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	02/23/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and time frames to meet residents' medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #1) reviewed for care plans, in that. The facility failed to update Resident #1's care plan to reflect Resident #1 was attempting to eat non-food items. This failure could affect residents who have care areas not addressed by the care plans by not having their needs met and putting them at risk of not receiving appropriate care.The findings included: Record review of Resident #1's admission record, dated 02/21/2026, reflected an [AGE] year-old female initially admitted on [DATE] and re-admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities), need for assistance with personal care, mild protein calorie malnutrition, dysphagia (difficulty in swallowing), and major depressive disorder. Record review of Resident #1's quarterly MDS assessment, dated 02/11/2026, reflected Resident #1 had a BIMS of 8 out of 15, indicating moderate cognitive impairment. Record review of Resident #1's care plan, undated, reflected no mention of Resident #1 attempt to eat non-food items. Record review of Resident #1's Comprehensive Encounter, dated 02/17/2026 and authored by NP, reflected .[Family member] reports patient has been trying to eat non-food items such as pennies and curtain hooks. Interview on 02/22/26 at 04:26PM, CNA B and CNA C revealed they knew Resident #1 would eat non-food items and had to keep an eye on Resident #1 more frequently. They revealed they knew about how to care for a resident by looking at Resident #1's care plan and verbal report from nursing staff on previous shifts. They revealed for this behavior they were unsure if it was in the care plan but that they knew about this from other staff members. Interview on 02/23/26 at 10:06 AM, the DON revealed he was not made aware that Resident #1 was trying to eat non-food items and he would update the care plan to include this for resident care. Interview on 02/23/26 at 11:46AM, the ADM revealed he supposed that Resident #1 attempting to eat non-food objects could be added to the care plans for the nursing staff to address these issues as needed. Observation and attempted interview on 02/21/2026 at 12:33 PM, Resident #1 appeared confused and would not respond appropriately to interview. There was no observation made of Resident #1 attempting to eat non-food items. Record review of facility's policy Care Plan Revisions Upon Status Change, dated 10/24/2022, reflected 1. The comprehensive care plan will be reviewed and revised as necessary, when a resident experiences a status change.

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
	455869	A. Building B. Wing	02/23/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record reviews the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and were systematically organized, for 1 of 6 residents (Resident #1) reviewed for consents for accurate medical records. 1. The facility failed to ensure that there was a doctor order on 01/21/2026 in Resident #1's electronic medical record to reflect that 1 enema (a procedure in which liquid or gas is injected into the rectum, typically to expel its contents) was given to Resident #1. 2. The facility failed to ensure the bathing documentation for Resident #1, accessed on 02/22/2026, was complete and included Resident #1 had a bed bath on 02/17/2026, resident refused on 02/16/2026, and bathing was not applicable on 02/13/2026. These failures could place residents at risk for inaccurate medical records.The findings included:Record review of Resident #1's admission record, dated 02/21/2026, reflected an [AGE] year-old female initially admitted on [DATE] and re-admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities), need for assistance with personal care, colostomy status (surgical opening for the colon in the abdomen), major depressive disorder, and Parkinson's disease (a movement disorder of the nervous system that worsens over time. Record review of Resident #1's quarterly MDS assessment, dated 02/11/2026, reflected Resident #1 had a BIMS of 8 out of 15, indicating moderate cognitive impairment. It further revealed Resident #1 needed substantial/maximal assistance for showering/bathing. Record review of Resident #1's care plan reflected [Resident #1] has an ADL self-care performance deficit r/t Parkinson's exacerbation, initiated 12/03/2025, reflected Provide supportive care, assistance with mobility as needed. Document assistance as needed. 1.Record review of Nurse's Note, dated 01/21/2026 and authored by LVN A, reflected Received new order for enema x1 and start MiraLAX daily for constipation. Record review of discontinued doctor's orders reflected Miralax Oral Powder 17 GM/SCOOP was ordered on 01/21/2026 by LVN A to Give 1 scoop by mouth in the morning for constipation. There was no order for an enema that was reflected. Interview on 02/23/2026 at 12:22 PM, LVN A revealed she received verbal orders from the NP to give Resident #1 an enema. LVN A was not at the facility to confirm or deny that there was not a doctor's order for an enema in Resident #1's electronic medical record. She revealed she could not recall if she had put this order into resident's electronic medical record, but she was trained to do this. She revealed it was important to have a doctor's order reflected in Resident #1's electronic medical record, so that it was known what time the enema was given to Resident #1 and if it was effective. 2. Record review of Resident #1's bathing documentation, accessed on 02/22/2026 at 04:02PM, reflected resident had a shower 02/02/2026, 02/05/2026, 02/12/2026, and 02/19/2026. Record review of Resident #1's updated bathing documentation, accessed 02/23/2026 at 10:05AM, reflected resident had a shower 02/02/2026, 02/05/2026, 02/12/2026, and 02/19/2026. The update accurately reflected Resident #1's complete bathing documentation as follows: a bed bath on 02/17/2026 (CNA unknown), resident refused on 02/16/2026 (CNA unknown), and bathing was not applicable on 02/13/2026 (CNA unknown). Observation and attempted interview on 02/21/2026 at 12:33 PM, Resident #1 appeared confused and would not respond appropriately to interview. Resident #1 appeared clean with no foul odors. Interview on 02/22/26 at 04:26PM, CNA B and CNA C revealed they gave Resident #1 showers regularly, They revealed they were trained and needed to document showers or baths in the residents' electronic medical record to keep track of resident's showers or baths. Interview on 02/23/26 at 10:06 AM, the DON revealed the showers for Resident #1 were not updated in her medical record and they should be up to date. He revealed the bathing documentation was now up to date (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	02/23/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with showers/baths that Resident #1 received. He revealed he could not find the doctor's order for an enema in Resident #1's electronic medical record, but the nurse had received a verbal order from Resident #1's NP. He revealed this order should be reflected in the electronic medical record. Interview on 02/23/26 at 11:46AM, the ADM revealed he would expect the electronic medical records for residents to be up to date to ensure accuracy for the treatment of residents. Record review of facility's policy Activities of Daily Living (ADLs), dated 05/26/2023, reflected Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care.6. Documentation shall be completed at the time of service, but no later than the shift in which the care service occurred. Record review of facility's policy Documentation in Medical Record, dated 10/24/2022, reflected Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.