STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676481	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lavaca Bay Nursing and Rehabilitation Center	118 Trinity Shores Drive Port Lavaca, TX 77979

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on interview and record review the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 5 days a week, for 1 of 1 facility reviewed for nurse staffing. The facility failed to have RN coverage for 5 days on 11/08/2025, 11/22/2025, 11/27/2025, 11/30/2025, and 01/31/2026. This failure could place residents at risk of harm by denying residents the advanced critical thinking skills a registered nurse could provide.The findings included: Review of the facility's RN timecards from 10/01/2025 through 03/23/2026, revealed there were no RN hours for 11/08/2025, and 11/30/2025. The review of the RN timecards revealed there were less than eight hours for RN coverage on Saturday,11/22/2025, 11/27/2025, and 01/31/2026. Review of the facility census dated 11/08/2025 documented a population of 96 residents. The census dated 11/22/2025 documented a population of 94 residents. The census dated 11/27/2025 documented a population of 96 residents. The census dated 1/30/2025 documented a population of 95 residents, and the census dated 01/31/2026 documented a population of 95 residents. During an interview with the administrator on 03/27/2026 at 9:05AM, the administrator stated he could not confirm there was RN coverage on 11/08/26, 11/22/25, 11/27/25, 11/30/25, and 01/31/26. On days 11/08/2025 and 11/30/2025 there were zero RN Covered hours. On 11/22/2025, 11/27/2025, and 01/31/2026 there were less than eight hours covered by an RN within a 24-hour period. The administrator reported the nurses had either called in late or didn't show up and it fell under the DON responsibility to ensure there was RN coverage. During a follow up interview with the administrator on 03/27/26 at 9:32 AM, The Administrator said he doesn't have a policy for RN coverage and followed the CMS rules. During an interview with the DON on 03/27/2026 at 9:42AM, The DON reported for the days there was no RN coverage, someone could have called in sick. The DON stated an RN was needed for the staff in case there was a situation that required an assessment or something more than an LVN could provide. The DON stated she didn't think an RN not being at the facility would compromise the patient. The DON reported that some of the LVN staff struggled communicating with the doctor and therefore the RN was needed. The DON stated if an RN was not available the staff members could call her as well if there was a problem.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 3 of 12 residents (Residents #12, #13, and #65) who were reviewed for resident assessments. 1. The facility failed to document Resident #13's use of anxiolytic and hypoglycemic medications on the quarterly MDS (Minimum Data Set) assessment. 2. The facility failed to document Resident #65's diagnosis of schizoaffective disorder as an active diagnosis on the resident's MDS. 3.The facility failed to document Resident #12's diagnosis of schizoaffective disorder as an active diagnosis on the resident's MDS These failures could place residents at risk of improper or incorrect care or of not receiving services necessary for their physical, mental, and psychosocial well-being.The findings included: 1. Record review of Resident #13's admission sheet dated 12/28/23 documented a [AGE] year-old male resident with diagnoses including dementia, type 2 diabetes mellitus, insomnia, depression, hyperlipidemia (high cholesterol), hypertension (high blood pressure), paranoid schizophrenia, and anxiety. Record review of Resident #13's quarterly MDS assessment dated [DATE] documented a BIMS score of 15 indicating intact cognition. Further review of Resident #13's MDS in Section N0415. High-Risk Drug Classes: Use and Indication revealed the assessment did not record the use of anxiolytic or hypoglycemic medications. Record review of Resident #13's order summary documented an order for Temazepam (a benzodiazepine which slows down the central nervous system) with an order date of 4/29/2025, and an order for Janumet (a combination dipeptidyl peptidase-4 inhibitor and biguanide which lowers blood glucose) with an order date of 01/16/2025. Temazepam was ordered as Temazepam 15mg, Give 1 capsule by mouth at bedtime. Janumet was ordered as Janumet 50-1000mg, Give 1 tablet orally two times a day. Record review of Resident #13's December 2025 and January 2026 MARs revealed the resident received Temazepam and Janumet daily as prescribed during the seven day lookback period from 12/31/25 through 01/06/2026. Record review of Resident #13's care plan with an initiation date of 6/01/2025 documented the resident has Diabetes Mellitus ., with a goal of The resident will have no complications related to diabetes through the review date. Further review of Resident #13's care plan with an initiation date of 12/10/2025 documented the resident has a psychosocial well-being problem (potential) r/t Pain, Social isolation, Depression, Schizophrenia, Delusional d/o, Anxiety ., with a goal of The resident will have no indications of psychosocial well being problem by/through review date. 2. Record review of Resident #65's face sheet dated 3/25/26 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia, schizoaffective disorder, anxiety disorder, major depressive disorder, and disorder of adult personality and behavior. Record review of Resident #65's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills. Record review of Resident #65's quarterly MDS assessment, under Section I – Active Diagnosis indicated the resident had (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Non-Alzheimer's Dementia, Anxiety Disorder, and Depression, but did not indicate the resident was diagnosed with Schizophrenia (e.g., schizoaffective and schizophreniform disorders). Record review of Resident #65's quarterly MDS assessment, under Section N - Medications indicated the resident was treated with antipsychotic medications on a routine basis. Record review of Resident #65's Order Summary Report dated 3/25/26 reflected the following: - Olanzapine oral tablet 5 mg, give 1 tablet by mouth at bedtime for schizophrenia related to schizoaffective disorder with order date 7/28/25 and no end date. - Trazadone oral tablet 100 mg, give 1 tablet by mouth at bedtime related to schizoaffective disorder, with order date 3/24/26 and no end date. Record review of Resident #65's document titled Physician Review of Active Diagnosis, signed by the physician and dated 12/1/25 reflected the resident had a diagnosis of schizoaffective disorder. Resident #65's Physician Review of Active Diagnosis document reflected the physician certified that the referenced diagnoses were active and have a direct relationship to the resident's skilled care, current functional status, mood or behavior, treatments, nursing monitoring, or risk of death. Record review of Resident #65's document titled Physician Review of Active Diagnosis, signed by the physician and dated 2/26/26 reflected the resident had a diagnosis of schizoaffective disorder. Resident #65's Physician Review of Active Diagnosis document reflected the physician certified that the referenced diagnoses were active and have a direct relationship to the resident's skilled care, current functional status, mood or behavior, treatments, nursing monitoring, or risk of death. Record review of Resident #65's initial psychiatric assessment dated [DATE] reflected the resident had a primary diagnosis of major depressive disorder, and was treated for schizoaffective disorder, depressive type. Resident #65's initial psychiatric assessment document reflected the resident was referred related to anxiety, psychosis, hallucinations, wandering, obsessive/compulsive thoughts or behaviors, medication evaluation, and had previous mental health diagnosis including schizophrenia. 3. Record review of Resident #12's face sheet dated 03/25/2026 revealed a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder, unspecified (mental health condition that combines symptoms of schizophrenia and mood disorders without specifying the type of mood disorder present),. Record review of Resident #12's MDS dated [DATE] documented a BIMS score of 4 out of 15 indicating severe cognitive impairment. Further review of the MDS under Section I – Active Diagnoses Psychiatric/Mood Disorder revealed the assessment did not include a diagnosis of schizoaffective disorder in the box next to I6000 Schizophrenia (e.g., schizoaffective and schizophreniform disorders. Record review of Resident #12's March 2026 MAR documented the following orders: -Sertraline HCl Tablet 100 MG: Give 1 tablet by mouth at bedtime related to schizoaffective disorder, unspecified with a start date of 01/16/2026 -Behavior monitoring- Antidepressants Behavior code: 0. None, 1. Withdrawn, 2. Loss of Appetite, 3. Crying, 4. Lack of Interest, 5. Apathy, 6. Feeling of Helplessness, 7. Feelings of Worthlessness, 8. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Suicidal ideations, 9. Insomnia, 10. Other (Document in PN) Interventions: Document in PN every shift. with a start date 01/16/2026 Record review of Resident #12's care plan provided on 03/25/2026 revealed a focus area for the following: [Resident #12] uses antidepressant medication (SERTRALINE) r/t schizoaffective disorder., initiated on 02/11/2026, with interventions including Monitoring behaviors, notify MD of new or worsening behaviors initiated on 02/11/2026. Record review of Resident #12's admission history and physical dated 04/16/2025 with Resident #12's physician signature dated 01/22/2026 recorded schizoaffective disorder under the assessment section. Record review of Resident #12's psychiatric periodic evaluation dated 1/2/2026, at their previous facility, recorded a diagnosis of F25.9 Schizoaffective disorder, unspecified condition under the diagnosis, assessment and plan section. During an interview with the Administrator on 3/25/26 at 3:37 PM, the Administrator stated they only have a policy on MDS timelines and use the RAI manual for everything else. During an interview with the MDS RN C on 3/26/26 at 4:13 PM, MDS RN C stated each staff member is responsible for ensuring the accuracy of the information they include on the MDS assessment. MDS RN C further stated it was important for the MDS to be accurate, because it drives the care plan of a resident and helps in providing good resident care. MDS RN C stated they do not want inaccuracies on the MDS, because depending on the section, it could affect resident care. During an interview with MDS RN B on 3/26/26 at 4:40 PM, MDS RN B stated they use the RAI manual when they asked if they have an MDS policy. During an interview with the DON on 3/26/26 at 5:07 PM, the DON stated if the MDS requires medication to be included, then the medication should be coded on there. The DON further stated it was important for the MDS to be accurate because they use MDS to let insurance know what they are billing, for the services they are giving to the resident, and the psychotropic medication monitoring. The DON stated her expectation for the MDS was that they reflect what a resident's chart says, and if they think there is an error, they should question it before the MDS is submitted. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025, noted in section N0415: High-Risk Drug Classes: Use and Indication, Steps for Assessment 1. Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day lookback period . and Coding Instructions Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Further revealed noted in Section I: Active Diagnosis reflected in part, Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.Coding Instructions. Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.Active Diagnoses.Psychiatric/Mood Disorder.schizophrenia (e.g., schizoaffective and (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schizophreniform disorders).Coding Tips. There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 of 8 residents (Resident #14) reviewed for resident rights. CNA F referred to Resident #14 as honey and sweetie during catheter/incontinent care. This failure could place residents at risk of loss of dignity and self-worth.The findings included: Record review of Resident #14's face sheet dated 3/26/26 reflected a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included mixed receptive-expressive language disorder, aphasia following cerebrovascular disease, dysphagia, and depression. Record review of Resident #14's most recent comprehensive MDS assessment dated [DATE] reflected the resident's speech clarity was clear, was sometimes understood - ability was limited to making concrete requests, and responded adequately to simple, direct communication. Resident #14's comprehensive MDS reflected he was severely cognitively impaired for daily decision-making skills. Record review of Resident #14's comprehensive care plan with revision date 7/6/25 reflected the resident had impaired cognitive function or impaired thought processes related to dementia and inattention with interventions that included to use the resident's preferred name, face the resident when speaking and make eye contact. Resident #14's comprehensive care plan reflected the resident understands consistent, simple, directive sentences. Observation on 3/26/26 at 10:15 a.m. during incontinent care, CNA F addressed Resident #14 as sweetie and honey when asking the resident to lower his legs. Resident #14 had to be assisted to lower his legs. During an interview on 3/26/26 at 10:45 a.m., Resident #14 nodded his head to indicate that he had been offended when referred to as honey and sweetie. Resident #14 could not elaborate on why he was offended by being referred to as honey and sweetie. Resident #14 was asked by the State Surveyor if he should be addressed by his name, and Resident #14 nodded, indicating yes. During an interview on 3/26/36 at 10:47 a.m., CNA F stated she should not have referred to Resident #14 as honey or sweetie because it was considered a dignity issue and the resident should have been addressed with respect, perhaps by saying his name. During an interview on 3/26/26 at 5:26 p.m., the DON stated it was her expectation for the staff to refer to the residents by their proper name, unless the resident agreed to the use of a resident nick name. The DON stated terms of endearment should not be used, unless the residents agreed to it. Record review of the facility document titled Rights of Elderly Individuals, undated reflected in part, .An elderly individual has the right to be treated with dignity and respect for the personal integrity of the individual, without regard to race, religion, national origin, sex, age, disability.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident's environment remains as free of accident hazards as is possible, for 1 of 5 residents (Resident #82), reviewed for accidents. The facility failed to ensure Resident #82 did not have scissors and nail clippers in her room. This failure could place the resident at risk of injury and contribute to avoidable accidents and a decline in health.The findings include: Record review of Resident #82's face sheet dated 03/25/2026 revealed a [AGE] year-old female readmitted to the facility on [DATE], with an original admission date of 06/11/2025, with diagnoses that include anxiety disorder (uncontrollable worry about everyday issues, affecting everyday functioning), major depressive disorder recurrent, mild (persistent feelings of sadness, loss of interest in activities, and various emotional and physical problems), and muscle weakness. Record review of Resident #82's MDS dated [DATE] revealed a BIMS of 15 out of 15 indicating no cognitive impairment and recorded the needed use of setup or clean-up assistance with personal hygiene. Record review of Resident #82's care plan provided on 03/25/2026 revealed a focus area for the following: [Resident #82] has an ADL self-care performance deficit r/t weakness, impaired mobility., initiated on 09/17/2025, with interventions including Functional performance: personal hygiene: The resident requires (setup or cleanup assistance) for personal hygiene initiated on 09/17/2025. During an observation on 03/24/2026 at 3:32 p.m., revealed Resident #82 had 1 pair of scissors and 2 nail clippers lying on their bedside table. During an observation and interview on 03/25/2026 at 8:55 a.m., revealed Resident #82 1 pair of scissors and 2 nail clippers lying on their bedside table. Resident #82 stated she was not sure if staff knew about the scissors or nail clippers, but that staff were very vigilant when they came in and out of her room. Resident #82 stated she has clipped her fingernails but cannot do her toenails. Resident #82 stated they have not been told they can not have nail clippers or scissors in their room. Resident #82 stated she had not had any issues with using either scissors or nail clippers. Resident #82 stated every morning her family member does come into her room. During an interview on 03/26/2026 at 12:03 p.m., CNA D stated residents were not allowed to have nail clippers or scissors in their rooms and if they did, CNA D would have to let a nurse know. CNA D stated Resident #82 should not have scissors or nail clippers in their room. CNA D stated that sometimes confused residents have wandered in and out of rooms and some residents like to go to other residents' rooms to visit. CNA D stated the risk to residents that have scissors or nail clippers in their room would be residents might hurt themselves on accident or hurt others. During an interview on 03/26/2026 at 12:20 p.m., RN A stated residents could not have knives or anything they could turn into harming themselves. RN A stated they were not aware of anyone on the hall Resident #82 resides that could have scissors or nail clippers in their room. RN A stated they were not sure if Resident #82 could have scissors or nail clippers in their room and would have to ask the ADON or DON. RN A stated they had seen residents go in and out of other residents' rooms to visit but not wander. RN A stated the danger of having scissors or nail clippers in the resident's room could be a bleeding risk or if they were not cognitively aware they would not be able to understand how to use them. During an interview on 03/26/2026 at 12:36 p.m., the ADON stated residents were not supposed to have scissors or nail clippers in their rooms. The ADON stated if a resident could independently use sharp items, it would be kept in the nurse's cart or medication room and brought to the resident when needed. The ADON stated they were not aware of any residents who could have nail clippers or scissors in their room. The ADON stated the risk could be residents with dementia could go in there and get them, residents could cut themselves, or cut their nails too short and risk infection During an interview on 03/26/2026 at 12:47 p.m., the DON stated residents cannot have anything sharp in their room unless they had a lock box and the items were kept in there but that they really do not allow sharps in resident rooms. The DON (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated sharps that belong to residents were kept in the medication room. The DON stated if residents could use clippers independently it would have been documented in the Kardex and the resident would have to have to had return demonstrate safe use of nail clippers. The DON stated they have seen residents wander but mainly in the memory care unit. The DON stated the risk could be residents could clip their skin or other residents could get ahold of the sharps. During an interview on 03/26/2026 at 2:47 p.m., the DON stated they did not have a policy regarding sharps but provided a document from the admission packet with a list of prohibited items. Record review of the facility's policy, Visitation, Spousal Arrangements & Other Accommodations, no date, revealed:Prohibited Items- . no sharps objects (including razor blades, straight razors, knives or push pins) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for one of four medication carts (400/right side 600 nurse medication cart) observed for drug storage and labeling. 1.The facility failed to ensure all insulin pens located inside the 400/right side 600 nurse medication cart were properly labeled with opened dates.2.The facility failed to ensure Resident #37 did not have a bottle of allergy medications at the bedside. These failures could place residents at risk of receiving inadequate treatments and medication misuse.The findings included: 1.During an observation on 3/26/26 at 2:33 PM of the 400/right side 600 nurse medication cart, an undated insulin pen was observed lying in the top drawer of the cart with no opened date written anywhere on the pen itself or on the label on the pen. During an interview with LVN E on 3/26/26 at 2:33 PM, LVN E stated it was important for the opened date to be documented on the pen because of the longevity of the pen and once it goes past its longevity, you get rid of it and get a new one. LVN E stated when she sees an undated pen in the cart, she should get a new one since the undated insulin might not have the desired effect for a resident. LVN E stated she would discard the undated pen. During an interview with the DON on 3/26/26 at 5:07 PM, the DON stated it was important to date insulin when it was taken out of the refrigerator, because they know when it will expire based on the date of removal. The DON further stated her expectation for staff was that they would not use any insulin from a medication cart if it was undated, and it was unknown how long it had been out of the refrigerator. The DON stated she expected her staff to dispose of any undated insulins in the medication carts. 2. Record review of Resident #37's face sheet dated 3/25/26 reflected an [AGE] year old female admitted to the facility on [DATE] with diagnoses that included lack of coordination, chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breathe due to airflow blockage and inflammation in the airways), anxiety disorder, allergy, heart failure, and need for assistance with personal care. Record review of Resident #37's most recent quarterly MDS assessment dated [DATE] reflected the resident had impaired vision, used corrective lenses, and was cognitively intact for daily decision-making skills. Record review of Resident #37's Order Summary Report dated 3/25/26 reflected the following: - Cetrizine oral tablet 10 mg, 1 tablet by mouth one time a day related to allergy with order date 10/6/25 and no end date. Record review of Resident #37's comprehensive care plan with revision date 11/18/25 reflected the resident had impaired cognitive function/impaired thought processes related to advanced age with interventions that included to administer medications as ordered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/24/26 at 12:02 p.m., Resident #37 stated she was given medications by the facility staff but stated she was perfectly capable of giving herself medications. Resident #37 was observed with a small nightstand next to her recliner on the right with the top drawer open approximately halfway. The top drawer of the nightstand was observed with a bottle of allergy pills. Resident #37 stated she had last taken an allergy pill from the bottle seen in the top drawer last night (3/23/26) and believed the staff were aware she kept the medication at the bedside. During an observation and interview on 3/26/26 at 8:00 a.m., Resident #37 was observed with a small nightstand next to her recliner on the right with the top drawer open approximately halfway. The top drawer of the nightstand was observed with a bottle of allergy pills. Resident #37 stated she preferred to keep her own bottle of allergy pills at the bedside and stated she believed the nursing staff were aware she kept the medication at the bedside because it was in plain sight. Resident #37 stated she took an allergy pill last night (3/24/26) and it helped. During an observation and interview on 3/26/26 at 8:20 a.m., Med Aide H stated she was not aware Resident #37 could administer her own medications. Med Aide H stated, as far as I know, there are no residents in the facility who were care planned to take their own medications. Med Aide H observed a bottle of allergy pills in the top drawer of Resident #37's nightstand and stated she was not aware the resident had the allergy pills and would have to take the medication and give it to the DON. Med Aide H stated any medications left at the bedside could possibly be consumed by another resident or Resident #37 could have an off day and take too many and have a negative reaction. Med Aide H stated, there's a reason why we're here. During an interview on 3/26/26 at 8:30 a.m., LVN I stated, during the shift change, nursing staff made initial rounds of the residents and then received report. LVN I stated, Resident #37 was capable of self-medication and was able to keep medications at the bedside, not pills though. LVN I stated, any medications given orally were given by a nurse or medication aide. LVN I stated, for a resident to self-medicate there needed to be a doctor's order, an assessment, an observation to ensure the resident was capable of self-medicating, and it needed to be care planned. LVN I stated Resident #37 could not self-medicate with medications the staff were not aware she had and the resident could possibly overmedicate, another person could take the medication not intended for them, and the resident could have a drug reaction to other medications prescribed. LVN I stated during initial rounds most residents are still sleeping, and the lights are out, and rounds are to ensure the resident is safe. LVN I stated she would have to confiscate Resident #37's allergy pills and investigate if it was a medication she had already been prescribed. LVN I stated, Resident #37 already took scheduled physician ordered allergy medications at night and stated, I guess she's double dosing. During an interview on 3/26/26 at 5:18 p.m. the DON stated Resident #37 had an assessment to self-medicate from February 2026 for the use of eye drops. The DON stated, after being made aware Resident #37 had a bottle of allergy pills at the bedside, the resident was ok to use it. The DON stated she had educated the resident's family member, who provided Resident #37 with the bottle of allergy pills, to give the medication to nursing staff. The DON stated, right now, there are no residents in the facility who can self-medicate, they need to be assessed for it. Record review of the facility document titled Medication Policies with revision date 10/1/19 reflected in part, .When medication is ordered for use at the bedside, the medication label contains, in addition to the instructions for use, a notation that may be self-administered and stored at bedside. Review of the facility policy titled Labeling of Medications with a revision date of 10/01/19 noted All (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676481	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lavaca Bay Nursing and Rehabilitation Center	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drugs and biological in the Facility are labeled in accordance with all Federal and State regulations . and Prescription medications will be labeled with the following information H. Expiration date.