STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all alleged violations involving mistreatment, neglect, abuse or misappropriation of resident property were reported immediately, but not later than 2 hours if the alleged violation involved abuse or resulted in serious bodily injury, to other officials (including to the State Agency) for one (1) of five (5) residents (Resident #1) reviewed for abuse. The ADMIN, who is the Abuse Coordinator, failed to immediately report (within 2 hours) an allegation of abuse made by Resident #1's family member on 01/21/2026 to HHSC. The failure could affect 46 residents and could result in undetected abuse and/or decline in feelings of safety and well-being.The findings included: Record review of Resident #1's admission Record, dated 02/03/2026, revealed a [AGE] year-old female admitted on [DATE]. Under Contacts, Resident #1 was listed as Self and Resident #1's family member was noted as [NAME] to Responsible Party and Emergency Contact #1. Record review of Resident #1's Diagnosis Report, undated and accessed on 02/03/2026 at 10:25 a.m., revealed diagnoses including spastic hemiplegic cerebral palsy (a type of cerebral palsy, a neurological disorder that damages part of the brain, that affects muscle control and movement on one side of the body), generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry about every day issues), and unspecified spina bifida (a condition that affects the spine and spinal cord and can lead to incontinence, loss of feeling, and leg paralysis) with hydrocephalus (a condition that can result in increased pressure in the skull and cause headaches, nausea, vomiting, double vision, and seizures). Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1 had a BIMS score of 15, indicating she was cognitively intact. Resident #1's mood interview revealed she felt down, depressed, or hopeless and felt bad about herself or that she was a failure or had let herself or her family down seven (7) to eleven (11) days or half or more of the days (over the last two weeks). Her behavior symptoms were documented as having not exhibited physical, verbal, or other behavioral symptoms directed toward others and had not exhibited potential indicators for hallucinations or delusions. She had rejected evaluations or care one (1) to three (3) days per week. Record review of Resident #1's Care Plan, undated and accessed on 02/03/2026 at 10:32 a.m., revealed the following problems and interventions:- Problem: Ineffective coping related unmet emotional needs, low self-esteem, and inadequate coping strategies R/T seeking validation and attention from multiple male figures, difficulty forming appropriate interpersonal boundaries. Going into male rooms saying, they asked for me to come in. making up stores., date initiated 01/21/2026 and revised on 01/27/2026. - Intervention: Assist the patient in identifying triggers for sexualized or attention-seeking behaviors., date initiated 01/21/2026. - Intervention: Collaborate with the interdisciplinary team., date initiated 01/21/2026. - Intervention: encourage verbal expression of feeling and unmet emotional needs., date initiated 01/21/2026. - Intervention: Establish a therapeutic nonjudgemental relationship., date initiated 01/21/2026. - Intervention: Identifying (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
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	triggers for sexualized or attention seeking behavior., date initiated 01/21/2026. - Intervention: set clear consistent boundaries regarding appropriate behaviors., date initiated 01/21/2026. - Intervention: Teach and reinforce alternative coping strategies assertive communication., date initiated 01/21/2026.- Problem: The resident has a behavior problem. Crys [sic] out, yells at family and staff, refuses to wait for assistance for transfers or assist to toilet, will go into visitors RR alone. Pt has made comments of wanting to find a boyfriend in the facility., date initiated 08/01/2025 and revised on 01/27/2026. - Intervention: continue with behavioral support, date initiated 02/03/2026. - Intervention: Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed., date initiated 08/01/2025. - Intervention: Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes., date initiated 01/01/2026. - Intervention: Provide a program of activities that is of interest and accommodates residents status., date initiated 01/01/2026. Record review of Resident #2's admission Record, dated 02/03/2026, revealed a [AGE] year-old male admitted on [DATE]. Record review of Resident #2's Diagnosis Report, undated and accessed on 02/03/2026 at 10:25 a.m., revealed diagnoses including fusion of spine, cervical region (a surgical procedure that involves permanently connecting two or more vertebra in the neck region to eliminate movement between them), radiculopathy, cervical region (a condition characterized by the compression of a nerve root in the neck, leading to symptoms such as pain, numbness, and tingling), and acute respiratory failure with hypoxia (a medical condition where the lungs cannot provide adequate oxygen to the blood). Record review of Resident #2's Quarterly MDS, dated [DATE], reflected Resident #2 had a BIMS score of 15, indicating he was cognitively intact. Resident #2's mood interview revealed he had not experienced little interest or pleasure in doing things or felt down, depressed (a state of general unhappiness or in low spirits), or hopeless over the last two weeks. His behavior symptoms were documented as having not exhibited physical, verbal, or other behavioral symptoms directed toward others and had not exhibited potential indicators for hallucinations or delusions. He did not have documented rejection of care. Record review of facility file labeled with Resident #1 and Resident #2's names revealed the following documents:- Receipt of Complaint / Grievance, dated 01/21/2026 with ADMIN and DON noted as person receiving complaint/grievance and complaint/grievance made by Resident #1's family member for Resident #1. - The nature of the complaint/grievance was noted as Residents RP ([family member type]) brought her into my office stating resident was going to tell me & DON about a male resident being inappropriate with her. - The final resolutions were noted as Resident was moved to [room number] as [sic, resident family member]'s request. It was learned through investigation that male & female resident had a consensual relation with intimate encounters happened on occasion, according to what [Resident #1] stated, however., facility couldn't prove any type of relationship or innappropriatness [sic] happenning [sic] between residents. - A typed Interview with resident [Resident #1] with [family member] present, dated 01/21/2026 at 02:30 p.m. revealed Resident #1 reported Resident #2 had touched her five (5) times with three (3) occurrences on Saturday, 01/17/2026 and two (2) occurrences on Sunday, 01/18/2026. Resident #1's interview notes included that she, Resident #1 had invited Resident #2 into her room to view a woman with large breasts on her television, which led to Resident #2 having touched Resident #1's breasts. Resident #1 stated she later went to Resident #2's room by his invitation, where he told her not to enter his room but stay at the doorway and he kissed her mouth. She stated she would watch the hallway to ensure no one was coming. Resident #1 denied reporting the incidents to staff or telling Resident #2 no because she liked the way he made her body feel. She (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he also touched her private area over her clothes and that she lowered her pants while sitting in the wheelchair so he could touch her more intimately. She stated she moved his hand away when she felt uncomfortable. She stated there were times when she did not verbally consent but he, Resident #2 knew she consented and there were times when she told him no, I do not want to do this now. Resident #1 was noted to have been asked if she would like the facility to contact law enforcement because she was forced and she stated No. - A typed Interview with resident [Resident #2] (room [room location] bedside), dated 01/21/2026 at 03:30 p.m. with the interview noted to have been done at Resident #2's bedside revealed Resident #2 was aware that males were not to enter female resident's rooms and female residents were not to enter male resident's rooms. He confirmed Resident #1 invited him into her room on Saturday, 01/17/2026 around 03:00 p.m. to 04:00 p.m. He stated, she called me into her room to see something on television. He stated when he entered Resident #1's room there were ladies on the television and the other resident, Resident #1, said something about the size of the lady's breasts on the television. He stated that he did not usually watch that type of stuff on television and had exited the room. He denied having any type of relationship with Resident #1 other than waving hello when she passed in her wheelchair. He denied ever touching another resident other than a handshake. He confirmed that he had given Resident #1 a necklace that did not fit him and some food at one time. He denied ever having been touched by Resident #1.- Typed interview notes by OTR A included: - On 01/21/2026, Resident #1's family member approached OTR A at a local church event and notified her of a sexual assault on Resident #1. Resident #1's family member had reported the assault occurred at the facility on 01/19/2026 and stated the facility abuse coordinator was already notified and a report had been made to the state, HHSC earlier in the day, 01/21/2026. - On 01/22/2026, Resident #1 came to her normal therapy session but looked tearful. OTR A noted she asked Resident #1 if she was okay and Resident #1 replied that she was just confused and upset. OTR A told Resident #1 that she had spoken to Resident #1's family member the day prior and she was available if Resident #1 wanted to talk. Resident #1 reported she lied to her family member because she feared what her family member would think. She stated she had had a consensual relationship with an older man for some time now. She described the contact and stated she liked him touching her. OTR A documented Resident #1 stated she was lonely and wanted a relationship very badly. OTR A noted Resident #1 had a history of sexually inappropriate behaviors towards other patients and staff, lying and manipulating, and was concerned that if she told the truth this time no one would ever believe her again. She documented Resident #1 wanted to keep the truth from her family member for now, but she did not want to get the male resident in trouble. OTR A noted she encouraged Resident #1 to speak with her counselor on how to tell her family member the truth. - On 01/23/2026, Resident #1 was crying in the therapy gym and reported the other residents did not want to be her friend anymore because she lied and that she felt like the other residents knew and would not forgive her. Resident #1 reported that she keeps lying about somethings and cannot seem to keep her story straight. She did not want to take any personal responsibility but knew she needed to. - Three (3) Resident Investigation Interviews, dated 01/21/2026 with all three noted to have denied having experienced verbal or physical abuse by a staff person or having witnessed any residents doing inappropriate things. - Critical Behavior Monitoring Log, dated 01/21/2026 - 01/23/2026, on Resident #2 noted to have started monitoring at 03:00 p.m. on 01/21/2026 to 11:00 p.m. on 01/23/2026. Resident #2 was noted to be primarily in his bedroom, with one instance of him in the hallway and another of him in the bathroom. He was noted as lying down, asleep, walking, sitting, awake, watching television/movie, or eating. He was documented as calm during all notations. During an interview on 02/03/2026 at 09:41 a.m., LCSW B revealed she had been (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	providing Resident #1 with private, not associated with the nursing facility, therapy services. She revealed Resident #1 reported to her that Resident #1 was engaged in a sexual relationship with another resident. LCSW B stated she was only aware of the one incident reported by Resident #1. During an observation on 02/03/2026 at 10:00 a.m., a posting on a facility hallway wall was noted to identify the ADMIN as the abuse coordinator. During an observation and interview on 02/03/2026 at 12:00 p.m., Resident #2 was observed sitting in a wheelchair in his room watching television. He revealed he had not experienced any issues with other residents except for a male resident in which the staff intervened quickly, and he was not harmed. He stated he tried to stick to himself and did not like to sit and interact with other residents very much. He stated he had not had a romantic relationship with any other residents at the facility and had never intentionally touched another resident. During an observation and interview on 02/03/2026 at 12:08 p.m., Resident #1 was observed sitting in a wheelchair in the back dining room with a staff member and other residents present in the room. She had pushed her lunch tray away from her, had an earbud in her ear, and appeared to be interacting with her phone. Following a request for interview, Resident #1 requested to discuss the incident in a private location. At 12:22 p.m., in a private office, Resident #1 revealed she and Resident #2's relationship had started as a friendship where she had received a few snacks and trinkets from Resident #2. She revealed the physical aspect of their relationship changed when on a cold day, date unknown, Resident #2 noted that Resident #1 was cold and had offered her a hug. Resident #1 stated she said sure, agreed to a second hug, and then kissed Resident #2 on the cheek. Resident #1 stated the next day she invited Resident #2 into her room to see something on the television, a person with large breasts. She stated this led to Resident #2 indicating he preferred women more closely sized to Resident #1 and he proceeded to slightly touch her breast and then kissed her. She stated she liked the physical contact and gave Resident #2 an invitation to do other things, including touching her intimately. Resident #1 stated after that day, Resident #2 would invite her to his room and while sitting in her wheelchair in Resident #2's doorway, she would watch the hall for staff members while Resident #2 would touch her sexually. Resident #1 stated she initiated some of the contact and stated Resident #2 was not forcing her. She stated she knew how to stand up for herself and say no. She stated when she told her counselor, LCSW B, about the relationship, the counselor stated the other resident, Resident #2, was being forceful and when she, LCSW B, stated Resident #1 had to tell her family member she, Resident #1 panicked. Resident #1 stated she told her counselor, LCSW B the same information and that it was not rape. She stated she lied because she did not want her family member to know. She stated she felt safe in the facility and felt that she should have gone to him, Resident #2, more maturely to end the romantic part of their relationship instead of saying that he, Resident #2, was being forceful. She stated she avoided Resident #2 now because the facility staff set boundaries between them, so they do not cross paths, but when she saw Resident #2 in the facility, she did not feel fear but did feel embarrassment and shame. She stated Resident #2 is an old man and not threatening to her. She stated following the report of the incident she was moved rooms per her family member's request and with her agreement due to previously living in a room across the hall from Resident #2. She stated she discussed the incident with facility staff, the ADMIN and DON and she felt they convinced her that the police did not need to be involved. She stated, to be honest, at that moment, I don't know if I wanted the police involved. Resident #1 stated she was capable and involved in making personal medical decisions. During an interview on 02/03/2026 at 01:22 p.m., Resident #1's family member revealed she found out about Resident #1's report of having had a physical relationship with another resident on 01/21/2026. She revealed Resident #1 was typically frequently moody, and she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had not observed any changes in Resident #1's mood prior to the reported incident. She revealed she and Resident #1 had been going through a rough month prior to this reported incident which resulted in them not speaking frequently. She revealed Resident #1 had called her the day prior to the therapy session, on 01/20/2026, and had stated she wanted to speak to her therapist about something very serious and did not want her, Resident #1's family member, to hear. She stated she felt concerned following the phone call. Resident #1's family member stated she reported Resident #1's physical relationship with another resident to the facility staff at the time Resident #1 returned to the facility on [DATE]. She stated the facility staff reacted quickly in moving Resident #1's room, per her request and with Resident #1's agreement. She revealed the facility staff discussed a police report and stated that they were going to file a report and complete an internal investigation. She stated upon her return to the facility, on the same day, 01/21/2026 at unknown time, she had asked the ADMIN if they had called the police and was told that Resident #1 did not want the facility to file one. She revealed on the same night, Resident #1 told her that the facility staff had convinced her that she did not need to file a police report. Resident #1's family member revealed she would not say that she had observed Resident #1 to feel more fearful since the reported incident but more so uncomfortable as a resident in the facility. She stated she felt Resident #1 was safe where her current room was located and was aware the facility staff were discouraging Resident #1 from going down her prior hall, where Resident #2 resided. During an interview on 02/03/2026 at 02:14 p.m., LCSW B revealed she had been providing Resident #1 with private therapy services for three (3) to four (4) years. She revealed her therapy sessions with Resident #1 were weekly and the first and only mention of a sexual encounter or regarding relationships was on the reported day of the incident, 01/21/2026. LCSW B revealed Resident #1 appeared to have increased anxiety and emotional effect on the day she reported the relationship but had returned to her regular, nothing of increased note, during her following two sessions. LCSW B stated she was working with Resident #1 regarding her statement that she lied about the incident due to her family member knowing and feeling shame and embarrassment about the incident. She stated she reported the incident to Adult Protective Services, and she understood when she reported the incident and spoke with an Adult Protective Services officer that the police and HHSC would be contacted. During an interview on 02/03/2026 at 02:42 p.m., CNA C revealed she was familiar with Resident #1 and Resident #2. She revealed she believed Resident #1 had been more emotional recently and that Resident #1 was just uncomfortable with her recent room change and Resident #1 felt that she did not have any friends. CNA C stated she never observed any interactions between Resident #1 and Resident #2 other than them being friendly and talking in the hallway. She denied having observed any suspicious or unusual interactions between the two residents. CNA C revealed the DON explained that Resident #1 had reported having had a relationship with Resident #2, Resident #1's room was changed, and that staff were to ensure Resident #1 was comfortable and to try to prevent the two residents from interacting. CNA C stated she had observed Resident #1 initially try to go down Resident #2's hallway, but when the intervention was explained, Resident #1 was initially upset but did understand. CNA C stated she had not observed any changes in Resident #2's behaviors but that he did not typically leave his room. During an interview on 02/03/2026 at 02:22 p.m., the ADMIN revealed the facility did not submit a self-report regarding the reported incident between Resident #1 and Resident # 2 because the facility investigation found what Resident #1 was claiming was not true. During an interview on 02/03/2026 at 02:53 p.m., LPN D revealed she was familiar with Resident #1 and Resident #2. She revealed she had not observed any changes in either resident's behaviors or mood. She revealed she had not received any complaints from Resident #1 regarding safety or emotional distress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She stated she was aware of the reported incident involving both residents because the DON notified her individually because she was working in the hall where Resident #1 was relocated to and the DON wanted to ensure she was knowledgeable to monitor Resident #1 for any type of stress or crying. During an interview on 02/03/2026 at 03:05 p.m., Therapy Provider E stated he had seen Resident #1 on 01/20/2026. He stated he completed a BIMS assessment for her on the same day, 01/20/2026. He revealed that if a resident was assessed with a BIMS over 12 and was considered alert and oriented, then the resident would have been considered competent. He revealed he would need to review his documentation for Resident #1 to verify that she was determined to be competent. During an interview on 02/03/2026 at 04:09 p.m., Therapy Provider E stated he assessed Resident #1 to have a BIMS of 13 and she was alert and oriented times four (4; refers to a person's level of awareness regarding knowing who they are, where they are, what time it is, and what is happening around them). He stated that anyone assessed with a BIMS more than 12, they (the contracted psychiatry services company) would consider the resident capable of making personal decisions. He stated Resident #1 was able to tell him why she was a resident at the nursing facility, list her medications, and explain if she was doing better with the medication she was prescribed for her depression. During an interview on 02/03/2026 at 04:33 p.m., the DON revealed when she and the ADMIN first tried to interview Resident #1 on 01/21/2026 Resident #1 was starting to explain how she was interested in Resident #2 and when she and the ADMIN tried to explain that the feelings were normal, Resident #1's family ended that part of the discussion. The DON revealed that later on in the day, time not specified, Resident #1's family member left the facility and Resident #1 came back to the ADMIN's office and stated she did not want to get anyone in trouble, she liked how the contact felt, and she wanted to go on birth control. The DON revealed she and the ADMIN explained to Resident #1 that she was saying one thing to them and another to her family member and Resident #1 was adamant about not telling anyone including calling the police because she did not want rumors. The DON stated she was unsure if a state report was completed but knew the police were not called because Resident #1 said she did not want them notified. The DON stated the facility moved Resident #1's room per her request and started an investigation into the incident. The DON stated Resident #1's interview revealed Resident #1 initiated the invitation to her room. The DON stated Resident #1 stated she had a right to have a boyfriend when consent was discussed and stated Resident #1 knew what she was doing and knew what she wanted. The DON stated Resident #2 was adamant he never touched Resident #1. The DON revealed for state reports, the procedure was to normally call their corporate team to discuss and she knew they did discuss the incident. She revealed the Administrator was responsible for making the report to state. The DON stated determinations of a resident's capacity to consent was based on the resident's BIMS score and Resident #1 would sometimes state if she did not want her family member to know something regarding her care and/or status. The DON revealed she believed they did an abuse and neglect training following this reported incident. During an interview on 02/03/2026 at 05:02 p.m. the ADMIN revealed the reported incident between Resident #1 and Resident #2 was initially reported by Resident #1's family member and that the family member felt Resident #1 having a relationship with a man was inappropriate. The ADMIN revealed that when she asked Resident #1 what occurred, Resident #1 said that Resident #2 had made a move on her and she did not like it and started to cry and did not ask for it. The ADMIN stated Resident #1 went into details regarding the incident. The ADMIN stated after Resident #1's report, she asked Resident #1 to step out of the office and asked Resident #1's family member what she would like to be done and Resident #1's family member requested for Resident #1's room to be changed. The ADMIN stated they moved Resident #1 and started an investigation. The ADMIN stated following Resident #1's family (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member leaving, Resident #1 came back and told her and the DON that she had invited him, Resident #2, into her room, made an inappropriate comment, that she then went to his room where they kissed. She stated she liked it and kept coming back multiple times a day. The ADMIN revealed Resident #1 stated she did not want to say that in front of her family member. The ADMIN revealed that she and the DON went to interview Resident #2, who denied the allegations. The ADMIN revealed Resident #1 had a good relationship with OTR A and Resident #1 had told OTR A that she had lied and just liked the attention. The ADMIN revealed the facility would review a resident's BIMS score and a resident's behavior in general to determine capacity to consent and Resident #1 was alert and oriented and made her own decisions. The ADMIN revealed as part of their investigation they interviewed the three (3) residents that occupied the rooms closest to Resident #1's prior room and Resident #2's current room and no witnesses to the alleged relationship were found. The ADMIN revealed the staff were in-serviced on abuse and neglect following the alleged incident and psych services were notified. The ADMIN revealed the alleged incident was initially treated as abuse but during the two (2) hours that the facility had to report, Resident #1 had changed her story and stated she was lying. Record review of In-Service Training Report, dated 01/21/2026 with topic Abuse/Neglect/Exploitation, reflected 17 staff signatures indicating receipt of the training. Record review of facility policy titled Abuse, Neglect and Exploitation, dated as implemented 07/11/2025, reflected Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: . ‘Alleged Violation' is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.Policy Explanation and Compliance Guidelines: .IV. Identification of Abuse, Neglect and Exploitation .B. Possible indicators of abuse include, but are not limited to:1. Resident, staff or family report of abuse.VII. Reporting/ResponseA. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, . Record review of facility policy titled Incidents and Accidents, dated as implemented 08/15/2022, reflected Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Compliance Guidelines: .4. The following incidents/accidents require an incident/accident report but are not limited to: alleged abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, the facility failed to post on a daily basis information that included the facility name, current date, total number and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census for 4 of 4 days (01/31/2026 - 02/03/2026) reviewed for posting of required information. The facility failed to post the required current nurse staffing and census information from 01/31/2026 to 02/03/2026. This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census. The findings included: During an observation on 02/03/2026 at 10:14 a.m. and at 04:15 p.m., a document labeled [facility name] Direct Care Daily Staffing 8-Hour, dated 01/30/2026, was posted on a wall of the front lobby/ front dining space. The document included the following information: current census and the number and hours worked of registered nurses, licensed vocational nurses, medication aides, and certified nurse aides for the 06:00 a.m. - 02:00 p.m. shift, 02:00 p.m. - 10:00 p.m. shift, and the 10:00 p.m. - 6:00 a.m. shift. During a telephone interview on 02/03/2026 at 04:33 p.m., the DON revealed she used to be responsible for posting the daily census and nurse staffing posting; however, the ADON took over the responsibility in February (of 2026). She stated the posting is expected to be posted in the dining room and in addition the staff have a sign-in sheet. She stated there was also a staff schedule posted in the employee breakroom. She stated she did not believe the daily census and nurse staffing posting having not been posted for several days would have impacted the residents or facility guests because they could ask staff who was on schedule and when they could expect a certain staff member back. She stated facility guests and residents were not supposed to have access to the employee breakroom but would sometimes peak into the room and would therefore also be able to view the staff schedule. During an interview on 02/03/2026 at 04:56 p.m., the ADON revealed she was not too familiar with the daily census and staff posting because she had just started being responsible for doing the staffing schedules. She revealed she was aware that the facility had a sheet that was posted daily regarding this information, and it was the responsibility of the person that managed the staffing. She stated she believed the DON was posting the form and was unsure why the posting on 02/03/2026 was dated 01/30/2026. She stated she had not taken over this responsibility, but she was the DON's back-up. She stated on the weekends, 01/31/2026 was a Saturday and 02/01/2026 was a Sunday, she was unsure if the daily census and nurse staffing posting was posted or not and did not know the procedures for those days. She revealed she did not believe the residents or facility guests would have been impacted by the posting not having been current because they could ask the staff directly. The ADON stated she was unsure if there was a facility policy regarding the posting of the daily census and nurse staffing. During an interview on 02/03/2026 at 05:02 p.m., the ADMIN revealed the DON was responsible for posting the daily census and nurse staffing posting. She stated for the weekends, the DON would prepare the postings and leave them for the weekend staff. She stated the weekend staff, specifically the weekend nurse supervisor, was responsible for moving the pre-prepared sheets. She stated she believed the lack of posting the document daily could impact the residents and facility guests because they might want to know who was working or how many staff were working the floor, but they might also ask staff directly. During an interview on 02/03/2026 at 05:32 p.m., the ADON revealed she had just created and posted the current day's (02/03/2026) daily census and nurse staffing posting. She revealed she found the prior day's postings behind the 01/30/2026 posting and believed the staff just did not flip the sheets around. During an interview on 02/03/2026 at 06:18 p.m., the ADMIN revealed she could not find a facility policy regarding the daily census and nurse staffing posting. She (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675395	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Val Verde Nursing and Rehabilitation Center	100 Hermann Dr Del Rio, TX 78840

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	stated the facility procedures were to follow the state and federal regulations.