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	12/13/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 resident (Resident's #2) reviewed for respiratory care. The facility failed to ensure Resident #2's oxygen tubing and nasal cannula was handled by qualified staff. This failure could place residents who receive respiratory care at risk of developing respiratory complications and a decreased quality of care. Findings included. Record review of Resident #2's face sheet, dated 12/11/24 revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included heart failure, cough, need for assistance with personal care and morbid obesity due to excess calories. Record review of Resident #2's most recent quarterly MDS assessment, dated 10/25/24 revealed the resident was cognitively intact for daily decision-making skills and required oxygen therapy. Record review of Resident #2's Order Summary Report, dated 12/11/24 revealed the following order: - Oxygen at 2 LPM via NASAL CANNULA every shift for hypoxia (condition in which there is inadequate supply of oxygen to the tissues of the body to meet their metabolic needs) with order date 4/18/24 and no stop date. Record review of Resident #2's comprehensive care plan, with revision date 12/10/24 revealed the resident required oxygen therapy and received oxygen via nasal cannula continuously. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/11/24 at 9:57 a.m., CNA D and CNA E assisted Resident #2 transfer from the bed to the wheelchair via a sit to stand machine. Resident #2 was observed with the oxygen concentrator operating via the nasal cannula attached to her nares. Resident #2 agreed to allow CNA D to remove the nasal cannula as the resident was transferred with the sit to stand machine from the bed to the wheelchair. CNA D continued to hold the cannula in her hand during the transfer and when Resident #2 was seated on the wheelchair, CNA D took a brush and brushed the resident's hair. During this time, LVN A walked into the resident's room and Resident #2 revealed she needed the oxygen. CNA D then took the oxygen tubing and disconnected it from the oxygen concentrator and connected it to the oxygen tank attached to Resident #2's wheelchair. CNA D then took the other end of the nasal cannula and placed it over Resident #2's nares. During a joint interview on 12/11/24 at 10:04 a.m., CNA D and CNA E acknowledged they had not received any training on oxygen use or training on changing the oxygen tubing. CNA D acknowledged she had placed the oxygen tubing from the oxygen tank and placed the cannula on the resident but could not recall if she had ever had a competency training on oxygen use. During an interview on 12/11/24 at 10:15 a.m., LVN A revealed, Resident #2 had current orders for continuous oxygen and was tasked with ensuring the oxygen concentrator was operating per orders. LVN A revealed she believed the CNA staff were allowed to attach the oxygen tubing from the concentrator to the oxygen tank but were not allowed to mess with the knobs. LVN A acknowledge she had never really seen the CNA staff handle the oxygen tubing until CNA D was observed moving the oxygen tubing. LVN A stated, typically that doesn't happen. It would be a nursing task. Not sure what our facility policy is. During an interview on 12/11/24 at 10:25 a.m., the DON revealed he believed the CNAs were allowed to and had been trained to remove the oxygen tubing from the oxygen concentrator and attach to the oxygen tank and vice versa but were not allowed to adjust the oxygen settings. During a follow up interview on 12/11/24 at 10:38 a.m., the DON acknowledged the CNAs removing and/or replacing the oxygen tubing was not part of their competency evaluation training. The DON stated, they should not be doing it. The DON revealed the facility did not have a policy.

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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** 39075 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 5 resident rooms (Resident #1), 1 of 5 hallways, 300 hall, and 1 of 1 medication cart. 1. The facility failed to ensure medications were not left at the bedside or on the floor for Resident #1. 2. The facility failed to ensure there were no medications found on the floor and the medication cart on the 300 hall was left unlocked and unattended. This deficient practice could place residents at risk of medication misuse or drug diversion. The findings included: 1. Record review of Resident #1's face sheet, dated 12/11/24 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke; occurs when blood flow to part of the brain is interrupted/reduced resulting in lack of oxygen to the brain), pain in right shoulder, pain in right knee, non-displaced fracture of surgical neck of right humerus, chronic pain, and need for assistance with personal care. Record review of Resident #1's most recent MDS assessment, dated 10/1/24 revealed the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #1's Order Summary Report, dated 12/11/24 revealed the following orders: - May crush medications and/or open capsules PRN as per pharmacy guidelines, with order date 9/16/24 and no stop date - Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth three times a day for Pain, with order date 9/20/24 and no stop date Record review of Resident #1's comprehensive care plan, with revision date 10/4/24 revealed the resident was on pain medication therapy with an intervention to administer analgesic medications as ordered by the physician. Further review of Resident #1's comprehensive care plan revealed the resident had a fracture of the right humerus, revision date 11/8/24 and interventions that included to give pain, and anti-inflammatory medications as ordered. During an observation and interview on 12/10/24 at 10:38 a.m., Resident #1 stated the doctor had placed an arm sling observed on the right upper arm. Resident #1 was observed with a small, white, intact oval pill on the counter of the nightstand to the left of the resident's bed. Resident #1 stated the nurse had given her medications in the morning but could not identify what she had been given and was not aware of any medications left on the nightstand. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 12/10/24 at 10:46 a.m., LVN A stated she started her shift at 6:00 a. m., but had not administered any medications to Resident #1. LVN A revealed the resident received scheduled medications from the MA and revealed MA B was assigned to Resident #1. LVN A stated she was not aware Resident #1 had been assessed to self-administer medications. LVN A observed the small, white, intact oval pill on the counter of the nightstand to the left of Resident #1's bed and revealed she could not identify the pill. As LVN A picked up the unidentified pill and walked to Resident #1's doorway, a beige colored capsule was observed on the floor to the right of the doorway. LVN A stated, it's not good because we don't know if the resident (Resident #1) took her scheduled medication, we don't know what they are and somebody else could pick it up and take it. LVN A further revealed, if the medication was for pain, it could affect controlling the resident's pain and if a resident took the medication and it was not prescribed to them it could cause an adverse effect. During an observation and interview on 12/10/24 at 10:58 a.m., MA B acknowledged she had administered medications to Resident #1 earlier in the morning, around 8:00 a.m. LVN A showed MA B the small, white, intact oval pill found on Resident #1's nightstand and MA B stated it appeared to be the resident's prescribed Tylenol Extra Strength Oral Tablet 500 MG. MA B could not identify the capsule found on the floor near Resident #1's doorway. MA B stated she believed the resident had pocketed her pills but was offered extra water and believed the resident had swallowed the medication. MA B stated, the problem with medications being found could signify the resident was not taking a prescribed pain medication which could result in the resident having pain and not knowing why. MA B revealed it the resident could possibly save the medication for later and results in double dosing which could cause an adverse effect. MA B further acknowledged, other residents who wander could possibly ingest the medication and it could make them sick. 2. Observation on 12/10/24 at 11:12 a.m. revealed a small, round white pill was seen on the floor in the 300 hall. During an observation and interview on 12/10/24 at 11:13 a.m., LVN C acknowledged the small, round white pill observed on the floor but could not identify it. LVN C stated, medications found on the floor could potentially be picked up by the residents and ingested which was considered a safety issue. LVN C then picked up the unidentified pill and stated she would dispose of it. LVN C was observed walking to the nurse's station from the 300 hall but did not lock her medication cart before leaving. The medication cart was left unlocked and unattended from 11:15 a.m. until 11:21 a.m., when LVN C returned to the 300 hall. LVN C acknowledged the medication cart should not have been left unlocked and unattended because anybody could have access to it just as the medication found on the floor. During an interview on 12/11/24 at 3:14 p.m., the DON acknowledged it was important to ensure all medications and carts were locked and secured to prevent unauthorized access, and anybody could have access to the medication cart but the person with a key. The DON further stated, a resident could have unauthorized access to a medication or medication cart if left unlocked and if so, a bad adverse effect could occur to the resident. Record review of the facility policy and procedure titled, Medication Administration, dated 10/24/22 revealed in part, .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this stated, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .15. Observe resident consumption of medication .