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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guadalupe Valley Nursing and Rehabilitation 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 - Minimal harm or potential for actual harm 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 5 residents (Resident #1) reviewed for resident rights.The facility failed to notify Resident #1's provider of his change in condition when the Wound Care Nurse identified the resident developed a Stage 2 pressure ulcer on 8/6/25.This failure could affect residents by placing them at risk for a delay in medical treatment, decline in health, and death.The findings included:Record review of Resident #1's face sheet dated 10/7/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on 8/18/25 with diagnoses that included sepsis (condition in which the body's response to infection causes widespread inflammation, leading to tissue damage, organ failure, or death), secondary malignant neoplasm of right lung (cancer has metastasized/spread and it not the original primary cancer), malignant neoplasm of kidney (cancerous tumor that starts at the kidney), acute cystitis without hematuria (a sudden inflammation or infection of the bladder that does not involve blood in the urine), heart failure, severe protein-calorie malnutrition (serious form of undernutrition), dysphagia, oropharyngeal phase (difficulty swallowing that occurs during the first part of swallowing, when food or liquid moves from the mouth through the throat and into the esophagus), muscle wasting and atrophy (the wasting away or decrease in size of a body part, tissue, or organ), weakness, need for assistance with personal care, pain in the right and left hip, hypokalemia (low level of potassium in the blood), and hypertension (high blood pressure). Record review of Resident #1's admission MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, required partial/moderate assistance with mobility/transfers, had an indwelling urinary catheter, was always incontinent of bowel, and was at risk of developing pressure ulcers/injuries.Record review of Resident #1's discharge MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, required partial/moderate assistance with mobility/transfers, was always incontinent of bowel and bladder, and had one unhealed Stage 2 pressure ulcer (a partial-thickness loss of skin involving the epidermis and/or dermis indicating the damage does not extend through the full thickness of the skin or underlying muscle).Record review of Resident #1's Order Summary Report for active orders as of 7/23/25, and dated 10/7/25 revealed the following:- Mattress: Pressure Reduction for skin protection every shift related to sepsis with order date 7/23/25 and no stop dateRecord review of Resident #1's Order Summary Report for active orders as of 8/1/25 and dated 10/8/25 revealed the following:- Mattress: Pressure Reduction for skin protection every shift related to sepsis with order date 7/23/25 and no stop date- Apply zinc base cream to the buttock area, every shift for Blanchable redness to bilateral buttocks with order date 7/25/25 and no stop dateRecord review of Resident #1's comprehensive care plan with initiated date 7/24/25 and revision date 8/20/25 reflected the resident had a potential/actual impairment to skin integrity related to incontinence and impaired mobility with a goal for the resident not to have complications related to gluteal fold peeling and interventions that included assistance with turning and positioning, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, diet as ordered, pressure reduction mattress, and use of a draw sheet or lifting device to move the resident. Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse on 7/31/25 and electronically signed on 8/1/25 revealed the resident had no new wounds.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse on 8/6/25 and electronically signed on 8/6/25 revealed the resident had a Stage 2 pressure wound to the sacrum, staged by the Wound Care Nurse. Resident #1's Skin and Wound Evaluation document revealed on the Additional Care Section, None was checked, and the Notifications section: Practitioner Notified, Resident/Responsible Party Notified, Dietician Notified, and Therapy (PT, OT, ST) were left blank.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse on 8/13/25 and electronically signed on 8/13/25 revealed the resident had a Stage 2 pressure wound to the sacrum staged by the Wound Care Nurse. Resident #1's Skin and Wound Evaluation document revealed on the Additional Care section, the resident had a moisture barrier and positioning wedge, and the Notifications: Practitioner Notified, Resident/Responsible Party Notified, Dietician Notified, and Therapy (PT, OT, ST) were left blank.During an interview on 10/8/25 at 1:41 p.m., the Wound Care Nurse stated Resident #1 had cancer and believed the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 5 residents (Resident #1) reviewed for care plans:The facility failed to develop a person-centered care plan with interventions that addressed Resident #1's pressure wound, refusals for offloading and repositioning and wound care treatments.This failure could place residents at risk of not having their needs and preferences met.The findings included:Record review of Resident #1's face sheet dated 10/7/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on 8/18/25 with diagnoses that included sepsis (condition in which the body's response to infection causes widespread inflammation, leading to tissue damage, organ failure, or death), secondary malignant neoplasm of right lung (cancer has metastasized/spread and it not the original primary cancer), malignant neoplasm of kidney (cancerous tumor that starts at the kidney), acute cystitis without hematuria (a sudden inflammation or infection of the bladder that does not involve blood in the urine), heart failure, severe protein-calorie malnutrition (serious form of undernutrition), dysphagia, oropharyngeal phase (difficulty swallowing that occurs during the first part of swallowing, when food or liquid moves from the mouth through the throat and into the esophagus), muscle wasting and atrophy (the wasting away or decrease in size of a body part, tissue, or organ), weakness, need for assistance with personal care, pain in the right and left hip, hypokalemia (low level of potassium in the blood), and hypertension (high blood pressure).Record review of Resident #1's admission MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, required partial/moderate assistance with mobility/transfers, had an indwelling urinary catheter, was always incontinent of bowel, and was at risk of developing pressure ulcers/injuries. Record review of Resident #1's discharge MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, required partial/moderate assistance with mobility/transfers, was always incontinent of bowel and bladder, and had one unhealed Stage 2 pressure ulcer (a partial-thickness loss of skin involving the epidermis and/or dermis indicating the damage does not extend through the full thickness of the skin or underlying muscle).Record review of Resident #1's Order Summary Report for active orders as of 7/23/25, and dated 10/7/25 revealed the following:- Mattress: Pressure Reduction for skin protection every shift related to sepsis with order date 7/23/25 and no stop dateRecord review of Resident #1's Order Summary Report for active orders as of 8/1/25 and dated 10/8/25 revealed the following:- Mattress: Pressure Reduction for skin protection every shift related to sepsis with order date 7/23/25 and no stop date- Apply zinc base cream to the buttock area, every shift for Blanchable redness to bilateral buttocks with order date 7/25/25 and no stop dateRecord review of Resident #1's comprehensive care plan with initiated date 7/24/25 and revision date 8/20/25 reflected the resident had a potential/actual impairment to skin integrity related to incontinence and impaired mobility with a goal for the resident not to have complications related to gluteal fold peeling and interventions that included assistance with turning and positioning, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, diet as ordered, pressure reduction mattress, and use of a draw sheet or lifting device to move the resident.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse on 7/31/25 and electronically signed on 8/1/25 revealed the resident had no new wounds. Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse on 8/6/25 and electronically signed on 8/6/25 revealed the resident had a Stage 2 pressure wound to the sacrum.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse on 8/13/25 and electronically signed on 8/13/25 revealed the resident had a Stage 2 pressure wound to the sacrum and reflected the Patient noncompliant with turn and repositioning, poor food intake. During an interview on 10/8/25 at 1:41 p.m., the Wound Care Nurse stated Resident #1 had cancer and believed the resident had developed a Stage 2 pressure wound to the sacrum or coccyx. The Wound Care Nurse stated the resident was pleasant and would not resist care, but he did have one or two refusals for wound care.During an interview on 10/8/25 at 4:29 p.m., the DON stated he believed Resident #1 had cancer, possibly prostate cancer, and had metastasized to the upper body. The DON stated he did not recall Resident #1 having had a pressure wound, but with him (Resident #1) not wanting to be turned, not wanting

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident's environment remains as free of accident hazards as is possible, for 1 of 1 resident (Resident #2), in the facility reviewed for accidents, in that:The facility failed to ensure Resident # 2 did not have disposable razors in his room.This failure could place residents at risk of injury and contribute to avoidable accidents and a decline in health.The findings include:Record review of Resident #2's face sheet dated 10/07/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included diabetes, other sequelae following unspecified cerebrovascular disease (lingering affects due to a disruption in blood flow to the brain), major depressive disorder, anxiety disorder, chronic pain syndrome, gastro-esophageal reflux disease (frequent acid reflux), and long term us of insulin.Record review of Resident #2's MDS dated [DATE] documented a BIMS of 14 out of 15 indicating independent decision making and recorded the needed use of supervision or touching assistance with personal hygiene.Record review of Resident #2's care plan provided on 10/07/2025 recorded a focus area for the following: Resident # 2 has an ADL self-care performance deficit r/t weakness, malnutrition, initiated on 03/22/2023, with interventions including PERSONAL HYGIENE: The resident requires set up assistance to limited assist by 1 staff with personal hygiene and oral care initiated on 03/22/2023.Record review of Resident # 2's care plan provided on 10/07/2025 did not address Resident # 2's ability to keep razors in his room. During an observation on 10/07/2025 at 9:36 a.m., in Resident #2's room there was three disposable razors beside the sink. During an interview on 10/08/2025 at 8:51 a.m., Resident #2 stated he shaved himself and staff have not helped him. Resident #2 stated the staff provide the razor and typically take it back when Resident #2 is finished shaving. Resident #2 stated he prefers to shave himself. During an observation on 10/08/2025 at 8:54 a.m., in Resident #2's room was three disposable razors beside the sink. During an interview on 10/08/2025 at 8:55 a.m., CNA B stated Resident #2 mostly does his hygiene and personal care for himself. CNA B stated Resident #2 showers himself but with shaving staff assist. When asked if Resident #2 can have disposable razors in his room CNA B stated they were not sure if Resident #2 was allowed to have disposable razors in their room but would assume no. When asked if any directive or information had been given regarding residents having disposable razors in their room CNA B stated they have not been told anything about disposable razors being in residents rooms at the facility. When asked where disposable razors come from CNA B stated they get them from the supply closet. When asked what the danger would be for a resident to have disposable razors in their room CNA B stated the resident could hurt themselves, residents could fight, and another resident could potentially hurt themselves. During an interview on 10/08/2025 at 9:06 a.m., LVN C stated Resident #2 required assist times one, and he was a brittle diabetic. When asked about Resident #2's activities of daily living LVN C stated that staff is preferred to supervise Resident #2 during showers and staff shaved him. When asked about the process for shaving Resident #2, LVN C stated nurses get the disposable razors and shaving cream from the locked supply closet and shave Resident #2 at the sink. When asked if Resident #2 can have disposable razors in their room LVN C stated residents are not allowed to have disposable razors in their room due to the possibility of the disposable razor being used as a weapon, or to hurt themselves, or a dementia patient could get ahold of it. When shown where the disposable razors was located in Resident #2's room, LVN C confirmed Resident #2 had three blue disposable razors on the side of the sink and removed them from Resident #2's room.During an interview on 10/08/2025 at 4:30 p.m., the DON stated regarding residents who request to shave two things can happen the first being if the resident has a high enough BIMS score greater than 12 the resident can shave themselves if the resident has BIMS lower than 12 then a CNA or nurse would assist. The DON stated razors are kept in the supply closet which only staff have access to. When asked if Resident #2 can have a disposable razor in their room the DON stated if he could it would have to be documented in Resident #2's care plane. After reviewing Resident #2's care plan the DON stated nothing was found regarding disposable razors or shaving on Resident #2's care plan.During an interview on 10/09/2025 at 8:12 a.m., the Administrator stated that depending on residents BIMS they are technically allowed to have razors in their room but that it needs to be care planned. When asked if Resident #2 could have disposable razors in their room the Administrator stated to their understanding it had not been care planned. When asked about the danger of Resident #2 having had a disposable razor in their room the Administrator stated they want to be able to keep track of things and that it could lead to improper use At

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being for 1 of 1 nurse (Wound Care Nurse) reviewed for competent nursing care.The facility failed to ensure the Wound Care Nurse was aware of notification of changes to the RN Unit Manager or designee per facility policy when she identified Resident #1 with a Stage 2 pressure ulcer.These deficient practices affect residents who depend on nursing care and could place residents at risk for injury, infection and a decline in health. The findings included:Record review of Resident #1's face sheet dated 10/7/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on 8/18/25 with diagnoses that included sepsis (condition in which the body's response to infection causes widespread inflammation, leading to tissue damage, organ failure, or death), secondary malignant neoplasm of right lung (cancer has metastasized/spread and it not the original primary cancer), malignant neoplasm of kidney (cancerous tumor that starts at the kidney), acute cystitis without hematuria (a sudden inflammation or infection of the bladder that does not involve blood in the urine), heart failure, severe protein-calorie malnutrition (serious form of undernutrition), dysphagia, oropharyngeal phase (difficulty swallowing that occurs during the first part of swallowing, when food or liquid moves from the mouth through the throat and into the esophagus), muscle wasting and atrophy (the wasting away or decrease in size of a body part, tissue, or organ), weakness, need for assistance with personal care, pain in the right and left hip, hypokalemia (low level of potassium in the blood), and hypertension (high blood pressure).Record review of Resident #1's admission MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, required partial/moderate assistance with mobility/transfers, had an indwelling urinary catheter, was always incontinent of bowel, and was at risk of developing pressure ulcers/injuries. Record review of Resident #1's discharge MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, required partial/moderate assistance with mobility/transfers, was always incontinent of bowel and bladder, and had one unhealed Stage 2 pressure ulcer (a partial-thickness loss of skin involving the epidermis and/or dermis indicating the damage does not extend through the full thickness of the skin or underlying muscle).Record review of Resident #1's Order Summary Report for active orders as of 7/23/25, and dated 10/7/25 revealed the following:- Mattress: Pressure Reduction for skin protection every shift related to sepsis with order date 7/23/25 and no stop dateRecord review of Resident #1's Order Summary Report for active orders as of 8/1/25 and dated 10/8/25 revealed the following:- Mattress: Pressure Reduction for skin protection every shift related to sepsis with order date 7/23/25 and no stop date- Apply zinc base cream to the buttock area, every shift for Blanchable redness to bilateral buttocks with order date 7/25/25 and no stop dateRecord review of Resident #1's comprehensive care plan with initiated date 7/24/25 and revision date 8/20/25 reflected the resident had a potential/actual impairment to skin integrity related to incontinence and impaired mobility with a goal for the resident not to have complications related to gluteal fold peeling and interventions that included assistance with turning and positioning, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, diet as ordered, pressure reduction mattress, and use of a draw sheet or lifting device to move the resident.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse (LVN) on 7/31/25 and electronically signed on 8/1/25 revealed the resident had no new wounds.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse (LVN) on 8/6/25 and electronically signed on 8/6/25 revealed the resident had a Stage 2 pressure wound to the sacrum, staged by the Wound Care Nurse (LVN). Resident #1's Skin and Wound Evaluation document revealed on the Additional Care Section, None was checked, and the Notifications section: Practitioner Notified, Resident/Responsible Party Notified, Dietician Notified, and Therapy (PT, OT, ST) were left blank.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse (LVN) on 8/13/25 and electronically signed on 8/13/25 revealed the resident had a Stage 2 pressure wound to the sacrum staged by the Wound Care Nurse (LVN). Resident #1's Skin and Wound Evaluation document revealed on the Additional Care section, the resident had a moisture barrier and positioning wedge, and the Notifications: Practitioner Notified, Resident/Responsible Party Notified, Dietician Notified, and Therapy (PT, OT, ST) were left blank.During an interview on 10/8/25 at 1:41 p.m., the Wound

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to determine that drug records were in order and that an account of all controlled substances was maintained and periodically reconciled for 8 of 17 residents (Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10, and Resident #11) and 4 of 6 medication carts (MC #1, MC #2, MC #4 and MC #6) reviewed for pharmaceutical services. 1. The facility failed to ensure discontinued/expired medications were removed from the medication carts on (4) occasions.2. The facility failed to ensure the administration and count of controlled substances were reconciled on (3) occasions.3. The facility failed to ensure counts of controlled medications were completed/signed for on (28) occasions. These deficient practices could put residents at risk for diversion and reduced effectiveness of medications. Findings included: 1. Record review of Resident #4's admission Record, dated 9/26/25, revealed the resident was re-admitted on [DATE] with diagnoses which included: History of Malignant Neoplasm of Breast (uncontrollable cell growth that destroy body tissue), Dementia (group of thinking and social symptoms that interferes with daily functioning), Congestive Heart Failure (condition in which the heart can't pump blood well enough to meet the body's needs), Anxiety (feeling of dread, fear, or uneasiness) and Spondylosis (degeneration of the bones and discs of the spine).Record review of Resident #4's Order Summary, dated 2/24/25, revealed: LORazepam Oral Tablet 0.5MG (Lorazepam) *Controlled Drug* Give 1 tablet by mouth every 12 hours as needed for anxiety.for 14 days. Record review of Resident #4's Individual Resident's Controlled Substance Record revealed LORAZEPAM 0. 5 MG TABLET TAKE ONE TABLET BY MOUTH EVERY 12 HOURS AS NEEDED FOR 14 DAYS. Further review of this record revealed the last administration of Lorazepam was on 3/6/25. Observation of controlled substance reconciliation on 9/24/25, beginning at 11:48 pm, revealed a blister pack with tablets labeled LORAZEPAM 0.5 MG Tablet for Resident #4. Further observation revealed AS NEEDED FOR 14 DAYS . During an interview on 9/24/25 at 11:50 pm, LVN A said when a medication was ordered for a specific number of days, the medication was discontinued after the number of days it was ordered for, removed from the cart and given to the DON. Record review of Resident #6's admission Record, dated 9/26/25, revealed the resident was re-admitted on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), Pain in Shoulders. Record review of Resident #6's Order Summary, dated 9/26/25, revealed: TraMADol HCl Tablet 50 MG Give 1 tablet by mouth three times a day for pain.Order Date 06/26/2024. Observation of controlled substance reconciliation on 9/24/25, beginning at 11:48 pm, revealed a blister pack with tablets labeled TRAMADOL 50 MG take 1 tablet by mouth 4 times a day PRN for pain, 1 of 2 expiration date 6/22/25, for Resident #6. Further observation revealed a second blister pack with tablets labeled TRAMADOL 50 MG take 1 tablet by mouth 4 times a day PRN for pain, 2 of 2 expiration date 6/22/25, for Resident #6. Record review of Resident #6's September MAR, dated 9/26/25, revealed Tramadol 50 mg PRN was not administered. Record review of Resident #11's admission Record, dated 9/26/26, revealed the resident was admitted on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning).Record review of Resident #11's Order Summary, dated 9/26/25, revealed: Lorazepam oral concentrate 2 mg/mL, give 0.25 mL by mouth every 4 hours PRN.Observation of controlled substance reconciliation on 9/25/25, beginning at 2:09 pm, revealed a bottle labeled Lorazepam Oral Concentrate 2 MG/ML with an expiration date of 3/31/26; however, the box had a use by date of 8/2/25. Record review of Resident #11's September MAR, dated 9/26/25, revealed Lorazepam oral concentrate 2 mg/mL was not administered. 2. Record review of Resident #5's admission Record, dated 9/25/25, revealed the resident was re-admitted on [DATE] with diagnoses which included: Atherosclerosis of Arteries of Bilateral Legs (The build-up of fats, cholesterol, and other substances in and on the artery walls), Pain in Right Foot, and Non-pressure Chronic Ulcer (wound that does not heal within 6 weeks) of Right Foot. Record review of Resident #5's quarterly MDS assessment, dated 9/9/25, revealed the resident had a BIMS score of 15 (suggesting intact cognition). Record review of Resident #5's Order Summary, dated 9/25/25, revealed: HYDROcodone-Acetaminophen Oral Tablet 7.5-300 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain.Order Date 02/24/2025. Observation, on 9/25/25, of medication administration with LVN G, beginning at 11:42 am, revealed: Resident #5's blister pack of Hydrocodone-APAP 7.5-300 mg, 1 tablet orally q6 hours PRN

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	455869	A. Building B. Wing	12/10/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the medication error rate was not five percent or greater for 1 of 5 residents (Resident #12). The facility had a medication error rate of 45% based on 5 errors out of 11 opportunities. LVN D failed to administer medications as ordered to Resident #12 by administering Gabapentin (for neuropathy), Cyclobenzaprine (for pain), Colace (for constipation), Carboxymethylcellulose Sodium ophthalmic gel (dry eyes), and Rosuvastatin (for high cholesterol) 2 hours and 12 minutes before the scheduled time. This failure could place residents at risk of not receiving the desired therapeutic effect of their medications. Findings included: Record review of Resident #12's admission Record, dated 9/26/25, revealed the resident was re-admitted on [DATE] with diagnoses which included: Dry Eye Syndrome, Constipation, Hemiparesis (weakness or an inability to move one side of the body), Hemiplegia (paralysis or weakness to one side of the body) and Hyperlipidemia (elevated cholesterol). Record review of Resident #12's Order Summary Report, dated 9/26/25, revealed: Gabapentin oral tablet 100 mg, give 1 tablet by mouth two times a day; Cyclobenzaprine oral tablet 10 mg, give 1 tablet by mouth two times a day; Colace capsule 100 mg, give 100 mg by mouth two times a day; Rosuvastatin oral tablet, give 1 tablet by mouth at bedtime; Carboxymethylcellulose Sodium ophthalmic gel 1%, instill 1 drop in both eyes two times a day. Observation and interview on 9/25/25 at 3:38 pm, revealed LVN D administered: Gabapentin oral tablet 100 mg, give 1 tablet by mouth two times a day; Cyclobenzaprine oral tablet 10 mg, give 1 tablet by mouth two times a day; Colace capsule 100 mg, give 100 mg by mouth two times a day; Rosuvastatin oral tablet, give 1 tablet by mouth at bedtime; Carboxymethylcellulose Sodium ophthalmic gel 1%, instill 1 drop in both eyes two times a day to Resident #12. LVN D said the medications were not due yet but was going to administer them. LVN D further stated that some residents liked their medications administered at a specific time. LVN D said she had not read the bottle of eye drops and had not realized it was not the correct dose. During an interview on 9/26/25 at 10:32 am, Resident #12 said she did not know what medications she received, when she received it or how many drops LVN D put in her eyes on 9/25/25. During an interview on 9/26/25 at 5:35 pm, ADON B said medications ordered to be administered BID where to be administered at 6 am - 10 am and 6 pm - 10 pm, unless specified in the order. ADON B further stated HS medications were to be administered between 6 pm - 10 pm. ADON B said staff should not administer medications over 2 hours before the specified time because, depending on the medication, it could affect the efficacy of the medication. Record review of the facility's policy Medication Administration revised 10/24/22, read: .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.11. Compare medication source.to verify resident name, medication name, form, dose, route, and time.b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. Medication timing. BID 9 am, 9 pm HS 9pm.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 residents (Resident #11) reviewed for medication labeling. The facility failed to ensure medications were correctly labeled. These deficient practices could place residents at risk of medication misuse and drug diversion. Findings included: Record review of Resident #11's admission Record, dated 9/26/25, revealed the resident was admitted on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #11's Order Summary Report, dated 9/26/25, revealed: Lorazepam oral concentrate 2mg/mL by mouth every 4 hours PRN. Observation on 9/25/25 at 2:15 pm revealed Resident #11's Lorazepam was in the refrigerator, stored in a plastic baggie. Further observation revealed the baggie contained a box with a label that was partially illegible. Further observation revealed the medication bottle inside the box had a manufacturer label on it, but did not have a label with the resident or prescription information. LVN G said staff knew who the medication was prescribed to because the name was on the box. During an interview on 9/25/25 at 2:17 pm, the DON said the pharmacy said they were unable to send replacement medication labels to the facility. The DON further stated the pharmacy said that they needed to have the medication in hand to properly relabel them. The DON said the facility was unable to send medications back to the pharmacy for labeling because residents would be without their medications. During an interview on 9/26/25 at 1:54 PM, the PharmD said he was not sure what the facility's procedure was but was sure the facility could handwrite labels for medication bottles/syringes. The PharmD further stated that typically the pharmacy labels the bottles/syringes as well, but the facility was supposed to call the pharmacy to let them know if a medication needs labeling so that the medication could be picked up from the facility and labeled. The PharmD said it was important for bottles/syringes be labeled so the staff knew what resident to administer the medication to. Record review of the facility's policy, Pharmacy Provider Requirements dated 10/1/19, read: .4. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to.E. Labeling all medications dispensed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, that are complete; and accurately documented for 1 of 2 residents (Resident #1) reviewed for medical records:The facility failed to document wound care dressing changes on the Treatment Administration Record (TAR) for Resident #1 on 8/2/25, 8/3/25, 8/5/25, 8/8/25, 8/13/25, 8/14/25, and 8/16/25.These failures could place residents at risk for missed treatments and care which could result in the deterioration of the wound and/or development of an infection.The findings included:Record review of Resident #1's face sheet dated 10/7/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged on 8/18/25 with diagnoses that included sepsis (condition in which the body's response to infection causes widespread inflammation, leading to tissue damage, organ failure, or death), secondary malignant neoplasm of right lung (cancer has metastasized/spread and it not the original primary cancer), malignant neoplasm of kidney (cancerous tumor that starts at the kidney), acute cystitis without hematuria (a sudden inflammation or infection of the bladder that does not involve blood in the urine), heart failure, severe protein-calorie malnutrition (serious form of undernutrition), dysphagia, oropharyngeal phase (difficulty swallowing that occurs during the first part of swallowing, when food or liquid moves from the mouth through the throat and into the esophagus), muscle wasting and atrophy (the wasting away or decrease in size of a body part, tissue, or organ), weakness, need for assistance with personal care, pain in the right and left hip, hypokalemia (low level of potassium in the blood), and hypertension (high blood pressure).Record review of Resident #1's admission MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, required partial/moderate assistance with mobility/transfers, had an indwelling urinary catheter, was always incontinent of bowel, and was at risk of developing pressure ulcers/injuries.Record review of Resident #1's discharge MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, required partial/moderate assistance with mobility/transfers, was always incontinent of bowel and bladder, and had one unhealed Stage 2 pressure ulcer (a partial-thickness loss of skin involving the epidermis and/or dermis indicating the damage does not extend through the full thickness of the skin or underlying muscle).Record review of Resident #1's Order Summary Report for active orders as of 8/1/25 and dated 10/8/25 revealed the following:- Apply zinc base cream to the buttock area, every shift for Blanchable redness to bilateral buttocks with order date 7/25/25 and no stop dateRecord review of Resident #1's TAR for August 2025 revealed the following:- Apply zinc base cream to the buttock area every shift (twice daily) for Blanchable redness to bilateral buttocks with start date 7/25/25. The TAR was missing documentation on the following days:8/2/25, Saturday day shift8/3/25 Sunday night shift8/5/25 Tuesday day shift8/8/25 Friday night shift8/13/25 Wednesday night shift8/14/25 Thursday day shift8/16/25 Saturday day shiftRecord review of Resident #1's comprehensive care plan with initiated date 7/24/25 and revision date 8/20/25 reflected the resident had a potential/actual impairment to skin integrity related to incontinence and impaired mobility with a goal for the resident not to have complications related to gluteal fold peeling and interventions that included assistance with turning and positioning, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, diet as ordered, pressure reduction mattress, and use of a draw sheet or lifting device to move the resident. Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse (LVN) on 7/31/25 and electronically signed on 8/1/25 revealed the resident had no new wounds.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse (LVN) on 8/6/25 and electronically signed on 8/6/25 revealed the resident had a Stage 2 pressure wound to the sacrum, staged by the Wound Care Nurse. Resident #1's Skin and Wound Evaluation document revealed on the Additional Care Section, None was checked, and the Notifications section: Practitioner Notified, Resident/Responsible Party Notified, Dietician Notified, and Therapy (PT, OT, ST) were left blank.Record review of Resident #1's Skin and Wound Evaluation document completed by the Wound Care Nurse (LVN) on 8/13/25 and electronically signed on 8/13/25 revealed the resident had a Stage 2 pressure wound to the sacrum staged by the Wound Care Nurse. Resident #1's Skin and Wound Evaluation document revealed on the Additional Care section, the resident had a moisture barrier and positioning wedge, and the Notifications: Practitioner Notified, Resident/Responsible Party Notified, Dietician Notified, and Therapy (PT, OT, ST) were left blank.During an interview on 10/8/25 at 9:45 a.m., LVN G stated the

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Residents #12) reviewed for infection control. The facility failed to ensure LVN D followed proper infection control practices during medication administration on 9/26/25. This deficient practice could place residents at risk for exposure to pathogens causing infection resulting in diminished quality of life. Findings included: Record review of Resident #12's admission Record, dated 9/26/25, revealed the resident was re-admitted on [DATE] with diagnoses which included: Dry Eye Syndrome, Constipation, Hemiparesis (weakness or an inability to move one side of the body), Hemiplegia (paralysis or weakness to one side of the body) and Hyperlipidemia (elevated cholesterol). Record review of Resident #12's Order Summary, dated 9/26/25, revealed: Gabapentin Oral Tablet 100 MG (Gabapentin) Give 1 tablet by mouth two times a day. Observation of medication administration for Resident #12 on 9/26/25 beginning at 3:48 pm revealed LVN D had a capsule lying on a piece of paper on top of the medication cart. Further observation revealed LVN D picked up the capsule with her bare hand and placed it into the medication cup. LVN D said it was a Gabapentin capsule and she had placed it there because she thought Resident #12 required her medications to be crushed. During interview on 9/26/25 at 4:17 pm, LVN D said she had put the Gabapentin aside because it was a capsule and could not be crushed. LVN D further stated she did not have a reason for placing the capsule on top of the paper on the medication cart instead of in a medication cup. LVN D said this could put the resident at risk for infection, adding that medications should be handled in a clean manner, for example: not putting medications on top of the cart and performing hand hygiene. During interview on 9/26/25 at 5:35 pm, ADON B said placing a medication capsule on top of a paper on the medication cart was not acceptable due to cross contamination. ADON B further stated medications should go from the blister pack or bottle straight to a medication cup. ADON B said not following this procedure could cause infection. Record review of the facility's policy Medication Administration revised 10/24/22, read: .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.13. Remove medication from source, taking care not to touch medication with bare hand.