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	05/10/2024

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 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** 44906 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 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 16 residents (Resident #24, #46) reviewed for care plans, in that: 1. The facility failed to ensure wound care management was included on the Care Plan for Resident #24 when he developed pressure injury wounds on 4/17/2024. 2. The facility failed to ensure significant weight loss was included on the Care Plan for Resident #46 after she lost 7.14% of her body weight from 3/6/2024 to 4/8/2024. This failure could place residents at risk of not receiving the care needed to maintain their highest, most practicable, physical, social, and psychosocial level of well-being. The findings were: 1. Record review of the Admission Record revealed Resident #24 was a [AGE] year-old male originally admitted on [DATE]. Record review of the comprehensive MDS assessment, dated 4/15/2024 revealed Resident #24 was rarely or never understood [therefore a BIMS assessment could not be completed]. Resident #24 had short- and long-term memory problems; and was moderately impaired in cognitive skills for daily decision making. Active diagnoses included pneumonia [infection in the lungs caused by bacteria, viruses or fungi that causes lung tissue to swell, cause fluid or pus to develop in lungs], and pressure ulcer of the left buttock, stage 2 [sore that has broken through the top layer of the skin and part of the layer below]. Under section M - Skin Condition, Resident #24 was coded as having a formal and clinical assessment for determination of Pressure Ulcer/Injury risk and was rated as not at risk of developing pressure ulcers/injuries and did not have any unhealed pressure ulcers/injuries. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Care Plan, printed 5/10/2024 at 12:11 PM, revealed Resident #24 had a problem area of ADL self-care performance deficit, with interventions that indicated he was totally dependent on staff for reposition and turning in bed and as necessary, revised on 4/9/2024; and required skin inspection every shift, revised on 3/29/2024. No additional problem areas or interventions related to skin or wound care management were included. Record review of Daily Skilled Note dated 4/18/2024 at 1:45 PM authored by LVN C, revealed indication that skin was not intact. Record review of Order Details revealed Resident # 24 had orders to cleanse with wound cleanser, pat dry apply silvasorb, cover with non-adherent dressing and secure with tape one time per day to stage 2 [pressure injury] to left and right buttocks with start dates of 4/18/2024. In an interview on 5/10/2024 at 2:54 PM, the DON stated the resident had returned from the hospital on 4/09/2024. The DON stated the Wound Care Nurse was out on leave at this time, and the wound care management was delegated to various nurses each day to cover while the Wound Care Nurse was out. The Resident #24's pressure injury wounds had resolved 3/27/2024 prior to his hospitalization . In an interview on 5/10/2024 at 3:55 PM, the DON stated due to Resident 24's declining health status related to pneumonia, the pressure injuries developing were unavoidable as the area was friable due to previous, healed pressure injuries and the residents' diminished capacity to independently self-reposition as an energy conservation coping strategy. The DON stated that the wounds developed on 4/18/2024, but the nurse [LNV B] that assessed and documented the wounds that day was currently out on leave. The DON stated the wounds were discussed in medical morning meeting and physician orders were received for wound care treatment that day [4/18/2024]. The DON stated that Resident #24's care plan should have been updated to reflect the change in his condition and wound care management interventions within 2 weeks, if not sooner, of the wounds being discovered. The DON stated it was normally the responsibility of the Wound Care Nurse to update the Care Plan regarding wound care management; however, in this case, while the Wound Care Nurse was out, it was the responsibility of the nurse who discovered, and documented the wounds to update the Care Plan. The DON stated the risk of not having the care plan updated was that something could be missed, or delay treatment. 2. Record review of Resident #46's Face Sheet, dated 5/10/2024, reflected a [AGE] year-old female resident initially admitted on [DATE] with diagnosis including pressure ulcer of sacral region, stage 4, and type 2 diabetes mellitus without complications. Record review of Resident #46's Quarterly MDS Assessment, dated 4/4/2024, reflected Resident #46 had a BIMS score of 9, indicating the resident was moderately impaired. Further review of the Quarterly MDS Assessment reflected that Resident #46 had lost 5% or more in the last month or loss of 10% or more in last 6 months while not on a physician-prescribed weight-loss regimen. Record review of Resident #46's Dietary Progress Note, dated 4/9/2024, reflected that Resident #46 had a significant weight loss, was started on Megace, an appetite stimulant, and a recommendation to add fortified food to resident meals. Record review of Resident #46's Comprehensive Person-Centered Care Plan, dated 5/10/2024, reflected no problems, goals, or interventions relating to Resident #46's significant weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/10/2024 at 2:36 PM, the DON stated significant weight loss should be care planned as it is a significant change. The DON stated the MDS Nurse oversaw updating Care Plans and that they monitor any changes during morning meetings to determine if they are significant changes. In an interview on 5/10/2024 at 2:45 PM, the MDS Nurse stated she was unsure of why the significant weight loss was care planned and that the care plan generally is updated when there is a significant change such as weight loss. Record review of the facility policy entitled, Pressure Injury Prevention and Management, dated 8/15/2022, reflected under the heading Policy Explanation and Compliance Guidelines in section 4. Interventions for Prevention and to Promote Healing step f.) Interventions will be documented in the care plan and communicated to all relevant staff. Under section 6. Modifications of Interventions step b.) interventions on a resident's plan of care will be modified as needed .ii.) new onset or recurrent pressure injury development. Record review of the facility policy entitled, Care Plan Revisions Upon Status Change, dated 10/24/2022, reflected under the heading Policy Explanation and Compliance Guidelines in section 2. Procedure for reviewing and revising the care plan .step d.) The care plan will be updated with new or modified interventions. F.) care plans will be modified as needed by the MDS Coordinator or other designated staff member.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observation, interview, and record review the facility failed to ensure that residents were offered a therapeutic diet when there was a nutritional problem, and the health care provider orders a therapeutic diet for 1 of 8 Residents (Resident #46) reviewed for nutritional status in that: The facility failed to ensure Resident #46 was receiving the ordered therapeutic diet. These failures could place residents who are dependent on staff for their nutrition and hydration at risk for nutritional deficit, weight loss, skin breakdown, and overall decline in quality of life. Findings included: Record review of Resident #46's Face Sheet, dated 5/10/2024, reflected a [AGE] year-old female resident initially admitted on [DATE] with diagnosis including pressure ulcer of sacral region, stage 4, and type 2 diabetes mellitus without complications. Record review of Resident #46's Quarterly MDS Assessment, dated 4/4/2024, reflected Resident #46 had a BIMS score of 9, indicating the resident was moderately impaired. Further review of the Quarterly MDS Assessment reflected that Resident #46 had lost 5% or more in the last month or loss of 10% or more in last 6 months while not on a physician-prescribed weight-loss regimen. Record review of Resident #46's Comprehensive Person-Centered Care Plan, dated 5/10/2024, reflected no problems, goals, or interventions relating to Resident #46's significant weight loss. Record review of Resident #46's weight record reflected that on 3/6/2024, she weighed 145.6 lbs.; on 4/8/2024, she weighed 135.2 lbs. which is a -7.14% loss. Record review of Resident #46's orders reflected, Regular diet Mechanical Soft texture, Regular Liquids consistency, for fortified foods all meals -snacks of choice between meals with an order date and start date of 4/12/2024. Further review reflected that Resident #46 was on Megestrol Acetate Oral suspension for an appetite stimulant with an order date and start date of 4/18/2024. Record review of Resident #46's Dietary Progress Note, dated 4/9/2024, reflected that Resident #46 had a significant weight loss, was started on an appetite stimulant, and a recommendation to add fortified food to resident meals. Record review of Resident #46's meal ticket for lunch on 5/8/2024, and dinner on 5/10/2024 did not reflect that the resident was to have fortified foods at all meals. Further record review of other residents' meal tickets revealed their fortified diets listed on their meal tickets. Observation on 5/8/2024 at 12:35 PM, Resident #46 was observed in her room. Resident #46 requested a hamburger from the kitchen and was provided one. Interview attempt was not successful, as the resident declined to speak to surveyor. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/10/2024 at 2:15 PM, the Dietary Manager stated that dietary orders are automatically input into the system used to create meal tickets. The Dietary Manager stated he was not aware any of the meal tickets were incorrect, as they are automatically input based on the residents' orders. The Dietary Manager stated that nursing staff was in charge of inputting orders and he did not verify them. Interview on 5/10/2024 at 2:36 PM, the DON stated that orders for fortified meals are input into their electronic health record system and on the meal ticket by the next meal, as the meal ticket is based on resident orders. The DON states she is unsure why it is not on the meal ticket, as the orders were input correctly into the electronic health record system. The DON stated there was not a way of knowing if the resident was provided their therapeutic diet as ordered, but that the resident has gained a pound since their order was input for Megestrol, the appetite stimulant. Record review of policy titled, Diet Order Accuracy, dated 10/2018, reflected, The facility will conduct routine audits of the diet orders to ensure that residents receive the diet as ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44906 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 4 medication carts (the Nurses Medication Cart) reviewed for medication storage, in that; The facility failed to ensure the Nurses Medication Cart was locked when it was left unattended in the common area of in front of the nurses' station. This deficient practice could place residents at risk of medication misuse or drug diversion. The findings were: In an observation on 5/08/2024 at 12:21 PM the Nurse's Medication Cart was left unlocked and unattended in the common area in front of the nurse's station. The cart contained scissors, prescription and over the counter medications. There were staff, residents, and visitors in the immediate vicinity. In an interview on 5/08/2024 at 12:25 PM, LVN A stated the Nurses Medication Cart was her responsibility. LVN A stated the Nurses Medication Cart should not be left unlocked when not in use. LVN A stated she had been trained not to leave it unlocked when not attended. LVN A stated that the Nurses Medication Cart had been unlocked and unattended for just a few minutes while I had a small emergency with a resident who needed my attentions and I forgot to lock the cart as I rushed to that person's aid. In an interview on 5/10/2024 at 3:50 PM, the DON stated it was her expectation that medication carts are locked when not in active use. The DON stated medication aides and nurses were trained upon hire, in annual competency testing and via in-service trainings when the need arose. The DON stated that medication carts were spot checked through random Pharmacy checks and as needed by the DON and ADON. The DON stated there was risk to a resident if a medication cart was left unlocked and unattended. [The DON did not provide examples or further elucidate on the topic.] Record review of the facility policy entitled Medication Carts and Supplies for Administering Medications, revised 10/01/2019 revealed under the heading Procedure 2.) the medication cart is to be locked at all times when not in use. 3.) do not leave the medication cart unlocked or unattended in resident care areas.