STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on interview and record review, the facility failed to immediately inform the resident's physician and notify, consistent with his or her authority, notify a resident's representative when there was an accident involving the resident when there was a significant change in resident's physical, mental, or psychosocial status for 1 of 5 residents (Resident #1) reviewed for notification of changes in that: The facility failed to promptly notify Resident #1's physician and Resident #1's responsible party when Resident #1 exhibited right-sided facial drooping and edema and coolness to both hands on 4/20/24. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 4/24/24 at 5:23 p.m. While the IJ was removed on 4/26/24 the facility remained out of compliance at a level of potential harm with a scope identified as isolated until interventions were put in place to ensure prompt notification of a resident's physician and responsible party. This deficient practice could place residents at risk of not having their RP or physician informed when there is a change in condition resulting in a delay in medical intervention and decline in health. The findings were: Record review of Resident #1's face sheet, dated 4/23/24, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease [a progressive disease that affects memory and other important mental functions], late onset, muscle wasting and atrophy [shrinking of muscle or nerve tissue], not elsewhere classified, multiple sites, weakness, and hypertensive heart [heart problems caused by high blood pressure] and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1 did not have a BIMs score because Resident #1 was rarely/never understood. Record review of Resident #1's nursing progress notes revealed no progress notes for 4/20/24. There were the following nursing progress notes beginning 4/21/24: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Nursing progress note dated 4/21/24 and written by LVN A: Resident noted to having edema to right hand with coldness to touch more than left hand. [R]ight facial side drooping . [NP B] informed. Ordered venous doppler [an imaging test to check for blood flow] to [right upper extremity.] - Nursing progress note dated 4/22/24 and written by LVN A: [Physician D] was in facility doing rounds on residents. Informed him of resident right hand and facial drooping . [Physician D] saw resident, right hand not as swollen or as cold as yesterday and right side facial not as much. He ordered 3 view x-ray to right hand and wrist. - Nursing progress note dated 4/22/24 and written by the DON: [Resident #1's RP] and another individual unknown to this writer in DON office with concerns of [Resident #1.] She stated that [Resident #1] had a stroke and she knows what a stroke looks like, she asked this writer if [Resident #1] had a stroke, I explained that I was not in a position to give DX's [diagnoses] and explained what [NP B] had ordered and that [Physician D] was in not more than 3 hours ago to assess along with [n]ew orders. - Nursing progress note dated 4/23/24 and written by RN E: [Resident #1's RP] called and voiced her want to send [Resident #1] out to the ER for MRI of head . [NP B] notified of request , yet no order given to send pt to ER at this time . [NP B] voiced she tend to schedule MRI in AM. Record review of Resident #1's physician order, dated 4/23/24 revealed the following order by NP B: STAT CT OF THE BRAIN W/OUT IV CONTRAST R/O CVA. Record review of Resident #1's CT of head/brain, dated 4/23/24, revealed the following: Reason for exam: Facial Drooping . FINDINGS . There is an approximately 4 to 5 cm region of relative parenchyma hypodensity [darker portions of an imaging scan that indicate possible open or fluid-filled spots in the brain tissue] . this region of ischemia [inadequate blood supply] is new since 2021 its exact acuity [onset] is indeterminate. Suggest further evaluation with MRI of the brain . IMPRESSION . since comparison, progressive worsening of ischemic disease of cerebrum including a new cerebral infarct [blood flow disruption in the brain] involving the left parieto-occipital region [the back portion of the brain that involves vision and the brain's ability to comprehend input from your five basic sense.] During an interview on 4/23/24 at 9:07 a.m., Resident #1's RP stated she went to the facility on [DATE] at around 2:00 pm to 2:30 pm and found Resident #1 in her room with her (Resident #1's) face drooping on the right side. Resident #1's RP stated she reported the issue to LVN A, who did not go to assess Resident #1 at the time. Resident #1's RP stated while she was returning to Resident #1's room, CNA C stated yesterday, 4/20/24, Resident #1 had facial drooping and while she (CNA C) attempted to feed her breakfast on 4/20/24 food was falling out of Resident #1's mouth. Resident #1's RP stated when CNA C left, she noticed Resident #1's right hand were swollen and purple. Resident #1's RP stated she went out of Resident #1's room to report the findings to LVN A, who looked at Resident #1 and then left. Resident #1's RP stated another unknown nurse entered the room who stated she will report the findings to NP B. Resident #1's RP stated it was not normal for Resident #1 to have facial drooping and swollen, purple hands. Resident #1's RP stated about one year ago the facility called her (Resident #1's RP) stating Resident #1 had a stroke, but Resident #1's RP stated when she (Resident #1's RP) arrived at the facility Resident #1 was fine, but Resident #1's arm was hanging for a couple days. Resident #1's RP stated Resident #1's symptoms on 4/21/24 were worse than the issue about one year ago. Resident #1's RP stated she was not notified when the symptoms occurred on 4/20/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview and record review on 4/23/24 at 12:49 p.m., NP B stated Resident #1 had been her patient for three years. NP B stated Resident #1 had exhibited right hand weakness before in May 2023. NP B stated on Sunday at 3:33 p.m., she received a call from the nurse stating Resident #1's RP was in the facility, Resident #1's right hand was swollen, and Resident #1 had facial drooping to the right side. NP B stated, I said, well, [Resident #1's] had right-sided weakness on several occasions that have come and gone. But the cold extremities is concerning if she's not getting blood flow. So I said let's get a doppler and we'll see her the next day. NP B stated she did not believe Resident #1's symptoms was an emergent concern because Resident #1's vital signs were table and Resident #1 exhibited similar symptoms before. NP B stated, Then [Physician D] and his RN came to see [Resident #1] yesterday [4/22/24] at around 7:50 a.m. The nurse reported . [Resident #1's RP's concern], the drooping on her face, the right hand swelling and [Physician D] examined [Resident #1] and he said [Resident #1] didn't have facial drooping now, the extremities are the same temperature. But [Physician D] didn't see evidence of a stroke. I chose not to go there that morning [4/22/24] because [Resident #1 had] already been examined . At 9:30 p.m. that night I get a call from the night nurse that [Resident #1's RP] was requesting [Resident #1] to go to the ER and have an MRI of [Resident #1's] brain . NP B stated the local hospital could not do MRIs after 4:00 p.m. and instead she ordered for a CT scan the next morning, 4/23/24. NP B stated she believed it was a TIA and no irreversible brain damage was done. Resident #1's CT results of her head were reviewed with NP B at this time. In a follow-up interview on 4/23/24 at 1:57 p.m., NP B stated she spoke with [Physician D] and they felt nothing needed to be done for Resident #1 because Resident #1's symptoms resolve. During an interview on 4/24/24 at 9:59 p.m., CNA C stated she worked with Resident #1 during the weekend of 4/20/24 - 4/21/24. CNA C stated Resident #1 required total care and requires assistance with transfers. CNA C stated on 4/20/24 at around 7:00 a.m CNA C stated, Something about [Resident #1] didn't look normal.It looked like she had a stroke because her right side, her mouth was drooping on the right side. Her right arm was dangling. Her hand was ice cold. So I went and put her [right] hand over her abdomen and [Resident #1] just like-she mumbles a lot even when she was mumbling, it sounded like she was slurred. And when I fed [Resident #1], some of her food was coming out on the right side of her mouth. I went and reported to the [LVN A at around 7:00 - 7:30 a.m.] I said, 'I think she had a mild stroke or something. Maybe you can go take a look at her.' [LVN A] said, 'ok.' .[LVN A] said, 'that I let the night nurse know to keep an eye on her.' And we got busy so I assumed she went and checked on her. CNA C stated Resident #1's symptoms continued to 4/21/24 and additional on 4/21/24, Resident #1's hands became swollen. CNA C stated she only notified LVN A. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/24 at 11:04 a.m., RN F stated she was with Physician D when he examined Resident #1 on 4/22/24. RN F stated she and Physician D examined Resident #1 due to some right arm swelling. RN F stated NP B mostly followed Resident #1. RN F stated, [Physician D and I] examined her arm and [NP B] ordered a doppler. [Physician D] added an x-ray and that was basically our main focus. RN F stated Resident #1's arm was not very swollen and that Resident #1's nurse reported the symptoms started on Saturday, 4/20/24. RN F stated Resident #1 exhibited some facial drooping to the left side, which did not correlate with the swelling on Resident #1's right side. RN F stated an MRI could not be done with Resident #1 because Resident #1 could not sit still during the MRI examination. RN F stated a CT was not ordered during the examination on 4/22/24 because it wasn't the main focus of the examination. RN F stated a CT scan was ordered by [NP B]. RN F stated, [The CT] showed that it had progressive worsening and including a new cerebral infarction and it's hard to tell because they're comparing it to a CT from 2021. And from my understanding [Resident #1] had similar symptoms earlier last year. But then it kind of resolved itself. Like what happened now. By the time we saw her Monday [4/22/24], our main focus wasn't the facial drooping. [The facial drooping] seemed more like edema. And [Physician D] may have noticed some flattening but it wasn't correlating with what the CT showed.From the nurses' standpoint it had gotten better. During an interview on 4/24/24 at 1:07 p.m., LVN A stated she worked with Resident #1 during the weekend from 4/20/24 to 4/21/24. LVN A stated a change in condition was any difference from a resident's baseline. LVN A stated if she saw a resident had a change in condition she would notify [NP B] or the resident's physician as soon as she could. LVN A stated at around 10:00 a.m. on 4/20/24, [CNA C] had come and told me that [Resident #1] didn't look to good as far as-[CNA C] said [Resident #1] was kind of droopy when she was feeding her. So I didn't see when [CNA C] feed her [Resident #1] usually cries, it's a behavior thing. And I was just checking [Resident #1], I had gone in there and I was like ok, [Resident #1] was kind off on the right side her lip was a little down and doing her crying. I just kept an eye on [Resident #1] that day . [Resident #1] seemed ok and I passed it onto the night nurse [RN E.] The next day [4/21/24], [Resident #1] was up again and [Resident #1's RP] came and seemed concerned . I texted [NP B] after that and [NP B] ordered a doppler, which I put in.[Resident #1's RP] was concerned that she had a stroke. I didn't see anything indicating that. And I think that's what kind of threw her off. Like I said, I don't know what [CNA C] told her. When asked why she didn't notify Resident #1's physician or NP B, LVN A stated, At the time I didn't see a need for it. I was keeping an eye on her. When asked if there was anything she could have changed that weekend, from 4/20/24 to 4/21/24, LVN A stated, I felt I should have notified the doctor on Saturday [4/20/24.] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/24 at 1:25 p.m., the DON stated a change of condition was, anything from vital signs being abnormal to what [the resident's] normal baseline should be, discoloration, pain. Anything visual that would be different than their normal baselines.If there is an actual observed change in condition, first and foremost, if it's not a 911 issue, they'd contact the doctor . The timeframe [of the notification] would change depending on what's going on. It's time-sensitive, but it would be as quickly and as soon as possible. If there's an actual change in condition, and getting all your stuff together, it would be around 30 minutes. Unless it's more life-threatening and then you'd do it right away. When asked what he knew about what happened to Resident #1 during the weekend of 4/20/24, the DON stated, I know what [Resident #1's family told me, that they felt-they point-blank said she was having a stroke. And speaking with [LVN A] and [RN E], they both had made the comment that during Saturday day shift [4/20/24] and Saturday night to Sunday morning [4/21/24] there was no signs or symptoms of any type of facial disparity or changes. Nothing along that line. And at some point [NP B] was called.[NP B] had asked for a doppler. The doppler was done. [Physician D] was in Monday morning [4/22/24] and at that point he didn't see a sense of emergency or sense of a stroke. He did say that there's some slight swelling in her right hand. The DON stated he assessed Resident #1 and stated, the pulse was there. Very slight swelling. She was warm to touch. I didn't notice any facial changes and this was Monday morning-ish. Monday evening, about 9:30-10:00 at night. I got a call that [Resident #1's] family wanted [Resident #1] taken to the hospital for a stat MRI. [NP B] said there's no way that they're going to do a stat MRI at the hospital but she can have one done the following morning. [RN E] called the family. The family was ok with that. Tuesday morning [4/23/24], [Physician D] again came in just to lay eyes on her prior to her going out to the CT and the CT was done. [Resident #1] came back. No issues with the CT. [NP B] called the family and said maybe it was a transient type incident where it can come and go.[a] TIA absolutely could slightly trigger or resolve itself within moments. When asked if the facility had a quality assurance process to ensure physicians and nurse practitioners were promptly notified of a change in condition, the DON stated the facility had stand-up meetings every morning on Mondays through Fridays where they reviewed the nursing progress notes. When asked what sort of negative effects could occur to the residents if their physicians or nurse practitioners were not notified promptly, the DON stated, the change in condition could get worse. That's an if. During a follow-up interview on 4/24/24 at 2:00 p.m., NP B stated she would like to be notified of a change in condition at the time the change of condition was identified. NP B stated when LVN A called her on Sunday, LVN A did not state when the symptoms started. NP B stated she did not know when Resident #1's symptoms first started. NP B stated, I don't know where I heard this, I can't say, but someone has said [Resident #1's RP] came in Sunday [4/21/24] to see [Resident #1], found the change in condition, went out to notify the nurse, the [CNA] followed her into the room and said, [Resident #1] was like that yesterday [4/20/21] and I told the nurse.' But I heard that as second-hand information. I don't know that for a fact. NP B stated if there actually was a delay in notification, she would not have done anything differently for Resident #1 because Resident #1 had a history of similar symptoms before and because Resident #1's family had been verbal about not wanting aggressive care. During a follow-up interview on 4/24/24 at 3:08 p.m., the DON stated he had not done any education following 4/20/24 because he was awaiting the results of this current investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/24 at 3:16 p.m., RN E stated she worked with Resident #1 during the weekend of 4/20/24 to 4/21/24. RN E stated she worked the overnight shift. RN E stated on Saturday LVN A stated CNA C made a complaint that Resident #1 was not normal for her baseline. RN E stated she did not have any facial drooping, swollen hands, or purple hands during her shift beginning on the evening of 4/20/24 to the morning of 4/21/24. RN E stated she did not notify Resident #1's RP on 4/20/24 because she did not see the symptoms CNA C described. RN E stated LVN A made a noted on the 24 hour report that Resident #1 had facial drooping. In a follow-up interview on 4/24/24 at 3:47 p.m., LVN A stated CNA C notified her of Resident #1's symptoms in the morning, around 10:00 a.m. LVN A stated since the weekend of 4/20/24, she did not receive any educational in-service. The Administrator was notified of an IJ on 4/24/24 at 5:29 p.m. and was given a copy of the IJ Template and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 4/25/24 at 4:34 p.m. and included the following: Issue: F580 Notification of Changes Licensed Nurse performed a head to toe on resident #1 on 4/24/24 with no adverse findings documented in the medical record. To Identify Any Other Residents to Have the Potential: Beginning on 4/24/24, Licensed Nurse will evaluate all other residents in the center for any change in condition. Should any changes be made, the physician will be notified. The evaluation will be documented in the residents clinical record. Education/ System Change: On 4/24/24, the Director of Nursing / designee initiated reeducated with Licensed Nurses on the following topics: - Abuse and Neglect - Notification of Changes : Changes refer to any resident who may need to have their plan of care or altered their treatment significantly. Changes can include but not limited to the use of any medical procedure or therapy that has not been used on the resident before. Direct care will notify Licensed nurse of changes of condition. Licensed nurse will notify provider once assessment is complete if change of condition is noted. Notification of changes training will be completed upon hire and subsequently. - When a licensed nurse is notified of a change in condition, they will evaluate the resident in condition and document their evaluation in the clinical record. Licensed nurses will complete assessment of resident upon on notification of changes and will notify Medical Provider. DON/Designee will monitor this training upon hire and subsequently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 4/24/24, the Director of Nursing / designee initiated reeducated with Certified Nurse Aides, Nurse Aides, and Medication Aides on the following topics: - Abuse and Neglect - Notification of Change; Direct care will notify Licensed nurse of changes of condition. Licensed nurse will notify provided as appropriate. How will this notification be reported or tracked? Changes will be reviewed during clinical morning meeting by DON/Designee. - Re-education will continue until 100% of nursing staff are reeducated. Those that are PRN, agency and/ or out on FMLA/ LOA will have the education completed prior to accepting assignment for their next scheduled shift. DON/Designee will provide training. DON will validate 100% training completion using an employee roster Monitoring: Beginning 4/25/24 and going forward, the Director of Nursing / designee will review the 24- hour report in the morning clinical meeting to ensure that changes of condition documented in the clinical record are identified and communicated with the physician and the resident representative. Beginning 4/25/24 and on-going, the Director of Nursing or designee will monitor compliance each weekly morning. Results of findings will be discussed in the monthly QAPI meeting for three months and the plan will be continues as needed. Beginning 4/25/24 and on-going, the Administrator will attend the morning clinical meeting to ensure the Director of Nursing or designee is reviewing the 24-hour report in the morning clinical meeting to identify changes in condition. An AdHoc QAPI was conducted on April 24, 2024, by the Administrator, with the Medical Director, Director of Nursing, and the Regional Clinical Specialist to discuss the immediate jeopardy concerning F580 Notification of Changes and plan to correct. The surveyor verification of the Plan of Removal on 4/26/24 was as follows: Observation on 4/26/24 at 11:38 a.m. revealed Resident #1 was seen awake, alert, fully-dressed, and in no acute distress. Resident #1 was not interviewable at the time of observation, but facial symmetry was intact at the time of the observation. Record review of a nursing progress note, dated 4/24/24, revealed Resident #1 was assessed with no concerns identified. Record review of daily census, dated 4/24/24, revealed all 134 residents were assessed and documented in nursing progress notes. Record review of nursing progress notes revealed no concerns or recent changes in conditions were identified. Record review of educational in-services, dated from 4/24/24 to 4/25/24, revealed all staff members had been educated on abuse and neglect. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of educational in-services, dated from 4/24/24 to 4/25/24, revealed the facility educated all CNAs, NAs, LVNs, RNs and administrative nurses. Record review of CNA Orientation checklist, not dated, revealed Abuse/neglect/exploitation, and change of condition notification will be included in the orientation checklist used for CNAs, NAs, and CMAs. Record review of a charge nurse orientation checklist, not dated, revealed notification of family for resident changes will be included in the skills checkoff. Record review of a document titled, Morning Clinical Meeting, not dated, revealed the DON had a log to note any changes in condition and monitor compliance. The DON stated the results of this log will go to the monthly QAPI meeting. Record review of a document titled, QAPI Meeting Attendance and Agenda, not dated, revealed the facility plans to include the IJ and POR items in future QAPI monthly meetings as well as the morning meeting. Record review of a QAPI meeting, dated 4/24/24, revealed the IJ was discussed in a QAPI meeting. During interviews conducted on 4/26/24, 22 staff members (7 LVNs, 3 RNs, 9 CNAs, 2 CMAs, 1 NA) across both shifts were interviewed. All 22 staff members confirmed they received education on abuse, neglect, and notification of changes. Licensed nurses were able to verbalize they will evaluate a change of condition and notification medical provider promptly. All other nursing staff stated when they identify a change in condition they will notify the licensed nurse promptly. During an interview on 4/26/24 at 2:05 p.m., the DON stated he educated staff on abuse, neglect, and change of condition report. DON stated new staff will have abuse, neglect, and change of condition on their new hire check-off list. The DON confirmed they will review the 24-hour report in the morning clinical meeting to ensure any changes in conditions are documented and communicate to the physician and resident representative. The DON confirmed they had a QAPI meeting wherein they discussed the IJ. During an interview on 4/26/24 at 2:29 p.m., the Administrator stated he will provide oversight to the DON by attending the clinical morning meeting and he will ensure the POR items are discussed. The Administrator confirmed they will review the 24-hour report in the morning clinical meeting to ensure any changes in conditions are documented and communicate to the physician and resident representative. The Administrator confirmed they had a QAPI meeting wherein they discussed the IJ. On 4/26/24 at 5:40 p.m., the Administrator was notified the IJ was removed. However, the facility remained out of compliance at a level of potential harm with a scope identified as isolated due to the facility's need to monitor the implementation and effectiveness of its POR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 5 residents (Resident #1) reviewed for notification of changes in that: On 4/20/24, upon the first onset of Resident #1 's symptoms, LVN A failed to recognize significant change of condition until the Resident #1's RP voiced concerns on 4/21/24. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 4/24/24 at 5:23 p.m. While the IJ was removed on 4/26/24 the facility remained out of compliance at a level of potential harm with a scope identified as isolated until interventions were put in place to ensure prompt notification of a resident's physician and responsible party. This deficient practice could affect residents with a change in condition and place them at risk of a delay in medical intervention and decline in health. The findings were: Record review of Resident #1's face sheet, dated 4/23/24, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease [a progressive disease that affects memory and other important mental functions], late onset, muscle wasting and atrophy [shrinking of muscle or nerve tissue], not elsewhere classified, multiple sites, weakness, and hypertensive heart [heart problems caused by high blood pressure] and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1 did not have a BIMs score because Resident #1 was rarely/never understood. Record review of Resident #1's nursing progress notes revealed no progress notes for 4/20/24. There were the following nursing progress notes beginning 4/21/24: - Nursing progress note dated 4/21/24 and written by LVN A: Resident noted to having edema to right hand with coldness to touch more than left hand. [R]ight facial side drooping . [NP B] informed. Ordered venous doppler [an imaging test to check for blood flow] to [right upper extremity.] - Nursing progress note dated 4/22/24 and written by LVN A: [Physician D] was in facility doing rounds on residents. Informed him of resident right hand and facial drooping . [Physician D] saw resident, right hand not as swollen or as cold as yesterday and right side facial not as much. He ordered 3 view x-ray to right hand and wrist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Nursing progress note dated 4/22/24 and written by the DON: [Resident #1's RP] and another individual unknown to this writer in DON office with concerns of [Resident #1.] She stated that [Resident #1] had a stroke and she knows what a stroke looks like, she asked this writer if [Resident #1] had a stroke, I explained that I was not in a position to give DX's [diagnoses] and explained what [NP B] had ordered and that [Physician D] was in not more than 3 hours ago to assess along with [n]ew orders. - Nursing progress note dated 4/23/24 and written by RN E: [Resident #1's RP] called and voiced her want to send [Resident #1] out to the ER for MRI of head . [NP B] notified of request , yet no order given to send pt to ER at this time . [NP B] voiced she tend to schedule MRI in AM. Record review of Resident #1's physician order, dated 4/23/24 revealed the following order by NP B: STAT CT OF THE BRAIN W/OUT IV CONTRAST R/O CVA. Record review of Resident #1's CT of head/brain, dated 4/23/24, revealed the following: Reason for exam: Facial Drooping . FINDINGS . There is an approximately 4 to 5 cm region of relative parenchyma hypodensity [darker portions of an imaging scan that indicate possible open or fluid-filled spots in the brain tissue] . this region of ischemia [inadequate blood supply] is new since 2021 its exact acuity [onset] is indeterminate. Suggest further evaluation with MRI of the brain . IMPRESSION . since comparison, progressive worsening of ischemic disease of cerebrum including a new cerebral infarct [blood flow disruption in the brain] involving the left parieto-occipital region [the back portion of the brain that involves vision and the brain's ability to comprehend input from your five basic sense.] During an interview on 4/23/24 at 9:07 a.m., Resident #1's RP stated she went to the facility on [DATE] at around 2:00 pm to 2:30 pm and found Resident #1 in her room with her (Resident #1's) face drooping on the right side. Resident #1's RP stated she reported the issue to LVN A, who did not go to assess Resident #1 at the time. Resident #1's RP stated while she was returning to Resident #1's room, CNA C stated yesterday, 4/20/24, Resident #1 had facial drooping and while she (CNA C) attempted to feed her breakfast on 4/20/24 food was falling out of Resident #1's mouth. Resident #1's RP stated when CNA C left, she noticed Resident #1's right hand were swollen and purple. Resident #1's RP stated she went out of Resident #1's room to report the findings to LVN A, who looked at Resident #1 and then left. Resident #1's RP stated another unknown nurse entered the room who stated she will report the findings to NP B. Resident #1's RP stated it was not normal for Resident #1 to have facial drooping and swollen, purple hands. Resident #1's RP stated about one year ago the facility called her (Resident #1's RP) stating Resident #1 had a stroke, but Resident #1's RP stated when she (Resident #1's RP) arrived at the facility Resident #1 was fine, but Resident #1's arm was hanging for a couple days. Resident #1's RP stated Resident #1's symptoms on 4/21/24 were worse than the issue about one year ago. Resident #1's RP stated she was not notified when the symptoms occurred on 4/20/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview and record review on 4/23/24 at 12:49 p.m., NP B stated Resident #1 had been her patient for three years. NP B stated Resident #1 had exhibited right hand weakness before in May 2023. NP B stated on Sunday at 3:33 p.m., she received a call from the nurse stating Resident #1's RP was in the facility, Resident #1's right hand was swollen, and Resident #1 had facial drooping to the right side. NP B stated, I said, well, [Resident #1's] had right-sided weakness on several occasions that have come and gone. But the cold extremities is concerning if she's not getting blood flow. So I said let's get a doppler and we'll see her the next day. NP B stated she did not believe Resident #1's symptoms was an emergent concern because Resident #1's vital signs were table and Resident #1 exhibited similar symptoms before. NP B stated, Then [Physician D] and his RN came to see [Resident #1] yesterday [4/22/24] at around 7:50 a.m. The nurse reported . [Resident #1's RP's concern], the drooping on her face, the right hand swelling and [Physician D] examined [Resident #1] and he said [Resident #1] didn't have facial drooping now, the extremities are the same temperature. But [Physician D] didn't see evidence of a stroke. I chose not to go there that morning [4/22/24] because [Resident #1 had] already been examined . At 9:30 p.m. that night I get a call from the night nurse that [Resident #1's RP] was requesting [Resident #1] to go to the ER and have an MRI of [Resident #1's] brain . NP B stated the local hospital could not do MRIs after 4:00 p.m. and instead she ordered for a CT scan the next morning, 4/23/24. NP B stated she believed it was a TIA and no irreversible brain damage was done. Resident #1's CT results of her head were reviewed with NP B at this time. Observation on 4/23/24 at 1:28 p.m. revealed Resident #1 was seen lying in bed in position of comfort. Resident was yawning and shifting occasionally. Resident #1 was arousable, but went back to sleep. No facial drooping noted. In a follow-up interview on 4/23/24 at 1:57 p.m., NP B stated she spoke with [Physician D] and they felt nothing needed to be done for Resident #1 because Resident #1's symptoms resolve. During an interview on 4/24/24 at 9:59 p.m., CNA C stated she worked with Resident #1 during the weekend of 4/20/24 - 4/21/24. CNA C stated Resident #1 required total care and requires assistance with transfers. CNA C stated on 4/20/24 at around 7:00 a.m CNA C stated, Something about [Resident #1] didn't look normal.It looked like she had a stroke because her right side, her mouth was drooping on the right side. Her right arm was dangling. Her hand was ice cold. So I went and put her [right] hand over her abdomen and [Resident #1] just like-she mumbles a lot even when she was mumbling, it sounded like she was slurred. And when I fed [Resident #1], some of her food was coming out on the right side of her mouth. I went and reported to the [LVN A at around 7:00 - 7:30 a.m.] I said, 'I think she had a mild stroke or something. Maybe you can go take a look at her.' [LVN A] said, 'ok.' .[LVN A] said, 'that I let the night nurse know to keep an eye on her.' And we got busy so I assumed she went and checked on her. CNA C stated Resident #1's symptoms continued to 4/21/24 and additional on 4/21/24, Resident #1's hands became swollen. CNA C stated she only notified LVN A. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/24 at 11:04 a.m., RN F stated she was with Physician D when he examined Resident #1 on 4/22/24. RN F stated she and Physician D examined Resident #1 due to some right arm swelling. RN F stated NP B mostly followed Resident #1. RN F stated, [Physician D and I] examined her arm and [NP B] ordered a doppler. [Physician D] added an x-ray and that was basically our main focus. RN F stated Resident #1's arm was not very swollen and that Resident #1's nurse reported the symptoms started on Saturday, 4/20/24. RN F stated Resident #1 exhibited some facial drooping to the left side, which did not correlate with the swelling on Resident #1's right side. RN F stated an MRI could not be done with Resident #1 because Resident #1 could not sit still during the MRI examination. RN F stated a CT was not ordered during the examination on 4/22/24 because it wasn't the main focus of the examination. RN F stated a CT scan was ordered by [NP B]. RN F stated, [The CT] showed that it had progressive worsening and including a new cerebral infarction and it's hard to tell because they're comparing it to a CT from 2021. And from my understanding [Resident #1] had similar symptoms earlier last year. But then it kind of resolved itself. Like what happened now. By the time we saw her Monday [4/22/24], our main focus wasn't the facial drooping. [The facial drooping] seemed more like edema. And [Physician D] may have noticed some flattening but it wasn't correlating with what the CT showed.From the nurses' standpoint it had gotten better. During an interview on 4/24/24 at 1:07 p.m., LVN A stated she worked with Resident #1 during the weekend from 4/20/24 to 4/21/24. LVN A stated a change in condition was any difference from a resident's baseline. LVN A stated if she saw a resident had a change in condition she would notify [NP B] or the resident's physician as soon as she could. LVN A stated at around 10:00 a.m. on 4/20/24, [CNA C] had come and told me that [Resident #1] didn't look to good as far as-[CNA C] said [Resident #1] was kind of droopy when she was feeding her. So I didn't see when [CNA C] feed her [Resident #1] usually cries, it's a behavior thing. And I was just checking [Resident #1], I had gone in there and I was like ok, [Resident #1] was kind off on the right side her lip was a little down and doing her crying. I just kept an eye on [Resident #1] that day . [Resident #1] seemed ok and I passed it onto the night nurse [RN E.] The next day [4/21/24], [Resident #1] was up again and [Resident #1's RP] came and seemed concerned . I texted [NP B] after that and [NP B] ordered a doppler, which I put in.[Resident #1's RP] was concerned that she had a stroke. I didn't see anything indicating that. And I think that's what kind of threw her off. Like I said, I don't know what [CNA C] told her. When asked why she didn't notify Resident #1's physician or NP B, LVN A stated, At the time I didn't see a need for it. I was keeping an eye on her. When asked if there was anything she could have changed that weekend, from 4/20/24 to 4/21/24, LVN A stated, I felt I should have notified the doctor on Saturday [4/20/24.] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/24 at 1:25 p.m., the DON stated a change of condition was, anything from vital signs being abnormal to what [the resident's] normal baseline should be, discoloration, pain. Anything visual that would be different than their normal baselines.If there is an actual observed change in condition, first and foremost, if it's not a 911 issue, they'd contact the doctor . The timeframe [of the notification] would change depending on what's going on. It's time-sensitive, but it would be as quickly and as soon as possible. If there's an actual change in condition, and getting all your stuff together, it would be around 30 minutes. Unless it's more life-threatening and then you'd do it right away. When asked what he knew about what happened to Resident #1 during the weekend of 4/20/24, the DON stated, I know what [Resident #1's family told me, that they felt-they point-blank said she was having a stroke. And speaking with [LVN A] and [RN E], they both had made the comment that during Saturday day shift [4/20/24] and Saturday night to Sunday morning [4/21/24] there was no signs or symptoms of any type of facial disparity or changes. Nothing along that line. And at some point [NP B] was called.[NP B] had asked for a doppler. The doppler was done. [Physician D] was in Monday morning [4/22/24] and at that point he didn't see a sense of emergency or sense of a stroke. He did say that there's some slight swelling in her right hand. The DON stated he assessed Resident #1 and stated, the pulse was there. Very slight swelling. She was warm to touch. I didn't notice any facial changes and this was Monday morning-ish. Monday evening, about 9:30-10:00 at night. I got a call that [Resident #1's] family wanted [Resident #1] taken to the hospital for a stat MRI. [NP B] said there's no way that they're going to do a stat MRI at the hospital but she can have one done the following morning. [RN E] called the family. The family was ok with that. Tuesday morning [4/23/24], [Physician D] again came in just to lay eyes on her prior to her going out to the CT and the CT was done. [Resident #1] came back. No issues with the CT. [NP B] called the family and said maybe it was a transient type incident where it can come and go.[a] TIA absolutely could slightly trigger or resolve itself within moments. When asked if the facility had a quality assurance process to ensure physicians and nurse practitioners were promptly notified of a change in condition, the DON stated the facility had stand-up meetings every morning on Mondays through Fridays where they reviewed the nursing progress notes. When asked what sort of negative effects could occur to the residents if their physicians or nurse practitioners were not notified promptly, the DON stated, the change in condition could get worse. That's an if. During a follow-up interview on 4/24/24 at 2:00 p.m., NP B stated she would like to be notified of a change in condition at the time the change of condition was identified. NP B stated when LVN A called her on Sunday, LVN A did not state when the symptoms started. NP B stated she did not know when Resident #1's symptoms first started. NP B stated, I don't know where I heard this, I can't say, but someone has said [Resident #1's RP] came in Sunday [4/21/24] to see [Resident #1], found the change in condition, went out to notify the nurse, the [CNA] followed her into the room and said, [Resident #1] was like that yesterday [4/20/21] and I told the nurse.' But I heard that as second-hand information. I don't know that for a fact. NP B stated if there actually was a delay in notification, she would not have done anything differently for Resident #1 because Resident #1 had a history of similar symptoms before and because Resident #1's family had been verbal about not wanting aggressive care. During a follow-up interview on 4/24/24 at 3:08 p.m., the DON stated he had not done any education following 4/20/24 because he was awaiting the results of this current investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/24 at 3:16 p.m., RN E stated she worked with Resident #1 during the weekend of 4/20/24 to 4/21/24. RN E stated she worked the overnight shift. RN E stated on Saturday LVN A stated CNA C made a complaint that Resident #1 was not normal for her baseline. RN E stated she did not have any facial drooping, swollen hands, or purple hands during her shift beginning on the evening of 4/20/24 to the morning of 4/21/24. RN E stated she did not notify Resident #1's RP on 4/20/24 because she did not see the symptoms CNA C described. RN E stated LVN A made a noted on the 24 hour report that Resident #1 had facial drooping. In a follow-up interview on 4/24/24 at 3:47 p.m., LVN A stated CNA C notified her of Resident #1's symptoms in the morning, around 10:00 a.m. LVN A stated since the weekend of 4/20/24, she did not receive any educational in-service. Observation on 4/25/24 at 11:01 a.m. revealed Resident #1 was sitting in her wheelchair by a table in the day room. Resident #1 was fully-dressed and in no acute distress and making nonsensical mumbling noises. Resident #1 did not have facial drooping. The Administrator was notified of an IJ on 4/24/24 at 5:29 p.m. and was given a copy of the IJ Template and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 4/25/24 at 4:34 p.m. and included the following: To Identify Any Other Residents to Have the Potential: Beginning on 4/24/24, Licensed Nurse will evaluate all other residents in the center for any change in condition. Should any changes be made, the physician will be notified. The evaluation will be documented in the residents clinical record. Education/ System Change: On 4/24/24, the Director of Nursing / designee initiated reeducated with Licensed Nurses on the following topics: - Abuse and Neglect - Notification of Changes : Changes refer to any resident who may need to have their plan of care or altered their treatment significantly. Changes can include but not limited to the use of any medical procedure or therapy that has not been used on the resident before. Direct care will notify Licensed nurse of changes of condition. Licensed nurse will notify provider once assessment is complete if change of condition is noted. Notification of changes training will be completed upon hire and subsequently. - When a licensed nurse is notified of a change in condition, they will evaluate the resident in condition and document their evaluation in the clinical record. Licensed nurses will complete assessment of resident upon on notification of changes and will notify Medical Provider. DON/Designee will monitor this training upon hire and subsequently. - On 4/24/24, the Director of Nursing / designee initiated reeducated with Certified Nurse Aides, Nurse Aides, and Medication Aides on the following topics: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Abuse and Neglect - Notification of Change; Direct care will notify Licensed nurse of changes of condition. Licensed nurse will notify provided as appropriate. How will this notification be reported or tracked? Changes will be reviewed during clinical morning meeting by DON/Designee. - Re-education will continue until 100% of nursing staff are reeducated. Those that are PRN, agency and/ or out on FMLA/ LOA will have the education completed prior to accepting assignment for their next scheduled shift. DON/Designee will provide training. DON will validate 100% training completion using an employee roster Monitoring: Beginning 4/25/24 and going forward, the Director of Nursing / designee will review the 24- hour report in the morning clinical meeting to ensure that changes of condition documented in the clinical record are identified and communicated with the physician and the resident representative. Beginning 4/25/24 and on-going, the Director of Nursing or designee will monitor compliance each weekly morning. Results of findings will be discussed in the monthly QAPI meeting for three months and the plan will be continues as needed. Beginning 4/25/24 and on-going, the Administrator will attend the morning clinical meeting to ensure the Director of Nursing or designee is reviewing the 24-hour report in the morning clinical meeting to identify changes in condition. An AdHoc QAPI was conducted on April 24, 2024, by the Administrator, with the Medical Director, Director of Nursing, and the Regional Clinical Specialist to discuss the immediate jeopardy concerning F580 Notification of Changes and plan to correct. The surveyor verification of the Plan of Removal on 4/26/24 was as follows: Observation on 4/26/24 at 11:38 a.m. revealed Resident #1 was seen awake, alert, fully-dressed, and in no acute distress. Resident #1 was not interviewable at the time of observation, but facial symmetry was intact at the time of the observation. Record review of a nursing progress note, dated 4/24/24, revealed Resident #1 was assessed with no concerns identified. Record review of daily census, dated 4/24/24, revealed all 134 residents were assessed and documented in nursing progress notes. Record review of nursing progress notes revealed no concerns or recent changes in conditions were identified. Record review of educational in-services, dated from 4/24/24 to 4/25/24, revealed all staff members had been educated on abuse and neglect. Record review of educational in-services, dated from 4/24/24 to 4/25/24, revealed the facility educated all CNAs, NAs, LVNs, RNs and administrative nurses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455869	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing Center	1210 Eastwood Dr Seguin, TX 78155

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CNA Orientation checklist, not dated, revealed Abuse/neglect/exploitation, and change of condition notification will be included in the orientation checklist used for CNAs, NAs, and CMAs. Record review of a charge nurse orientation checklist, not dated, revealed notification of family for resident changes will be included in the skills checkoff. Record review of a document titled, Morning Clinical Meeting, not dated, revealed the DON had a log to note any changes in condition and monitor compliance. The DON stated the results of this log will go to the monthly QAPI meeting. Record review of a document titled, QAPI Meeting Attendance and Agenda, not dated, revealed the facility plans to include the IJ and POR items in future QAPI monthly meetings as well as the morning meeting. Record review of a QAPI meeting, dated 4/24/24, revealed the IJ was discussed in a QAPI meeting. During interviews conducted on 4/26/24, 22 staff members (7 LVNs, 3 RNs, 9 CNAs, 2 CMAs, 1 NA) across both shifts were interviewed. All 22 staff members confirmed they received education on abuse, neglect, and notification of changes. Licensed nurses were able to verbalize they will evaluate a change of condition and notification medical provider promptly. All other nursing staff stated when they identify a change in condition they will notify the licensed nurse promptly. During an interview on 4/26/24 at 2:05 p.m., the DON stated he educated staff on abuse, neglect, and change of condition report. DON stated new staff will have abuse, neglect, and change of condition on their new hire check-off list. The DON confirmed they will review the 24-hour report in the morning clinical meeting to ensure any changes in conditions are documented and communicate to the physician and resident representative. The DON confirmed they had a QAPI meeting wherein they discussed the IJ. During an interview on 4/26/24 at 2:29 p.m., the Administrator stated he will provide oversight to the DON by attending the clinical morning meeting and he will ensure the POR items are discussed. The Administrator confirmed they will review the 24-hour report in the morning clinical meeting to ensure any changes in conditions are documented and communicate to the physician and resident representative. The Administrator confirmed they had a QAPI meeting wherein they discussed the IJ. On 4/26/24 at 5:40 p.m., the Administrator was notified the IJ was removed. However, the facility remained out of compliance at a level of potential harm with a scope identified as isolated due to the facility's need to monitor the implementation and effectiveness of its POR.