

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Bethany Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  118 Trinity Shores Drive Port Lavaca, TX 77979	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</b></p> <p>Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 6 resident units (300 unit) reviewed for dignity.</p> <p>Laundry Aide X walked into several resident rooms in the 300 unit without knocking.</p> <p>This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth.</p> <p>The findings included:</p> <p>During an interview on 12/17/24 at 8:17 a.m., Resident #75, who resided on the 300 unit revealed sometimes staff had entered her room without knocking and it bothered her because it was an invasion of privacy. Resident #75 stated, what if they come in and I'm naked or something?</p> <p>Record review of Resident #75's most recent quarterly MDS assessment, dated 9/18/24 revealed the resident was cognitively intact for daily decision-making skills.</p> <p>Observation on 12/17/24 beginning at 8:51 a.m., revealed Laundry Aide X, who was delivering laundry on the 300 unit entered the following resident rooms without knocking:</p> <p>room [ROOM NUMBER] at 8:51 a.m.</p> <p>room [ROOM NUMBER] at 8:51 a.m.</p> <p>room [ROOM NUMBER] at 8:53 a.m.</p> <p>room [ROOM NUMBER] at 8:54 a.m.</p> <p>re-entered room [ROOM NUMBER] at 8:54 a.m.</p> <p>room [ROOM NUMBER] at 8:55 a.m.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>re-entered room [ROOM NUMBER] at 9:00 a.m.</p> <p>room [ROOM NUMBER] at 9:02 a.m.</p> <p>During an interview on 12/17/24 at 9:04 a.m., Laundry Aide X acknowledged she had entered resident rooms without knocking and revealed if the door was open to a resident room, she assumed there was no resident in the room and only knocked if a resident door was closed. Laundry Aide X acknowledged she was supposed to knock on the resident room door and announce laundry before entering the room. Laundry Aide X revealed she was working without help. Laundry Aide X stated, I should be knocking before going into a room because there could be patient care going on even if the door is open. I have been taught that I need to knock on the door to let the resident know I am coming in but sometimes some residents don't mind. I say yes, it is a violation of their rights.</p> <p>During an interview on 12/18/24 at 9:43 a.m., the Administrator acknowledged, not knocking on the door to a resident's room was not appropriate. The Administrator revealed it was his expectation for staff to knock on the resident's door before entering and announce themselves to gain permission from the resident. The Administrator acknowledged it was a resident rights issue.</p> <p>Record review of the facility policy and procedure titled, Resident Rights, dated February 2021 revealed in part, .Employees shall treat all residents with kindness, respect, and dignity . 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence .</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>39075</p> <p>Based on interview and record review, the facility failed to promote the residents' right to receive mail, for all facility residents:</p> <p>Facility staff did not distribute mail received on Saturdays to the residents.</p> <p>This deficient practice could result in residents not receiving mail in a timely manner and a diminished quality of life.</p> <p>The findings were:</p> <p>During a confidential resident group meeting on 12/17/24 at 3:00 p.m., 3 of 10 members of the resident group stated they never received mail on Saturdays because the Receptionist was off on the weekends.</p> <p>During an interview on 12/17/24 at 5:11 p.m., the Receptionist acknowledged she worked as the receptionist Monday through Friday and did not work on the weekends. The Receptionist revealed, during the week she collected the mail from the mailbox and the local post office. The Receptionist revealed, once she collected the mail, it was placed in a small nook labeled Activities behind the receptionist area. The Receptionist revealed, the Activity Director or the Activity Aide would then collect the mail from the small nook and distribute the mail to the residents from Monday to Friday. The Receptionist acknowledged any mail delivered on Saturday stayed in the mailbox until she returned to work on Monday.</p> <p>During an interview on 12/18/24 at 8:49 a.m., the Activity Director revealed she typically worked Monday through Friday and occasionally popped in on Saturdays. The Activity Director acknowledged the Receptionist was tasked with collecting the mail from the mailbox and the post office, and then the Activity Director or her aide were responsible for distributing the mail to the residents Monday through Friday. The Activity Director acknowledged that any mail delivered on Saturday stayed in the mailbox until the Receptionist returned to the facility the following Monday. The Activity Director stated, If I am able to get mail on Saturday, so should the residents.</p> <p>During an interview on 12/18/24 at 9:39 a.m., the Administrator revealed, the residents should be getting their mail everyday as it was a resident right.</p> <p>Record review of the facility policy and procedure titled, Mail and Electronic Communication, revision date 2017 revealed in part, .Resident are allowed to communicate privately with individuals of their choice and may send and receive personal mail, e-mail and other electronic forms of communication confidentially .4. Mail and packages will be delivered to the resident within twenty-four (24) hours of delivery on premises or to the facility's post office box (including Saturday deliveries) .</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34957</p> <p>Based on observation, interview and record review, the facility failed to implement its written policies and procedures that prohibit and prevent abuse, neglect, and misappropriation for 2 of 24 residents (Resident #31 and #64) reviewed for misappropriation.</p> <p>The facility did not conduct training after an allegation of misappropriation of \$20 involving Resident #31 on 11/22/24.</p> <p>The facility did not conduct training after an allegation of misappropriation involving the missing of two NARCO pills for Resident # 64 on 11/27/24.</p> <p>This failure could place residents at risk for misappropriation, a diminished quality of life, and psychosocial harm.</p> <p>The findings were:</p> <p>Record review of facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated Revised 2021 read: .Provide staff orientation and training/orientation programs that includes topics such as abuse prevention, identification and reporting of abuse . [ANE policy given to surveyor did not fully address the 7 elements to include investigation response]</p> <p>11/22/24 Misappropriation</p> <p>Record review of Resident #31's face sheet, dated 12/16/24, reflected a male age 70. The resident was admitted on [DATE] with diagnoses that included: acute kidney failure, hypertension, and Parkinson's disease (brain disease). The RP was listed as: family member.</p> <p>Record review of Resident #31's admission MDS, dated [DATE], reflected a BIMS score was 13 (cognitively intact).</p> <p>Observation and interview on 12/16/24 at 12:25 PM, revealed Resident #31 was in bed watching TV. The resident was alert and oriented to person and place. The resident stated, .my [family member] gave me the \$20 dollars when I went to the hospital. I put the \$20 in my lunch box. I cannot prove that the money was stolen. My [family member] told the Administrator about the missing money. [11/22/24] I do not have safe, nor do I want one. I do not keep money in my room. There was no other theft of other property. The resident stated the past Administrator was aware of the missing \$20 but the resident was not certain as to whether other staff were aware of the missing \$20.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 12/16/24 at 1:00 PM, the past interim Administrator stated he visited with the family and the money was lost or misplaced. The past Administrator stated, the facility's investigation did not reveal that anyone entered his (Resident #31) room. The past Administrator stated that the current plan was to replace the money. The past Administrator stated the resident was offered a locked box or to put money in a trust, but the resident refused. The Administrator stated there were no cameras in the room. The past Administrator stated, Abuse and neglect training was not done .yes we had an allegation of theft . The Administrator stated that in general we do abuse and neglect training when there was an allegation .we should have done the training as part of the 7 elements of ANE. The Administrator added that training was part of the overall ANE facility's policy. The Administrator stated that the family and resident made the allegation of the missing \$20 on 11/22/24. The past interim Administrator stated that there was no grievance process to include required training.</p> <p>During interview on 12/16/24 at 2:20 PM, the DON stated she started employment on 12/09/24 and was not aware of the incident involving the alleged theft of \$20 involving Resident #31. The DON stated when the incident was reported of alleged misappropriation in November 2024 training on ANE should have started for all staff as part of the facility's ANE policy. The DON stated the training needed to be done for staff to know how to report ANE and recognize ANE. The DON stated that she did not know why the training was not done on 11/11/24. [Except for the past Administrator, the staff was not aware of the missing \$20 on 11/22/24.]</p> <p>During an interview on 12/16/24 at 3:10 PM, LVN A stated when there was an allegation of ANE an in-service needed to be conducted for staff to know the signs of ANE and whom to report. LVN A stated she worked with Resident #31 for about 9 months. LVN A stated she did not remember whether she attended an in-service on ANE in November 2024 for the incident on 11/22/24.</p> <p>During an interview on 12/16/24 at 3:10 PM, Med Aide K stated: when there was an allegation of ANE an in-service needed to be conducted so staff knew the signs of ANE and whom to report. Med Aide K stated she worked with Resident #31 for about 3 years.</p> <p>During an interview on 12/17/24 at 8:30 AM, the past Administrator stated that the training done on 12/5/24 incorporated the incident on 11/22/24 but the training was not specific to the incident on 11/22/24.</p> <p>During a telephone interview on 12/17/24 at 10:00 AM, RN B stated the training on ANE on 12/5/24 was general training on ANE and not specific to the incident on 11/22/24. RN B stated, the training did discuss the incident of 11/22/24 as an example of misappropriation and a second example presented at the in-service involved as an example of neglect.</p> <p>Record review of facility's staff list dated 12/16/24 reflected the number of paid staff was 90.</p> <p>Record review of facility's general ANE training reflected training was done on 12/5/24 which was 13 days after the incident on 11/22/24.</p> <p>Record review of facility's grievance log form 11/22/2024 reflected a family member alleged that \$20 was missing out of the Resident #31's shaving kit. Resolution: money was returned on 12/16/24 [after surveyor's entrance].</p> <p>11/27/24 Misappropriation</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #64 's face sheet, dated 12/18/24 reflected a male age 74. The resident was admitted on [DATE] with diagnoses that included: joint replacement, cancer, and pain. The RP was listed as: resident.</p> <p>Record review of Resident #64 's admission MDS, dated [DATE], reflected the resident's BIMS score was 15 (cognitively intact).</p> <p>Record review of Resident #64's Physician' Orders, dated November 2024, reflected, hydrocodone NARCO) 10-325 every 6 hours for pain and arthritis PRN.</p> <p>Record review of Resident# 64's MAR, dated November 2024, reflected:</p> <p>11/26/24-No PRN NARCO given.</p> <p>11/27/24-No PRN NARCO given.</p> <p>11/28/24-10:52 AM-No entry that the medication (NARCO) was given on 11/28/24 at 3: AM as claimed by LVN H). Count was short 2 NARCO pills.</p> <p>Record review of Resident #64's Nurse's Notes dated from 11/27/24 and 11/28/24 reflected no notes establishing that NARCO was given to Resident #64.</p> <p>During an interview on 12/18/24 at 2:22 PM, the past Administrator stated: he was informed during the change shift on 12/6/24 that the narcotic count was short in an unknown cart. The past Administrator stated, The cart with the missing narcotics (NARCO) [for Resident # 64] was put out service and double locked pending an investigation. The past Administrator stated the DON did a reconciliation and two NARCO pills belonging to Resident #64 were found missing. The past Administrator stated that LVN H was suspended pending an investigation. The past Administrator stated that the facility's investigation could not account for the missing NARCO belonging to Resident #64. The past Administrator stated that LVN H signed the reconciliation form on 11/26/24 and could not account for the missing NARCO. The past Administrator stated that no in-service training was done for the staff except for LVN H on ANE.</p> <p>Record review of facility's investigation file reflected:</p> <p>NARCO count dated 11/27/24- was short 2 pills.</p> <p>Resident #64 was prescribed Hydrocodone 10-325 Mg (delivery of 40 pills on was 7/18/24).</p> <p>Written Statement by LVN H dated 12/2/24 reflected LVN H had no idea how there were 2 missing NARCO although he/she had signed for the blister pack. LVN H stated he/she left the cart opened and unsecured to help another resident for a short period of time.</p> <p>Statement 11/27/24: LVN A (night shift) identified that the reconciliation was incorrect and notified the DON.</p> <p>Statement 11/27/24: LVN I (day shift) count was incorrect for Resident #64.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>No in-service training sheets on ANE were present.</p> <p>During an interview on 12/18/24 at 3:21 PM, the DON stated she investigated the diversion and discovered the card in question was delivered in July 2024. The DON stated, the resident discharged home in September 2024 with the NARCO order. The DON stated the resident was readmitted [DATE] with 38 NARCO tablets and there were 2 missing from the card. [The DON stated that the count started with 38 and therefore no NARCO went missing] The card was signed in with 38 NARCOs by 2 nurses. On 11/26/24 the count was off 2 NARCO but LVN H signed for the 2 missing NARCOs. The DON stated LVN H signed for the additional 2 NARCOs. The DON stated, LVN H stated he left the cart opened on 11/27/24 during the night shift. The DON stated, LVN H accepted responsibility for the 2 missing NARCOs caused by the unsecured cart. The DON stated that she realized on 12/16/24 [date of surveyor's entrance] that training was not initiated on the day of the incident on 11/27/24 per the ANE policy; but training was started at the time of surveyor's entrance. [DON tried to explain that LVN H signed a card missing 2 NARCO and the incoming LVN A refused to accept the shift change reconciliation because 2 NARCO pills were missing. LVN H stated that the unsecured medication cart resulted in the 2 missing NARCO]</p> <p>During telephone interview on 12/18/24 at 3:44 PM, LVN A stated she identified that the reconciliation was incorrect on 11/27/24 at 6:00 AM and notified the DON. LVN A stated that LVN H did not give her a reason for the missing NARCO. LVN A stated that LVN H told her that he/she gave the medication (NARCO) to the Resident #64 on 11/27/23 at 3:00 AM and forgot to update the MAR.</p> <p>During a telephone interview on 12/18/24 at 4:17 PM, LVN H stated I was getting the pills for [Resident #64] around 3:00 AM in the morning of 11/27/24 and a call light went off .I left my cart unsecured .that is on me . there was a resident awake (Resident #50) near the cart and might have access to the unsecured cart .I gave the {Resident #64} his medication and at the end of shift if was when 11/27/24 at 6:00 AM) the missing NARCO was discovered . LVN H stated he forgot to document the narcotic sheet for Resident #64 of the NARCO given and also forgot to annotate the MAR November 2024. {The missing NARCO was a PRN medication for Resident #64 and not given on 11/27/24}</p> <p>During telephone interview on 12/18/24 at 5:30 PM, RN J stated she received a call on 11/27/24 about the drug diversion from another staff member. She directed that the Administrator be notified. RN J stated the cart with the missing medication was secured. RN J stated LVN H was suspended pending an investigation. RN J stated that LVN H did not give her an explanation on how the NARCO went missing.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 18 residents (Resident #23 and #74) reviewed for incontinence care.</p> <p>1. CNA Y wiped in the wrong direction and did not complete care when providing incontinent care to Resident #23.</p> <p>2. When CNA-L and CNA-M were providing incontinent and indwelling urinary catheter care to Resident #74 on 12/18/24, CNA-L did not clean the resident's genital area.</p> <p>These failures could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections.</p> <p>The findings included:</p> <p>1. Record review of Resident #23's face sheet, dated 12/18/24 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), lack of coordination, stage 3 chronic kidney disease (kidneys are damaged and can't filter blood the way they should), and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).</p> <p>Record review of Resident #23's most recent quarterly MDS assessment, dated 11/6/24 revealed the resident was severely cognitively impaired for daily decision-making skills and was always incontinent of bowel and bladder.</p> <p>Record review of Resident #23's comprehensive care plan, with edit date 11/20/24 revealed the resident was at risk for impaired skin integrity related to incontinence of bowel and bladder with approaches that included to monitor for incontinence and provide incontinence care as needed.</p> <p>Observation on 12/18/24 at 2:58 p.m., revealed during incontinent care to Resident #23, CNA Y, after cleaning Resident #23's vaginal area, was assisted by CNA Z and positioned Resident #23 onto her left side to expose her anal and buttock area. Resident #23 was observed with a copious amount of stool to the anal area. CNA Y took a wipe and wiped in the wrong direction from back to front on three different occasions to Resident #23's anal area. During each pass with a wipe to Resident #23's anal area, copious amounts of stool was observed. CNA Y then placed a clean brief on the bed and assisted by CNA Z, rolled Resident #23 onto her back. CNA Y and CNA Z acknowledged they completed incontinent care to Resident #23. The Surveyor requested CNA Y and CNA Z to unfasten the clean brief from Resident #23 and assisted the resident onto her left. The Surveyor requested CNA Y take a clean wipe and wipe Resident #23's anal area. CNA Y took a wipe and wiped Resident #23's anal area and revealed a copious amount of stool. CNA Y wiped Resident #23's anal area with several wipes until there was no stool seen on the wipe.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a joint interview on 12/18/24 at 3:19 p.m., CNA Y acknowledged she had caught herself when she wiped Resident #23's anal area in the wrong direction. CNA Y and CNA Z revealed, wiping in the wrong direction, from back to front could cause the resident to develop an infection, especially since the resident was elderly and had stool. CNA Y stated, You should stop wiping when the wipe does not have anymore stool, it comes out clean. CNA Y and CNA Z stated they had not had training on providing incontinent care while working for the facility but had been trained while working for the facility's sister facility.</p> <p>During an interview on 12/18/24 at 4:00 p.m., the DON stated the facility provided competency training on incontinent care recently. The DON stated it was her expectation when providing incontinent care to wipe from front to back to prevent infection and an increase in urinary tract infections. The DON further stated, when providing incontinent care, the aides should visualize the area and wipe the area until no stool was visualized. The DON stated, not wiping the area completely or correctly could result in skin breakdown if stool was left on the area.</p> <p>2. Record review of Resident #74's face sheet, dated 12/19/2024, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnosis of dementia (impairment of brain functions), peripheral vascular disease (reduced blood flow to the limbs), neuromuscular dysfunction of bladder (lack of bladder control), urinary tract infection (bladder infection), and hypertension (high blood pressure).</p> <p>Record review of Resident #74's quarterly MDS, dated [DATE], reflected his BIMS score was 3 of 15 reflecting he had severe cognitive impairment. Further record review of Resident #74's quarterly MDS, dated [DATE], indicated the resident had indwelling urinary catheter and was dependent (helper does all of the effort) for toilet hygiene and always incontinent to bowel.</p> <p>Record review of Resident #74's care plan, edited 10/02/2024, revealed The resident is at risk for infection related to indwelling medical device; to prevent the infection, all staff will utilize gown, gloves, and hand hygiene during high-contact resident care activities and the resident is incontinent of bowel as related to cognitive impairment. For intervention, monitor for incontinence and provide incontinent care as needed.</p> <p>Observation on 12/18/2024 at 10:15 a.m. revealed CNA-M held Resident #74, and CNA-L was cleaning the resident's groin area and indwelling urinary catheter. The CNA-M and CNA-L turned the resident to his right side and started cleaning the resident's buttock area, then put a new brief to the resident without cleaning the resident's penis.</p> <p>Interview on 12/18/2024 at 10:36 a.m. CNA-L stated she did not clean Resident #74's penis and cleaned only the catheter. The CNA-L stated she should have cleaned the resident's penis with a circular motion. Further interview CNA-L said she was nervous and forgot about cleaning Resident #74's penis.</p> <p>Interview on 12/18/2024 at 3:59 p.m. the DON stated CNA-L should have cleaned the resident's penis with a circular motion to prevent a possible urinary tract infection. The current DON said the previous DON completed the CNA-L's clinical skills checklist for perineal care on 12/07/2024, and CNA-L passed it. The DON had the responsibility to monitor and check the CNAs' skills.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of CNA Y's Clinical Skills Checklist dated 12/7/24 revealed the CNA had satisfied the requirements for performing incontinence care.</p> <p>Record review of CNA Z's Clinical Skills Checklist dated 12/9/24 revealed the CNA had satisfied the requirements for performing incontinence care.</p> <p>Record review of the facility policy and procedure, titled Perineal care, dated 10/24/2022, revealed in part, . It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown .9. If perineum (the region of the body located between the anus and the external genitalia) is grossly soiled, turn resident on side, remove any fecal material with toilet paper, then remove and discard .a. Cleanse buttocks and anus, front to back .12. Males . e. hold the shaft of the penis with one hand and was with the other. Begin cleansing tip of penis at urethral meatus using a circular motion and working outward.</p> <p>39075</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interview, and record review, the facility failed to ensure that licensed staff were able to demonstrate the specific competencies and skill sets necessary to care for resident's needs for 1 of 4 staff (CNA-K) reviewed for competencies.</p> <p>The facility failed to ensure CNA-L had competencies to care as evidence by CNA-L did not clean the resident's genital area when CNA-L was providing incontinent and indwelling urinary catheter care to Resident #74 on 12/18/2024.</p> <p>This failure could potentially affect residents by placing them for cross contamination and infections due to staff who lack the appropriate skills and competencies to provide minimize infections.</p> <p>Findings included:</p> <p>Record review of Resident #74's face sheet, dated 12/19/2024, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnosis of dementia (impairment of brain functions), peripheral vascular disease (reduced blood flow to the limbs), neuromuscular dysfunction of bladder (lack of bladder control), urinary tract infection (bladder infection), and hypertension (high blood pressure).</p> <p>Record review of Resident #74's quarterly MDS, dated [DATE], reflected his BIMS score was 3 of 15 reflecting he had severe cognitive impairment. Further record review of Resident #74's quarterly MDS, dated [DATE], indicated the resident had indwelling urinary catheter and required dependent (Helper does all of the effort) to toilet hygiene and substantial/maximal assistance (helper does more than half the effort) to chair/bed-to-chair transfer, and always incontinent to bowel.</p> <p>Record review of Resident #74's care plan, edited 10/02/2024, revealed The resident is at risk for infection related to indwelling medical device; to prevent the infection, all staff will utilize gown, gloves, and hand hygiene during high-contact resident care activities and the resident is incontinent of bowel as related to cognitive impairment. For intervention, monitor for incontinence and provide incontinent care as needed.</p> <p>Observation on 12/18/2024 at 10:15 a.m. revealed CNA-M hold Resident #74, and CNA-L was cleaning the resident's groin area and indwelling urinary catheter. The CNA-L and CNA-M turned the resident to right side and started cleaning the resident's buttock area, then put a new brief to the resident without cleaning the resident's penis.</p> <p>Interview on 12/18/2024 at 10:36 a.m. with CNA-L stated she did not clean Resident #74's penis and cleaned only the catheter. The CNA-L stated she should have cleaned the resident's penis with circular motion. Further interview with the CNA-L said she was nervous, forgot cleaning Resident #74's penis, and the facility conducted skill check off every year.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/18/2024 at 3:59 p.m. the DON stated CNA-L should have cleaned the resident's penis with a circular motion to prevent a possible urinary tract infection. The current DON said the previous DON completed the CNA-L's clinical skills checklist for perineal care on 12/07/2024, and CNA-L passed it. The DON had the responsibility to monitor and check the CNAs' skills.</p> <p>Record review of CNA-L's clinical Skills Checklist for Perineal care for male, dated 12/07/2024, indicated the CNA-L had performed all skills satisfactory which included .10. Wash perineal area starting with urethra and working outward. (If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches.) gently rinse and dry the area. A. retract fore skin of the uncircumcised male. B. wash and rinse urethra area using a circular motion, and C. continue to wash the perineal area including the penis, scrotum, and inner thigh. Do not reuse the sane washcloth or water to clean the urethra.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>50760</p> <p>Based on interviews and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 5 days of 30 days for November 2024 (11/10/24, 11/16/24, 11/18/24, 11/23/24, and 11/30/24) upon review for nursing services.</p> <p>The facility had less than 8 hours a day of RN coverage for 11/10/24, 11/16/24, 11/18/24, 11/23/24, and 11/30/24 for a total of 5 days from November 1, 2024 through November 30, 2024.</p> <p>This failure could result in residents not receiving the required services to meet their needs.</p> <p>The findings were:</p> <p>Record review of the facility timesheets revealed less than 8 hours a day of RN coverage for 11/10/24 (6.23 hours), 11/16/24 (5 hours), 11/18/24 (6.23 hours), 11/23/24 (6.23 hours), and 11/30/24 (5.5 hours).</p> <p>During an interview on 12/17/24 at 5:15 PM with the VP of Clinical, the VP of Clinical stated their nurses began to enter the facility on a consulting basis the first week of December 2024. The VP of Clinical stated the current acting ADON began serving as the acting ADON on 12/03/24, and that the current acting DON began serving as the acting DON on 12/09/24.</p> <p>During an interview on 12/18/24 at 10:09 AM with the acting DON, when asked what could happen if there was not a registered nurse present in the facility for 8 consecutive hours a day for seven days a week, the acting DON stated residents might have to get transferred to a hospital to receive the services they need that must be provided by a registered nurse, or there might be a delay in needed services if the resident was waiting for a registered nurse to arrive at the facility.</p> <p>Record review of the Nursing Services-Registered Nurse (RN) policy, dated 10/24/22, reflected the facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34957</p> <p>Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of residents for one of four carts reviewed for accuracy.</p> <p>1. Resident #64 had 2 missing hydrocodone (NARCO) tablets that were not documented as given and could not be accounted for during November 27, 2024.</p> <p>These failures could place residents who received medications, including narcotics at risk for not receiving the intended therapeutic effects of their prescribed medications and experiencing unintended and harmful effects of medications prescribed to others and place the facility at risk for drug diversion.</p> <p>The findings included:</p> <p>Record review of Resident # 64's face sheet, dated 12/18/24 reflected a male age 74. The resident was admitted on [DATE] with diagnoses that included: joint replacement, cancer, and pain. RP was listed as: resident.</p> <p>Record review of Resident #64's admission MDS, dated [DATE], reflected the resident's BIMS score was 15 (cognitively intact). Resident as incontinent of both bladder and bowel; transfer and bed mobility were extensive assistance.</p> <p>Record review of Resident #64's Physician' Orders, dated November 2024, reflected, hydrocodone NARCO) 10-325 every 6 hours for pain and arthritis PRN.</p> <p>Record review of Resident# 64's MAR, dated November 2024, reflected:</p> <p>11/26/24-No PRN NARCO given.</p> <p>11/27/24-No PRN NARCO given.</p> <p>11/28/24-10:52 AM-No entry that the medication (NARCO) was given on 11/28/24 at 3: AM as claimed by LVN H).</p> <p>Record review of Nurse Note dated from 11/27/24 and 11/28/24 reflected no notes establishing that NARCO was given to Resident #64.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/18/24 at 2:22 PM, the past Administrator stated he was informed during the change shift on 12/6/24 that the narcotic count was short in an unknown cart. The past Administrator stated, the cart with the missing narcotics was put out service and double locked pending an investigation. The past Administrator stated the DON did a reconciliation and two NARCO pills belong to Resident #64 were found missing. The past Administrator stated that LVN H was suspended pending an investigation. The past Administrator stated that the facility's investigation could not account for the missing NARCO belonging to Resident #64. The past Administrator stated that LVN H signed the reconciliation form on 11/26/24 and could not account for the missing NARCO. The past Administrator stated that no in-service training was done for the staff except for LVN H on ANE.</p> <p>Record review of facility's investigation file reflected:</p> <p>NARCO count dated 11/27/24- was short 2 pills.</p> <p>Resident # 64 was prescribed Hydrocodone 10-325 Mg (delivery of 40 pills on was 7/18/24).</p> <p>Written Statement by LVN H dated 12/2/24 stated LVN H had no idea how there were 2 missing NARCO although he/she had signed for the blister pack. LVN H stated he/she left the cart opened and unsecured to help another resident for a short period of time.</p> <p>Statement 11/27/24: LVN A (day shift) identified that the reconciliation was incorrect and notified the DON.</p> <p>Statement 11/27/24: LVN I (day shift) count was incorrect for Resident #64.</p> <p>During an interview on 12/18/24 at 3:21 PM, the DON stated she investigated the diversion and discovered the card in questioned was delivered in July 2024. The DON stated the resident discharged home in September 2024 with the NARCO order. The DON stated the resident was readmitted [DATE] with 38 NARCO tablets and there were 2 missing from the card. The card was signed in with 38 NARCOs by 2 nurses. On 11/26/24 the count was off 2 NARCO but LVN H signed for the 2 missing NARCOs. The DON stated LVN H signed for the additional 2 NARCOs. The DON stated LVN H stated he left the cart opened on 11/27/24 during the night shift. The DON stated LVN H accepted responsibility for the 2 missing NARCOs caused by the unsecured cart.</p> <p>During telephone interview on 12/18/24 at 3:44 PM, LVN A stated she identified that the reconciliation was incorrect and notified the DON. LVN A stated that LVN H did not give her a reason for the missing NARCO. LVN A stated that LVN H told her that he/she gave the medication (NARCO) to the Resident #64 on 11/27/23 at 3:00 AM and forgot to update the MAR.</p> <p>During a telephone interview on 12/18/24 at 4:17 PM, LVN H stated, I was getting the pills for Resident [#64] around 3 AM in the morning of 11/27/24 and a call light went off .I left my cart unsecured .that is on me .there was a resident awake [R#50] near the cart and might have access to the unsecured cart .I gave the Resident [#64]his medication and at the end of shift it was when the missing NARCO was discovered . LVN H stated he forgot to document the narcotic sheet for Resident #64 of the NARCO given and also forgot to annotate the MAR November 2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During telephone interview on 12/18/24 at 5:30 PM, RN J stated she received a call on 11/27/24 about the drug diversion from another staff member. She directed that the Administrator be notified. RN J stated the cart with the missing medication was secured. RN J stated LVN H was suspended pending an investigation. RN J stated that LVN H did not given her an explanation on how the NARCO went missing.</p> <p>Record review of facility's Controlled Substances policy dated April 2019 reflected: .controlled substances . are secured and maintained in a locked cabinet or compartment .Accurate accountability of the inventory of all controlled dugs is maintained at all times .</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on record review and interview, the facility failed to ensure any drug regimen irregularities reported by the Pharmacist Consultant were acted upon, for two residents (Residents #34 and #59) of five residents whose medications were reviewed.</p> <p>1. The facility's Pharmacy Consultant recommended the physician should consider a gradual dose reduction for Resident #34's Mirtazapine for depression on 11/25/2024. However, the facility failed to ensure communicating to the resident's primary care physician regarding the recommendation.</p> <p>2. The facility's Pharmacy Consultant recommended adding Do Not Crush to Resident #59's medication administration record for the resident's Diltiazem for hypertension (high blood pressure) on 10/22/2024. However, the facility failed to ensure adding the recommendation to the medication administration record.</p> <p>The failures could place residents receiving medications at risk for adverse consequences and could cause a decline in their physical, mental, and psychosocial condition.</p> <p>The findings were:</p> <p>1. Record review of Resident #34's face sheet, dated 12/19/2024, revealed the resident was [AGE] years old female and admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnosis of dementia (impairment of brain functions), micturition (urinary incontinence), muscle weakness, hypertension (high blood pressure), and depression.</p> <p>Record review of Resident #34's annual MDS, dated [DATE], reflected her BIMS score was 99 reflecting she could not complete cognitive assessment. Further record review of Resident #34's annual MDS, dated [DATE], indicated the resident was taking an antidepressant as ordered.</p> <p>Record review of Resident #34's care plan, edited 12/17/2024, revealed the resident has a diagnosis of depression and is at risk for increased depression, social isolation, and adverse consequences related to receiving an anti-depression medication, and for intervention, administer medication per physician orders and gradual dose reduction if indicated by physician as ordered/indicated.</p> <p>Record review of Resident #34's physician order, dated 02/12/2024, indicated the resident had the order of Remeron (Mirtazapine) 7.5 mg by mouth once a day at bedtime for major depressive disorder.</p> <p>Record review of Resident #34's medication administration record from 12/01/2024 to 12/31/2024 indicated the resident was receiving Remeron (Mirtazapine) 7.5 mg by mouth once a day at bedtime for major depressive disorder as scheduled time from 6:30 PM to 10:30 PM.</p> <p>Record review of Resident #34's Expanded Drug Regimen Review Report, dated 11/25/2024, indicated Please, follow up on letter to physician regarding trial discontinue of Mirtazapine in progress.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #34's medical chart from 11/25/2024 to 12/19/2024 indicated there was no medical records regarding facility communication of the pharmacist recommendation for discontinue of Mirtazapine for Resident #34's depression to the resident's primary care physician.</p> <p>Interview on 12/18/2024 at 4:26 p.m. the DON stated she could not find any record regarding facility communication of the pharmacist recommendation for discontinue of Mirtazapine for Resident #34's depression to the resident's primary care physician. The DON and all leadership group took over the facility on 12/16/2024 because a new company bought the facility, so they received the pharmacy review binder on 12/16/2024 from the previous leadership group. The DON did not know why the previous leadership group did not follow the pharmacist recommendation. It was the DON's responsibility to report all pharmacy recommendations to the physicians, and Resident #34 might not have the chance of gradual dose reduction.</p> <p>2. Record review of Resident #59's face sheet, dated 12/19/2024, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnosis of dementia (impairment of brain functions), hypertension (high blood pressure), muscle weakness, encephalopathy (brain dysfunction), type 2 diabetes mellitus (not control blood sugar in the body), and heart failure (not pumping blood enough).</p> <p>Record review of Resident #59's quarterly MDS, dated [DATE], reflected his BIMS score was 5 out of 15 which reflecting he had severe cognitive impairment. Further record review of Resident #59's quarterly MDS, dated [DATE], indicated the resident had active diagnosis of heart failure and hypertension.</p> <p>Record review of Resident #59's care plan, edited 10/30/2024, revealed the resident has a diagnosis of hypertension and is at risk for decreased cardiac output, activity intolerance and imbalanced nutrition. For intervention, administer medication per the physician orders. Refer to medication administration record for current medications.</p> <p>Record review of Resident #59's physician's order, dated 09/13/2024, indicated the resident had the order of Diltiazem tablet 6.0 mg at bedtime by mouth Hold of systolic blood pressure less than 120 or heart rate less than 60 for hypertension.</p> <p>Record review of Resident #59's medication administration record from 12/01/2024 to 12/31/2024 indicated the resident was receiving Diltiazem tablet 6.0 mg at bedtime by mouth Hold of systolic blood pressure less than 120 or heart rate less than 60 for hypertension as scheduled time from 6:30 AM to 10:30 AM. Further record review of the medication administration record indicated there was no Do Not Crush. Instructions reflected.</p> <p>Record review of Resident #59's Expanded Drug Regimen Review Report, dated 10/22/2024, indicated Recommended adding Do Not Crush to medication administration record for diltiazem for hypertension (high blood pressure).</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/18/2024 at 3:32 p.m. the DON stated the facility did not add Do Not Crush on Resident #59's medication administration record per the pharmacist's recommendation, and the DON and all leadership group took over the facility on 12/16/2024 because the new company bought the facility, so they received the pharmacy review binder on 12/16/2024 from the previous leadership group. The DON did not know why the previous leadership group did not follow the pharmacist's recommendation. It was DON's responsibility to report all pharmacy recommendations to the physicians, and Resident #59 might have the wrong drug strength over time.</p> <p>Record review of the facility policy, titled Medication Regimen Review, dated 11/28/2022, indicated . 5. The pharmacist shall communicate any irregularities to the facility in the following ways: a. verbal communication to the attending physician, director of nursing, and/or staff of any urgent needs. b. written communication to the attending physician, the facility's medical director, and the director of nursing.f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.</p>		

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NAME OF PROVIDER OR SUPPLIER  Bethany Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  118 Trinity Shores Drive Port Lavaca, TX 77979	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34957</p> <p>Based on observation, interview and record review, the facility failed to ensure that drugs and biologicals used in the facility were secured and distributed properly for one of four nurse medication carts (Hall 200 nurse medication cart and Hall 300 medication cart) reviewed for drug storage and use, as evidenced by:</p> <ol style="list-style-type: none"> <li>1. The nurse medication cart for the 300-hall contained 5 loose pills.</li> </ol> <p>These failures could place residents who received medications, including narcotics at risk for not receiving the intended therapeutic effects of their prescribed medications and experiencing unintended and harmful effects of medications prescribed to others and place the facility at risk for drug diversion.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. During an observation and interview on 12/17/24 at 9:15 AM of the nurse cart for the 300 hall with LVN F, revealed 5 loose pills in the bottom of the cart drawers that held the blister packs. When asked what could happen if loose pills are left in the cart, LVN F stated anything could happen if the pills were consumed by a resident for whom they were not prescribed. LVN F stated a resident could be allergic to one of the pills and the consequences could be horrific.</li> </ol> <p>During an interview on 12/18/24 at 10:16 AM with the acting DON, when asked what could happen if loose pills are found in the carts, the acting DON stated residents might not receive the medication they needed resulting in a delay in therapy, and if a resident consumed something that was not prescribed for them, the resident could experience adverse effects or an allergic reaction. The acting DON stated her expectation was for the staff to check carts per shift for loose pills.</p> <p>Review of the facility's policy titled Medication Carts and Supplies for Administering Meds dated 10/01/19, reflected the purpose of the mobile medication system is to ensure appropriate control and surveillance of resident assigned medications.</p> <p>Review of the facility's policy titled Disposal of Medications and Medication-Related Supplies dated April 2019, reflected unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed.</p> <p>50760</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interview, and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for five (5) (Resident #23, #25, #73, #74, and #78) of 18 residents reviewed for accuracy and completeness of clinical records.</p> <ol style="list-style-type: none"> <li>The facility failed to obtain a consent for Resident #23 to reside in the secure unit.</li> <li>Resident #25 was in the secure unit, but there was no physician order for putting the resident in the secure unit.</li> <li>The facility failed to obtain a consent and a physician's order for Resident #73 to reside in the secure unit.</li> <li>Resident #74 was in the secure unit, but there was no physician order for putting the resident in the secure unit.</li> <li>The facility failed to obtain a consent and a physician's order for Resident #78 to reside in the secure unit.</li> </ol> <p>This failure placed facility residents at risk for lack of resident right due to misinformation by incomplete and inaccurate medical records.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident #23's face sheet, dated 12/18/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), abnormalities of gait and mobility, major depressive disorder, recurrent, severe with psychotic symptoms, and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).</li> </ol> <p>Record review of Resident #23's most recent quarterly MDS assessment, dated 11/6/24 revealed the resident was severely cognitively impaired for daily decision-making skills.</p> <p>Record review of Resident #23's comprehensive care plan, dated 12/10/24 revealed the resident wandered and was an elopement risk and resided in the HOPE UNIT (secure unit) related to cognitive impairment secondary to advanced age.</p> <p>Record review of Resident #23's Physician Order Report, dated 12/1/24-12/18/24 revealed the following order:</p> <p>- May Reside on Hope Unit (secure unit), with order date 10/10/23 and no stop date</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #23's electronic health record revealed there was no consent obtained for the resident to reside in the secure unit.</p> <p>Observation on 12/18/24 at 2:58 p.m. revealed Resident #23 in the secure unit assisted by CNA Y and CNA Z during incontinent care.</p> <p>2. Record review of Resident #25's face sheet, dated 12/19/2024, revealed an [AGE] year old male, admitted to the facility on [DATE] and readmitted to the facility on [DATE]. His diagnoses included encephalopathy (brain dysfunction), heart failure (not pumping blood enough), pulmonary edema (too much fluid in the lung), type 2 diabetes mellitus (not control blood sugar in the body), and hypertension (high blood pressure).</p> <p>Record review of Resident #25's quarterly MDS, dated [DATE], reflected his BIMS score was 3 out of 15 which reflected he had severe cognitive impairment and not coded for behaviors. Further record review of Resident #25's quarterly MDS, dated [DATE], indicated the resident required dependent (helper does all of efforts) to sit to stand, chair-to-bed transfer, and toilet transfer.</p> <p>Record review of Resident #25's care plan, dated 2/11/2024, indicated the resident wanders (elopement risk), so resides at HOPE unit (secure unit) related to cognitive impairment secondary to advance age. For intervention, the facility staff will provide adequate supervision and assistance on performing activities dual livings and monitor resident's whereabouts to ensure safety.</p> <p>Record review of Resident #25's Consent for Placement in Secure Unit, dated 12/18/2024, indicated Resident #25's representative gave the consent for putting the resident in the secure unit.</p> <p>Record review of Resident #25's physician order, dated 12/01/2024 to 12/19/2024, indicated there was no physician order regarding putting the resident in the secure unit.</p> <p>Observation on 12/16/2024 at 2:40 p.m. revealed Resident #25 was sleeping on his bed in his room which was located in the secure and locked unit.</p> <p>Interview on 12/18/2024 at 5:12 p.m. with the DON stated to put residents in the secure unit, the facility needed to have an elopement assessment, BIMS score, care plan, consent, and physician order. There was no physician order for Resident #25 regarding putting the resident in the secure unit. The facility did not know why the resident did not have the physician order. The DON stated not having a physician's order might cause a lack of resident's right.</p> <p>3. Record review of Resident #73's face sheet dated 12/17/24 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), anxiety disorder (a normal reaction to stress in an intense, excessive, and persistent worry and fear about everyday situations), abnormalities of gait and mobility and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>Record review of Resident #73's most recent significant change MDS assessment, dated 10/31/24 revealed the resident was severely cognitively impaired for daily decision-making skills.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #73's Physician Order Report, dated 12/1/24-12/19/24 revealed there was no order for the resident to reside in the secure unit.</p> <p>Record review of Resident #73's comprehensive care plan, dated 12/10/24 revealed the resident had cognitive loss and dementia and resided in the Hope Unit (secure unit) related to history of wandering.</p> <p>Record review of Resident #73's electronic health record revealed there was no consent obtained for the resident to reside in the secure unit.</p> <p>Observation on 12/16/24 at 3:24 p.m. revealed Resident #73 in the secure unit sleeping in her room.</p> <p>Observation on 12/18/24 at 1:12 p.m. revealed Resident #73 with an unidentified staff in the secure unit being assisted from the wheelchair to the bed.</p> <p>4. Record review of Resident #74's face sheet, dated 12/19/2024, revealed a [AGE] year old male, admitted to the facility on [DATE] and readmitted to the facility on [DATE]. His diagnoses included dementia (impairment of brain functions), peripheral vascular disease (reduced blood flow to the limbs), neuromuscular dysfunction of bladder (lack of bladder control), urinary tract infection (bladder infection), and hypertension (high blood pressure).</p> <p>Record review of Resident #74's quarterly MDS, dated [DATE], reflected his BIMS score was 3 of 15 which reflected he had severe cognitive impairment. Further record review of Resident #74's quarterly MDS, indicated the resident required dependent (Helper does all of the effort) to toilet hygiene and substantial/maximal assistance (helper does more than half the effort) to chair/bed-to-chair transfer, and always incontinent to bowel.</p> <p>Record review of Resident #74's care plan, edited 12/10/2024, revealed the resident wanders (elopement risk), so resides at HOPE unit (secure unit) related to cognitive impairment secondary to advance age. For intervention, the facility staff will provide adequate supervision and assistance on performing activities dual livings and monitor resident's whereabouts to ensure safety.</p> <p>Record review of Resident #74's Consent for Placement in Secure Unit, dated 12/18/2024, indicated Resident #74's representative gave the consent for putting the resident in the secure unit.</p> <p>Record review of Resident #74's physician order, dated 12/01/2024 to 12/19/2024, indicated there was no physician order regarding putting the resident in the secure unit.</p> <p>Observation on 12/16/2024 at 2:36 p.m. revealed Resident #74 was sleeping on his bed in his room which was located in the secure and locked unit.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Record review of Resident #78's face sheet dated 12/18/24 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), psychotic disorder (any clinical symptom that entails a marked loss of contact with reality, notably including delusions, hallucinations, disorganized speech, or disorganized behavior), anxiety (a normal reaction to stress in an intense, excessive, and persistent worry and fear about everyday situations), abnormalities of gait and mobility, and bipolar disorder (mental health condition characterized by extreme mood swings).</p> <p>Record review of Resident #78's most recent quarterly MDS assessment, dated 11/15/24 revealed the resident was severely cognitively impaired for daily decision-making skills.</p> <p>Record review of Resident #78's Physician Order Summary, dated 12/1/24 to 12/18/24 revealed there was no order for the resident to reside in the secure unit.</p> <p>Record review of Resident #78's comprehensive care plan, dated 12/10/24 revealed the resident had cognitive loss, dementia and was an elopement risk and resided in the HOPE UNIT (secure unit) related to exit seeking behaviors secondary to cognitive impairment and advance age.</p> <p>Record review of Resident #78's electronic health record revealed there was no consent obtained for the resident to reside in the secure unit.</p> <p>During an interview on 12/18/24 at 5:12 p.m., the DON acknowledged Resident #23, #25, #73, #74 and #78 did not have a record of consent for the residents to reside in the secure unit. The DON further acknowledged Resident #25, #73, #74 and #78 did not have a physician's order for the residents to reside in the secure unit. The DON revealed the facility needed to implement an elopement assessment, BIMS score, care plan, consent, and physician order to place residents in the secure unit. The DON revealed the facility could not justify a reason why these residents did not have these elements implemented. The DON acknowledged, obtaining an elopement assessment, BIMS score, care plan, consent, and physician's order was needed to protect the resident's rights.</p> <p>On 12/19/24 at 9:14 a.m., the Administrator provided the Survey Team with an electronically signed consent for Resident #23, #25, #73, #74 and #78 to reside in the secure unit, all dated 12/18/24.</p> <p>Record review of the facility policy and procedure document titled, Charting and Documentation, revision date July 2017 revealed in part, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident medical record .c. Treatments or services performed .7. Documentation of procedures and treatments will include care-specific details .</p> <p>39075</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 1 resident (Resident #36) reviewed for hospice services, in that:</p> <p>The facility failed to monitor hospice aide and nursing visit per the hospice plan of care and keep the correct visit log sheet in Resident #36's hospice binder.</p> <p>This failure could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs.</p> <p>The findings were:</p> <p>Record review of Resident #36's face sheet, dated 12/19/2024, revealed the resident was a [AGE] year old female, admitted to the facility on [DATE] and readmitted to the facility on [DATE] with the diagnoses of Alzheimer's disease (destroy memories and thinking skills), muscle weakness, urinary tract infection (bladder infection), hypertension (high blood pressure), and muscle wasting and atrophy (loss of muscle mass).</p> <p>Record review of Resident #36's annual MDS, dated [DATE], reflected her BIMS score was 0 of 15 reflecting she had severe cognitive impairment. Further record review of Resident #36's annual MDS, indicated the resident required to substantial/maximal assistance (helper does more than half the effort) to sit to stand, chair-to-bed transfer, and toilet transfer.</p> <p>Record review of Resident #36's care plan, edited 12/10/2024, revealed the resident is on hospice and palliative services related to intrinsic and extrinsic factors such as Alzheimer's disease. For intervention, Hospice to guide overall management of plan of care with the facility, attend facility care plan meetings, weekly nursing assessment, provide hospice documentation to the facility.</p> <p>Record review of Resident #36's physician order, dated 12/06/2024, indicated the resident had the order of admit to hospice for Alzheimer's disease on 12/06/2024.</p> <p>Record review of Resident #36's hospice plan of care, dated 12/06/2024, indicated hospice aide and nurse should visit two times a week.</p> <p>Record review of Resident #36's patient visit log indicated the hospice nurse made a visit on 12/17/2024, and there was no more dates for signature regarding visit.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/18/2024 at 9:14 a.m. with the hospice clinical director of the hospice company on the phone stated the hospice aide and nurses visited two times the week from 12/08/2024 to 12/14/2024 to provide hospice care to Resident #36, but they did not sign on the visit log sheet. They might forget signing on the sheet.</p> <p>Interview on 12/18/2024 at 9:02 a.m. with LVN-F stated she did not know that the hospice nurse signed on the visit log only 12/17/2024. The LVN-F though the hospice aide and nurse might visit last week (from 12/08/2024 to 12/14/2024) as scheduled, but the nurse could not make sure if they visited or not. As a floor nurse, the nurse should have monitored, communicated with hospice staff, and kept hospice documentation.</p> <p>Interview on 12/18/2024 at 5:20 p.m. with the DON stated facility nurses should have monitored, communicated with hospice staff, and kept hospice documentation for Resident #36. The facility should have checked to ensure that the hospice nurse and aide made visits per the hospice plan of care and should have kept the record in Resident #36's hospice binder. The DON stated lack of communication with the hospice might cause lack of services to the resident. Further interview with the DON said the facility did not have specific hospice policy, and facility nurses had a responsibility to communicate with hospice nurses.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 (Residents #74) of 18 residents reviewed for infection control.</p> <p>CNA-L touched the new and clean brief with old and dirty gloves while providing incontinent and indwelling urinary catheter care to Resident #74 on 12/18/2024.</p> <p>This failure could place residents at risk for cross contamination and infections.</p> <p>The findings included:</p> <p>Record review of Resident #74's face sheet, dated 12/19/2024, revealed the resident was a [AGE] year old male, admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of dementia (impairment of brain functions), peripheral vascular disease (reduced blood flow to the limbs), neuromuscular dysfunction of bladder (lack of bladder control), urinary tract infection (bladder infection), and hypertension (high blood pressure).</p> <p>Record review of Resident #74's quarterly MDS, dated [DATE], reflected his BIMS score was 3 of 15 reflecting he had severe cognitive impairment. Further record review of Resident #74's quarterly MDS, dated [DATE], indicated the resident had indwelling urinary catheter and required dependent (Helper does all of the effort) to toilet hygiene and substantial/maximal assistance (helper does more than half the effort) to chair/bed-to-chair transfer, and always incontinent to bowel.</p> <p>Record review of Resident #74's care plan, edited 10/02/2024, revealed The resident is at risk for infection related to indwelling medical device; to prevent the infection, all staff will utilize gown, gloves, and hand hygiene during high-contact resident care activities and the resident is incontinent of bowel as related to cognitive impairment. For intervention, monitor for incontinence and provide incontinent care as needed.</p> <p>Observation on 12/18/2024 at 10:15 a.m. revealed CNA-M hold Resident #74, and CNA-L was cleaning the resident's groin area. CNA-L turned the resident to his right side and started cleaning the resident's buttock area, then put a new brief to the resident without changing CNA-L's old and dirty gloves.</p> <p>Interview on 12/18/2024 at 10:36 a.m. with CNA-L stated she touched Resident #74's new and clean brief with old and dirty gloves. CNA-L stated she should have changed her old and dirty gloves, and then put the new and clean brief to the resident. Further interview with the CNA-L said she was nervous and forgot to change her gloves.</p> <p>Interview on 12/18/2024 at 3:59 p.m. with the DON stated CNA-L should have touched Resident #74's new and clean brief with new and clean gloves. The DON had responsibility to monitor and check infection control to prevent any possible infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy and procedure, titled Perineal care, dated 10/24/2022, revealed . 15. Reposition as desired and cover the resident. 16. Remove gloves and discard. Perform hand hygiene. 17. Ensure call light is within reached.</p>

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>50760</p> <p>Based on interviews and record review, the facility failed to provide mandatory effective communications training to 1 of 25 (RN V) staff sampled for licensure and training.</p> <p>The facility failed to ensure that RN V had completed effective communications training.</p> <p>This failure could place residents at risk of being care for by untrained staff.</p> <p>The findings included:</p> <p>Review of the facility's training log, undated, showed no evidence of training for effective communications for RN V.</p> <p>During an interview on 12/18/24 at 10:55 AM with the Regional HR Manager, regarding licensure and training, it was noted that several sampled employees were missing required federal or state trainings.</p> <p>During an interview on 12/18/24 at 1:30 PM with the acting HR Coordinator, regarding licensure and training, it was noted that RN V was missing training for effective communications. The facility was provided time to locate and verify the missing trainings.</p> <p>During a second interview on 12/18/24 at 3:30 PM with the acting HR Coordinator, verified RN did not receive the effective communications trainings.</p> <p>During a third interview on 12/18/24 at 5:00 PM with the acting HR Coordinator and the Regional VP of Operations, the HR Coordinator stated that at the facility where she was the full time HR Coordinator, she and the Staffing Nurse were responsible for ensuring staff were receiving necessary trainings, and she was not sure who was responsible for training oversight at this facility. When asked what could happen to residents who were receiving care from staff who do not have all the required trainings, the acting HR Coordinator stated there could be consequences, and that residents could experience neglect or adverse outcomes if staff do not have the training to respond appropriately to situations like falls. The Regional VP of Operations stated that multiple applicants were being considered for the role of HR Coordinator and that until the position was filled, the Administrator would be responsible for staff training.</p> <p>Review of the Training Requirements policy dated 10/13/22, stated it is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers consistent with their expected roles.</p> <p>Review of the Nursing Services and Sufficient Staff policy dated 10/24/22, stated it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Bethany Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE  118 Trinity Shores Drive Port Lavaca, TX 77979	
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 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>50760</p> <p>Based on interviews and record review, the facility failed to provide required training on restraints for 5 of 25 (Activity Director, CNA Q, PTA O, CNA N, and the Speech Therapist) staff sampled for licensure and training.</p> <p>The facility failed to ensure that the Activity Director, CNA Q, PTA O, CNA N, and the Speech Therapist had completed their mandatory restraints training.</p> <p>This failure could place residents at risk of being cared for by untrained staff.</p> <p>The findings included:</p> <p>Review of the facility's training log, undated, showed no evidence of training for restraints for the Activity Director, CNA Q, PTA O, CNA N, and the Speech Therapist.</p> <p>During an interview on 12/18/24 at 10:55 AM with the Regional HR Manager, regarding licensure and training, it was noted that several sampled employees were missing required federal or state trainings.</p> <p>During an interview on 12/18/24 at 1:30 PM with the acting HR Coordinator, regarding licensure and training, it was noted that the Activity Director, CNA Q, PTA O, CNA N and the Speech Therapist were missing training for restraints. The facility was provided time to locate and verify the missing trainings.</p> <p>During a second interview on 12/18/24 at 3:30 PM with the acting HR Coordinator, verified that the Activity Director, CNA Q, PTA O, CNA N and the Speech Therapist did not receive training for restraints.</p> <p>During an interview on 12/18/24 at 5:00 PM with the acting HR Coordinator and the Regional VP of Operations, the HR Coordinator stated that at the facility where she was the full time HR Coordinator, she and the Staffing Nurse were responsible for ensuring staff were receiving necessary trainings, and she was not sure who was responsible for training oversight at this facility. When asked what could happen to residents who were receiving care from staff who do not have all the required trainings, the acting HR Coordinator stated there could be consequences, and that residents could experience neglect or adverse outcomes if staff do not have the training to respond appropriately to situations like falls.</p> <p>Review of the Training Requirements policy dated 10/13/22, stated it is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers consistent with their expected roles.</p> <p>(continued on next page)</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Nursing Services and Sufficient Staff policy dated 10/24/22, stated it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program.</p> <p>50760</p> <p>Based on interviews and record review, the facility failed to provide required Quality Assurance Performance Improvement (QAPI) training that outlines and informs staff of the elements and goals of the facility's QAPI program, for 10 of 25 (Housekeeper P, MA R, CNA S, Food Service Director, RN T, LVN U, Speech Therapist, Social Worker, Occupational Therapist, and LVN E) staff sampled for licensure and training.</p> <p>The facility failed to ensure that Housekeeper P, MA R, CNA S, Food Service Director, RN T, LVN U, Speech Therapist, Social Worker, Occupational Therapist, and LVN E had completed their mandatory QAPI training.</p> <p>This failure could place residents at risk of being care for by untrained staff.</p> <p>The findings included:</p> <p>Review of the facility's training log, undated, showed no evidence of training for QAPI for Housekeeper P, MA R, CNA S, the Food Service Director, RN T, LVN U, the Speech Therapist, the Social Worker, the Occupational Therapist, and LVN E.</p> <p>During an interview on 12/18/24 at 10:55 AM with the Regional HR Manager, regarding licensure and training, it was noted that Housekeeper P, MA R, CNA S, the Food Service Director, RN T, LVN U, the Speech Therapist, the Social Worker, the Occupational Therapist, and LVN E were missing required federal or state trainings.</p> <p>During an interview on 12/18/24 at 1:30 PM with the acting HR Coordinator, regarding licensure and training, it was noted that Housekeeper P, MA R, CNA S, the Food Service Director, RN T, LVN U, the Speech Therapist, the Social Worker, the Occupational Therapist, and LVN E, were missing training for QAPI. The facility was provided time to locate and verify the missing trainings.</p> <p>During a second interview on 12/18/24 at 3:30 PM with the acting HR Coordinator, verified Housekeeper P, MA R, CNA S, the Food Service Director, RN T, LVN U, the Speech Therapist, the Social Worker, the Occupational Therapist, and LVN E had not received the QAPI training.</p> <p>During a third interview on 12/18/24 at 5:00 PM with the acting HR Coordinator and the Regional VP of Operations, the HR Coordinator stated that at the facility where she was the full time HR Coordinator, she and the Staffing Nurse were responsible for ensuring staff were receiving necessary trainings, and she was not sure who responsible for training oversight at this facility. When asked what could happen to residents who were receiving care from staff who do not have all the required trainings, the acting HR Coordinator stated there could be consequences, and that residents could experience neglect or adverse outcomes if staff do not have the training to respond appropriately to situations like falls.</p> <p>(continued on next page)</p>		

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<p>F 0944</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Training Requirements policy dated 10/13/22, stated it is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers consistent with their expected roles.</p> <p>Review of the Nursing Services and Sufficient Staff policy dated 10/24/22, stated it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50760</p> <p>Based on interviews and record review, the facility failed to provide required training on behavioral health for 2 of 25 employees sampled for licensure and training.</p> <p>The facility failed to ensure that 2 of 25 staff reviewed for behavioral health training (RN V and the Physical Therapist) had completed this mandatory training.</p> <p>This failure could place residents at risk of not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being due to lack of staff training.</p> <p>The findings included:</p> <p>Review of the facility's training log showed no evidence of training for behavioral health for RN V and the Physical Therapist.</p> <p>During an interview on 12/18/24 at 10:55 AM with the Regional HR Manager, regarding licensure and training, it was noted that several sampled employees were missing required federal or state trainings.</p> <p>During an interview on 12/18/24 at 1:30 PM with the acting HR Coordinator, regarding licensure and training, it was noted that 2 of 25 employees sampled for licensure and training, were missing training for behavioral health. The facility was provided time to locate and verify the missing trainings.</p> <p>During a second interview on 12/18/24 at 3:30 PM with the acting HR Coordinator, the missing trainings were verified.</p> <p>During a third interview on 12/18/24 at 5:00 PM with the acting HR Coordinator and the Regional VP of Operations, the HR Coordinator stated that at the facility where she is the full time HR Coordinator, she and the Staffing Nurse are responsible for ensuring staff are receiving necessary trainings, and she is not sure who responsible for training oversight at [NAME] Senior Living. When asked what could happen to residents who are receiving care from staff who do not have all the required trainings, the acting HR Coordinator stated there could be consequences, and that residents could experience neglect or adverse outcomes if staff do not have the training to respond appropriately to situations like falls. The Regional VP of Operations stated that multiple applicants were being considered for the role of HR Coordinator and that until the position was filled, the Administrator would be responsible for staff training.</p> <p>Review of the Training Requirements policy dated 10/13/22, stated it is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers consistent with their expected roles.</p> <p>(continued on next page)</p>		

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F 0949  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Review of the Nursing Services and Sufficient Staff policy dated 10/24/22, stated it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.		