

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Amistad Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Riverside Dr Uvalde, TX 78801	

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 0558</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47611</p> <p>Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or others for 1 of 8 residents (Resident #4) reviewed for call light placement.</p> <p>The facility failed to ensure the call light was within reach for Resident #4.</p> <p>This deficient practice could place residents at risk of not receiving help as needed.</p> <p>The findings were:</p> <p>Record review of Resident #4's face sheet, dated 04/07/2025, revealed a female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4 had diagnoses which included: polyosteoarthritis (arthritis affecting multiple joints), dementia (syndrome that progressively affects a persons cognitive ability) and muscle weakness.</p> <p>Record review of Resident #4's MDS assessment, dated 03/11/2025, revealed the resident's BIMS score was 3, which indicated severe cognitive impairment.</p> <p>Record review of Resident #4's care plan, initiated date of 3/19/2025, revealed Resident #4 potential for falls/injuries . Be sure the resident's call light is within reach.</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 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 ensure residents had the right to send and receive mail, and to receive letters, package and other materials delivered to the facility or the resident through a means other than a postal service, including the right to privacy of such communications for 1 of 5 residents (confidential resident) reviewed for resident rights.</p> <p>The facility failed to ensure staff distributed 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 1 of 5 members group stated they never received mail on Saturdays because the Front Office Staff didn't work on Saturdays.</p> <p>During an interview on 4/7/25 at 3:16 p.m., the Receptionist stated she worked for the facility for almost 3 years and usually worked from Monday to Friday and sometimes on the weekends. The Receptionist stated she delivered personal mail to the residents daily from Monday to Friday. The Receptionist stated she believed the mailman delivered mail on Saturdays and when the mail was delivered it was placed in a mailbox (large white bin) and stored in the admissions office, which included packages. The Receptionist stated they had a weekend Clerical Staff who was newly hired but stated she knew the mail was not distributed over the weekend because when she returned to the facility on Monday morning, the mailbox had mail and packages stored in the admissions office. The Receptionist further stated, if I lived here and received personal mail on a Saturday and had to wait until Monday, I wouldn't like it because it could be something I have been waiting for and they (the residents) probably don't get personal mail that often and it would be nice to know you are receiving something from somebody. The Receptionist stated she was responsible for delivering personal mail to the residents.</p> <p>During an interview on 4/7/25 at 3:28 p.m., the Admissions Coordinator stated the facility received mail delivery from Monday to Saturday. The Admissions Coordinator stated the Receptionist received the mail and distributed personal mail to the residents from Monday to Friday. The Admissions Coordinator further stated, the Activities Director used to deliver the mail to the residents, but the facility did not have an Activity Director. The Admissions Coordinator stated, on Saturday's mail delivery, they (the staff) put the mail in my office or in the Business Office Managers office. Nobody sorts it on the weekend. The Admissions Coordinator further stated the mail sits in my office or the BOM's office until Monday. The Admissions Coordinator stated mail delivery to the residents was important because it was the resident's connection to the outside since they don't get that many visitors .</p> <p>(continued on next page)</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>During an interview on 4/7/25 at 3:41 p.m., the BOM stated he generally worked Monday to Friday and sometimes weekends. The BOM stated he often did not receive any mail unless the Receptionist had delivered it to him. The BOM stated the Receptionist was responsible for sorting the mail, which included the resident's personal mail. The BOM stated, most of the time I come in on Sundays, if I worked on a weekend, I know Sunday there is no mail delivery. I don't really know if the mail is being delivered on Saturday. I don't usually work on Saturday.</p> <p>During an interview on 4/8/25 at 10:51 a.m., the ADM stated mail delivered on a Saturday should be distributed on Saturday. The ADM further stated they had a Receptionist (Clerical Staff) and a manager on duty on the weekends and they should be processing the personal mail to the residents on Saturday instead of holding onto it until Monday. I don't know what the process is right now. The ADM further stated mail delivery to the residents was their right.</p> <p>A telephone interview on 4/9/25 at 10:12 a.m. with the weekend Clerical Staff was attempted but was unsuccessful. The Clerical Staff did not return the State Surveyors call.</p> <p>Record review of the facility's policy and procedure titled Resident Mail Delivery and Distribution, dated 2011, revealed in part, .The health care center will develop a system to deliver and distribute resident mail in accordance with privacy and confidentiality regulations .The Activity Department appoints a specific staff member or volunteers to coordinate mail delivery every day that the facility receives mail or parcels</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy and confidentiality in his or her personal and medical records for 1 of 1 resident (Resident #52) reviewed for residents' rights.</p> <p>The facility failed to ensure LVN D locked the medication cart computer screen and left Resident #52's information exposed.</p> <p>This failure could place residents at risk of resident-identifiable information being accessed by unauthorized persons.</p> <p>The findings included:</p> <p>Record review of Resident #52's face sheet, dated 4/8/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #52 had diagnoses which included cerebral infarction (type of stroke that occurs when blood flow to a part of the brain is blocked or significantly reduced, leading to tissue death), dementia (a decline in cognitive function that is severe enough to interfere with a person's daily life and activities), dysphagia (language disorder that results from damage to the brain affecting language), and urinary tract infection .</p> <p>Observation on 4/6/25 at 3:05 p.m. revealed the medication cart on Unit E had the computer screen open with Resident #52's information. Approximately a minute later, the DON walked into the unit and observed the medication cart on Unit E with the computer screen open with Resident #52's information. The DON then knocked on a resident room and notified LVN D .</p> <p>During an observation and interview on 4/6/25 at 3:06 p.m., LVN D stated the computer screen on the medication cart in Unit E was left with the computer screen open with Resident #52's information. LVN D stated she got distracted by a resident and forgot to lock the computer screen. LVN D stated, leaving patient information exposed was a HIPAA violation and information could be obtained by unauthorized persons, and it was an invasion of the resident's privacy.</p> <p>During an interview on 4/8/25 at 11:05 a.m., the DON stated it was her expectation that resident information should be private and stated she had seen the computer screen on the medication cart in Unit E open and in full view of the resident's information. The DON stated, the health information from that resident could be talked about and spread through to people who should not have that information.</p> <p>Record review of the facility's, undated, policy and procedure titled, Resident Rights, revealed in part, .The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy .The facility must protect and promote the rights of the resident .Privacy and confidentiality .The resident has a right to personal privacy and confidentiality of his or her personal and medical records</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075</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 2 residents (Resident #68 and #40) reviewed for indwelling urinary catheter care/incontinence care:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #68's indwelling urinary catheter drainage bag was not touching the floor and failed to provide proper incontinence care. 2. The facility failed to ensure Resident #40's indwelling urinary catheter drainage bag was not touching the floor. <p>This failure could place residents with indwelling urinary catheter devices at risk for the development of new or worsening urinary tract infections.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #68's face sheet dated 4/7/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute kidney failure (sudden loss of the kidneys' ability to filter waste products, balance fluids, and regulate electrolytes in the body), neuromuscular dysfunction of bladder (condition where the nerves and muscles that control bladder function do not work properly), retention of urine, and disorders of prostate (any condition that affects the small gland that produced seminal fluid which can affect urinary and reproductive function). <p>Record review of Resident #68's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, utilized an indwelling urinary catheter and was frequently incontinent of bowel.</p> <p>Record review of Resident #68's Order Summary Report dated 4/7/25 revealed the following:</p> <ul style="list-style-type: none"> - Ensure catheter strap in place and holding every shift change as needed with order date 11/18/24 and no end date - Ensure foley bag is in privacy bag while in bed or wheelchair every shift with order date 11/18/24 and no end date - Empty drainage bag every shift with order date 11/18/24 and no end date - Monitor indwelling urinary catheter every shift for leakage, blockage, sediment, buildup, or low output every shift with order date 11/18/24 and no end date - Provide catheter care every shift with order date 11/18/24 and no end date <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 - Few</p>	<p>Record review of Resident #68's comprehensive care plan with revision date 1/7/25 revealed the resident was incontinent of bowel and required assistance with toileting tasks and interventions that included to provide peri care after each incontinent episode. Further review of Resident #68's comprehensive care plan revealed the resident required the use of an indwelling urinary catheter with interventions that included to check tubing for kinks and maintain the drainage bag off the floor.</p> <p>During an observation on 4/6/25 at 12:29 p.m., Resident #68 was observed in the dining room eating lunch and the indwelling urinary catheter bag was strapped behind the resident's wheelchair touching the floor.</p> <p>During an observation on 4/7/25 at 8:18 a.m., Resident #68 was observed sitting up in the wheelchair and the indwelling urinary catheter bag was strapped behind the resident's wheelchair touching the floor.</p> <p>During an observation on 4/8/25 at 11:31 a.m., during catheter/incontinent care to Resident #68, CNA B used a disposable wipe to clean the resident's scrotum and wiped in the wrong direction from back to front. CNA B continued with catheter/incontinent care and used a disposable wipe to clean the resident's left inner thigh two times using the same area of the wipe. CNA B then took the same disposable wipe, folded it, and wiped Resident #68's right inner thigh two times using the same area of the wipe. CNA B completed catheter/incontinent care and assisted Resident #68 into the wheelchair. Resident #68's indwelling urinary catheter collection bag was strapped to the resident's wheelchair and the catheter drainage bag was observed touching the floor.</p> <p>During an observation and interview on 4/8/25 at 11:43 a.m., CNA B acknowledged Resident #68's indwelling urinary catheter drainage bag was touching the floor and should not have been because it was considered cross contamination and an infection control issue. CNA B further stated the indwelling urinary catheter drainage bag could get snagged on something or dislodge. CNA B stated, it can get caught on the wheels (of the wheelchair) when we are rolling him back and forth. CNA B acknowledged she had used the same area of the disposable wipe more than once while providing Resident #68 with catheter/incontinence care and considered it cross contamination. CNA B stated, wipe one time and then toss the wipe. CNA B acknowledged using the disposable wipe to wipe from back to front instead of from front to back when cleaning the resident's scrotum. CNA B stated wiping in the wrong direction was a problem because the germs could be wiped back up instead of away; same thing it's cross contamination and could result in the resident getting an infection, a rash, or something like that. CNA B stated she had received in-service competency training on catheter/incontinence care maybe a couple of months ago and had been in-serviced by ADON C. CNA C acknowledged it was the CNAs responsibility to ensure the indwelling urinary catheter bag was not touching the floor.</p> <p>During an interview on 4/8/25 at 2:04 p.m., ADON C stated, during incontinent care, it was expected to use the disposable wipe with one pass and then toss the wipe or turn the wipe and use a clean area. ADON C stated, if the wipe was used once, it should either be turned to a clean side, or the wipe should be tossed. ADON C further stated, no more than one pass should be made with the disposable wipe because that part of the wipe had already been used and there could be a problem with cross contamination and the resident could get an infection. ADON C stated the indwelling urinary catheter drainage bag was supposed to be kept off the floor because it could rupture or spill urine resulting in the resident getting an infection.</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 - Few</p>	<p>During an interview on 4/8/25 at 2:17 p.m., the DON stated, it was her expectation, when using a disposable wipe during catheter/incontinent care, the wipe should only be used once. The DON stated, you don't wipe more than once with the same wipe because it's cross contamination; they are basically just wiping back the dirty to what was supposedly just cleaned. The DON further stated, when providing catheter/incontinent care, should be wiping away from the area that you are wiping. Always wipe from front to back because if not you could be causing an infection. The DON stated, the indwelling urinary catheter drainage bag should not be touching the floor; cross contamination; the bag dragging on the floor could cause infection, it can cause trauma, it could be accidentally stepped on and dislodged.</p> <p>Record review of CNA B's Proficiency Audit dated 5/31/24 revealed she had satisfied the requirements for providing catheter care and perineal care.</p> <p>2. Record review of Resident #40's admission sheet dated 4/7/25 indicated a [AGE] year-old man with an original admitted [DATE] and a readmitted [DATE]. Resident #40 had diagnoses which included bladder dysfunction, hyperlipidemia (high cholesterol), dementia, muscle weakness, and chronic obstructive pulmonary disease (COPD).</p> <p>Record review of Resident #40's quarterly MDS assessment dated [DATE] indicated the resident was severely cognitively impaired for daily decision-making skills with a BIMS of 5, utilized an indwelling urinary catheter and was frequently incontinent of bowel.</p> <p>Record review of Resident #40's Order Summary Report dated 4/7/25 indicated the following:</p> <ul style="list-style-type: none"> - Empty drainage bag every shift with order date 2/6/25 and no end date - Ensure catheter strap in place and holding every shift change as needed with order date 2/6/25 and no end date - Ensure foley bag is in privacy bag while in bed or wheelchair every shift with order date 2/6/25 and no end date <p>Record review of Resident #40's comprehensive care plan with revision date 2/25/25 indicated the resident was incontinent of bowel and required assistance with toileting tasks and interventions that included Administer medications/treatments as per MD's order when indicated, Apply barrier cream as indicated, and Check resident frequent throughout the day and requested/required and assist with toileting as needed. Further review of Resident #40's comprehensive care plan indicated the resident required the use of an indwelling urinary catheter with interventions which included to check tubing for kinks and maintain the drainage bag off the floor.</p> <p>During an observation on 04/07/25 at 09:17 AM, Resident #40 was seen sitting in his wheelchair in the dining room with his catheter bag attached to the back of his wheelchair touching the floor.</p> <p>During an observation on 04/07/25 at 11:21 AM, Resident #40 was seen sitting in the dining room where he was moving his wheelchair back and forth. The bottom of the catheter bag was observed sliding back and forth on the ground as the wheelchair moved.</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 - Few</p>	<p>During an observation on 04/08/25 at 08:06 AM, Resident #40 was seen self-propelling in his wheelchair from the dining room to the 100 Hall. The catheter bag was strapped to the bottom of the wheelchair with the bag dragging against the floor as he moved down the hallway.</p> <p>During an observation and interview on 04/08/25 at 12:01 PM, CNA E stated Resident #40's catheter bag should not be touching the ground because of cross contamination. At the time of the interview Resident #40 was observed sitting in the dining room with his catheter bag touching the floor. When asked who was responsible for making sure a resident's catheter bag did not touch the floor, CNA E stated, we are.</p> <p>During an interview on 04/08/25 at 12:09 PM regarding catheter bag placement, CNA F stated, the CNAs are responsible for making sure it's not touching the floor, and they are supposed to pick it up. CNA F stated, an infection or an accident can happen and a resident can get sick if there's cross contamination, and they should be checking it frequently.</p> <p>During an interview on 04/08/25 at 02:04 PM with ADON C, when asked if at any point should the catheter bag should be touching the floor, ADON C stated no, because it can rupture and spill the urine, and it can also be infection control, and the resident could get an infection.</p> <p>During an interview on 04/08/25 at 02:16 PM, the DON stated the expectation for the catheter bag is that it not be touching the floor. The DON stated, it could be cross contamination with the bag touching the floor and cause infection, and it could dislodge or be accidentally stepped on.</p> <p>Record review of the facility's policy and procedure titled Perineal Care, dated 5/11/22, noted .An incontinent resident or urine and/or bowel should be identified, assessed, and provided appropriate treatment and services .Gently perform perineal care, wiping from 'clean,' urethral area, to 'dirty,' rectal area, to avoid contaminating the urethral area - CLEAN to DIRTY! .Use a clean area of the washcloth or pre-moistened cleansing wipes for each stroke .Do not wipe more than once with the same surface .</p> <p>Record review of the facility's policy and procedure titled Catheter Care with revision date 2/13/2007 revealed in part, .Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site . Be sure the catheter tubing and drainage bag are kept off the floor .</p> <p>50760</p>		

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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>50760</p> <p>Based on observations, interviews, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles for one of six medication carts (200 hall nurse cart) assessed for medication storage and labeling.</p> <p>The facility failed to ensure all medications located inside the 200 hall nurse cart were stored in labeled containers.</p> <p>This failure could place residents at risk of receiving inadequate treatments or ingesting medications for which they were not prescribed.</p> <p>The findings included:</p> <p>During an observation on 04/08/25 at 9:25 AM of the 200 hall nurse cart, five pills were observed lying in the bottom in the cart, not in labeled containers.</p> <p>During an interview on 04/08/25 at 9:25 AM regarding the loose pills in the 200 hall nurse cart, ADON C stated, they could get them confused and give it to a patient who isn't supposed to take them. ADON C stated, when they find loose pills they try to track what they are and then dispose of them.</p> <p>During an interview on 04/09/25 at 08:57 AM regarding the loose pills in the 200 hall nurse cart, the Acting Administrator stated, someone could get confused and give something to someone that they shouldn't have, and they wouldn't know what it is or who it's for.</p> <p>During an interview on 04/09/25 at 12:44 PM regarding the loose pills in the 200 hall nurse cart, LVN A stated, patients might not be getting their meds. LVN A stated, usually I go looking for it when a pill falls, and I should have looked through the cart to check for loose pills. LVN A stated, normally we just count narcotics, and if something falls, most of us get it immediately but they are also responsible for going through their cart.</p> <p>Review of the Medication Labeling Policy from the Pharmacy Policy & Procedure Manual 2003, noted All legend patient medications regardless of source shall be properly labeled as required in State regulations for Long Term Care Facilities. The policy further noted, Non-prescription drugs obtained from health food stores, or sources other than the provider pharmacy must be in the original manufacturer's container.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>50760</p> <p>Based on interviews and record review, the facility with more than 120 beds failed to employ a qualified social worker on a full-time basis, for 1 of 1 social services staff reviewed for qualifications of Social Worker.</p> <p>The facility, licensed for 200 beds, did not employ a full-time social worker.</p> <p>This failure could place residents at risk of social service and psychosocial needs not being met.</p> <p>The findings included:</p> <p>Record review of the facility's Daily Census Report, dated 4/6/25, noted the facility had a total licensed bed capacity of 200.</p> <p>Record review of the Facility Summary Report from the Texas Unified Licensure Information Portal (TULIP) noted the facility had a total licensed capacity of 200 beds.</p> <p>Record review of the facility's Contract Binder, showed no contract with a licensed social worker.</p> <p>During an interview on 4/6/25 at 1:14 PM, the DON stated the facility did not have a social worker and had not had a social worker for a while.</p> <p>During an interview on 04/08/25 at 03:53 PM, the Acting Administrator stated it was very difficult to find a social worker in this area, and they have a sign on bonus, and they have made offers to people who back out. The Acting Administrator stated, it has to be over a year, since the facility had a social worker because there was not one here this time last year. The Acting Administrator stated, it is hard because they have to relocate here and after the tragedy they have a bad reputation. The Acting Administrator stated a social worker is needed because the social worker coordinates social services for the residents. The Acting Administrator stated, right now the services are being provided by the nurses, they are just not being done by a licensed social worker.</p> <p>During an interview on 04/09/25 at 11:51 AM, the Compliance Nurse stated, there is no policy on social services.</p>