication pass. MA D stated she had lost her scissors, and this was the fastest way she could think to open the package. MA D apologized and stated it was wrong to open the package that way, but she was trying to be efficient. MA D stated she had attended in-services on infection control, and she did not think about cleaning the key before or after usage and realized this would be a problem. Not cleaning the key, before and after usage between residents could spread germs to the residents. Observation on 07/22/2025 beginning at 12:20 p.m., revealed CNA A in the main dining room serving lunch trays. CNA A did not use hand sanitizer, available in the dining room and served a tray to Resident #16. CNA A assisted Resident #16, cutting up her meat, opening the butter, buttered the bread (using Resident #16 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	knife), took the top off the desert, and set the utensil so the resident could use them. CNA A then returned to the service line, not utilizing hand sanitizer. CNA A served a tray to Resident #39 at the same table. CNA removed the utensils using the knife and fork to cut up the meat. The CNA opened up the butter, butter the bread (using the resident's knife), and opened up the dessert. CNA A returned to the service line, not using hand sanitizer. CNA A served a tray to Resident # 4. CNA A opened up the butter for him and took the top of the dessert. The CNA did not use hand sanitizer, leaving the dining room, to assist with hall service. Observation on 07/22/2025 beginning at 12:45 p.m., revealed CNA A walked down Hall 100 did not use hand sanitizer, that was available in the hallway, and served a tray to Resident #7. [SP4] CNA A touched and moved the overbed table in the resident's room, touched the hand and shoulder of Resident #37 and prepared the meal tray for the resident to eat lunch. CNA A did not have on gloves. CNA A was observed not to wash her hands or use hand sanitizer. Observation on 07/22/2025 beginning at 12:47 p.m., revealed CNA A was observed to enter Resident's #11, and #65 rooms setting up the resident's lunch trays, adjusting the overbed table, unwrapped the utensils, and removed tops off of the drinks for each resident. She did not complete hand hygiene before going to the next resident. An interview on 07/22/2025 at 1:10 p.m. with CNA A revealed she did not complete hand hygiene after direct contact with residents. CNA A stated she was supposed to use hand sanitizer in between serving each tray. CNA stated she had received in-service on hand hygiene and infection control. CNA said that she was aware it could spread germs and she was just trying to get the trays served timely. Observation on 07/23/2025 at 9:30 a.m., revealed LVN B the wound treatment nurse went to the treatment cart and started preparing to perform treatment to Resident #3's right lateral ankle. LVN B removed the supplies she needed for the treatment placing them on top of the treatment cart. LVN B then took the scissors out of the cart drawer and used the scissors to open packages and cut the treatment to fit the wound. LVN B did not clean the scissors before or after usage placing them back inside the treatment cart. LVN B donned her gloves and gown, entered Resident # 3's room and began her treatment. LVN B removed the old bandages from the ankle of Resident #3 checking drainage on the pad of the old dressing. LVN B cleaned the right ankle wound and applied the treatment and then applied the occlusive dressing to the wound. LVN B did not change her gloves from the time she started until the end of the treatment. She then removed her gloves and washed her hands, gathered the supplies, exiting the room. In an interview on 07/23/2025 at 10:00 a.m., LVN B stated she did not think about changing her gloves, the wound was so small and [NAME] well. LVN B stated that was part of the treatment process to change gloves from dirty to clean. LVN B stated you could spread infection if you did not follow the protocol, but this resident had no infection. In an interview on 07/24/2025 at 10:00 a.m., with the DON revealed she expected her staff to use hand sanitizer or wash their hands in between each contact with each resident. The DON stated if serving trays in the dining room, or on the hallways the staff should use the available hand sanitizer. The DON stated she had completed multiple infection control in-services in the past fourteen months, concerning hand washing/hand sanitizing and infection control. The DON stated when taking vital signs, the staff should place on a gown and gloves, if the resident is in contact isolation, prior to entering the room and always clean the equipment when completed. If the resident was not in contact the staff should clean all equipment between each usage. The DON stated she expected the nursing staff when conducting treatments to use appropriate dirty to clean techniques with gloves: dirty (removing bandages to cleaning hands and placing on a new pair of gloves for the new treatment, placing on treatment and new bandage). The DON stated if they were not following appropriate infection control practices, then the staff can spread germs to themselves and to the other residents. Record review of an in-service dated June 2025 log revealed CNA A, LVN C, and MA D received handwashing and hand sanitizing training, to prevent the spread of infection. Further review of in-service logs revealed an in-service conducted in June 2025 reflected: when passing trays in the hallways, sanitize after going in every room. Remember to wash your hands before starting meal service and use hand sanitizer between each tray served. Further review of the LVN B's (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	employee file reflected she had only been employed for two weeks and had infection control training during her orientation. Record review of the Facility's Policy titled Handwashing/Hand Hygiene revised August 2015 reflected: This facility considers hand hygiene the primary means to prevent the spread of infections . 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections .2. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors . 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies .7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . b. before and after direct contact with residents; . p. before and after assisting a resident with meals Record review of the Facility's Policy titled Infection Prevention and Control Program revised August 2016 reflected: . 1. The infection and control program is a facility-wide effort involving all disciplines and individual and is an integral part of the quality assurance and performance improvement program .7. prevention of infection. (3) educating staff and ensuring that they adhere to proper techniques and procedures. [SP1]		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater for 2 of 30 opportunities during medication pass resulting in an 6 percent (6%) error rate for 2 (Residents #25, and #63) of 4 residents observed for medication pass. 1. MA D failed to administer Resident #25's Biofreeze Cool the pain external gel 4% (gel for pain) her lower back.2. MA D failed to administer Resident #63's MiraLAX Oral powder 17grm (for constipation) with the appropriate amount of fluid. These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a decreased health status. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of five percent (5%) or greater for 2 of 30 opportunities during medication pass resulting in a 6 percent (6%) error rate for 2 (Residents #25, and #63) of 4 residents observed for medication pass. 1. MA D failed to administer Resident #25's Biofreeze Cool the pain external gel 4% (gel for pain) her lower back.2. MA D failed to administer Resident #63's MiraLAX Oral powder 17grm (for constipation) with the appropriate amount of fluid. These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a decreased health status. Findings included: Observation on 07/22/2025 at 9:15 a.m., revealed MA D did not administered the following medication to Resident #25: Biofreeze Cool the pain external gel 4% was administered by MA D to Resident #25's knees but not to her back. Review of Resident #25's Physician's Order dated 02/22/2025 reflected, Biofreeze Cool Gel 4% apply to knees and lower back three times a day for pain at 9:00 am, 3:00 p.m., and 9:00 p.m. Observation on 07/22/2025 at 10:00 a.m., revealed MA D administered the following medication to Resident #63: MiraLAX 17 gm. was administered to Resident #63 by MA D without the appropriate amount of fluid. Review of Resident #63's physician's order dated 07/21/2025 reflected MiraLAX Oral Powder 17 gm/scoop give one scoop one time a day with four to eight ounces of fluid at 8:00 a.m. In an interview at 05/28/24 at 11:15 a.m., MA D revealed she knew she had to apply the pain gel to both knees of Resident #25 but did not know about the back. She said she signs off on the medication administration record without looking thoroughly. MA D stated she knew better. MA D stated that the cups she thought offered 4 ounces of fluid, but was not sure, she had never measured the fluid, she just fills the cup up and gives it to Resident #63 and he has been drinking it. MA D stated she would have to slow down and be more thorough and read the orders completely. In an interview on 07/24/2025 at 10:00 a.m., the DON revealed the staff should be reading the medication administration record prior to and after giving the medication to be assured they were giving the correct medicines and at the right time. The DON stated the medication administration record gives the staff all the information for type of medication, how much, to give, and if it was by mouth, topical, or eye drops or nose spray. The MiraLAX was to be given with 4 to 6 ounces of a fluid and if the cups are not marked they should be measuring the amount the cup will hold to make sure the resident is getting the correct amount of fluid. Review of the facility policy and procedure Medication Administration dated revised December 2012 reflected, Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications should be administered in accordance with the orders. 7. The individual administering the medications must check the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 2 of 3 days reviewed (07/22/2025 and 07/23/2025) for nurse staffing posting. The facility failed to post the daily staffing information in a prominent place on 07/22/2025 and 07/23/2025. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. During an observation on 07/22/2025 at 9:00 AM, there was no daily staff posting in or around the front entrance or at the nurse's station. During an observation and interview on 07/23/2025 at 11:11 a.m., information regarding the current nurse staffing and census information was not available in a public posting. The DON revealed she could not locate the daily census and nurse staffing posting. She revealed the posting was the responsibility of Human Resources. She revealed she was unable to provide a timeline of how long the daily census and nurse staffing posting was missing. The DON stated the purpose of posting the daily census and nurse staffing was to inform the residents and facility guests to know how many staff members were working. The DON stated she was unsure if the lack of posting the daily census and nurse staffing would impact residents and facility guests because family members would ask how many staff were assigned to provide care to their loved one. During an interview on 07/23/2025 at 11:45 a.m., the HR revealed that the posting was kept at the receptionist desk daily. She also could not locate the daily census and nurse staffing posting. She revealed she did not know how long the daily nurse staffing information and census had not been posted. She stated she had not had any residents or family members ask about the posting and because staffing was primarily consistent, she did not believe the lack of the posting would have impacted them. Record review of the facility's policy titled, Staffing, Sufficient and Competent Nursing, revised August 2022, indicated, 6. Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.		