

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER Val Verde Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interview and record review the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional who was licensed or registered by the State for 1 of 1 facility reviewed for qualifications of activity professionals. The facility failed to have a qualified Activities Professional direct their activities program. This deficient practice could place residents at risk of not receiving approaches that were individualized to match the skills, abilities, and interests/preferences of each resident for activities. The findings included: During an interview on 08/11/2026 at 5:50 p.m., the Activity Director revealed that she has not obtained her certification as an activity director, but she started her online training as of February 2026. She stated that she has completed 8 of 12 modules of online training and the Administrator oversees her coursework and provides guidance in activities for the NF. She stated that she is unable to obtain an online transcript of her activity director's course she is enrolled in at this time. She stated that prior to accepting the full-time activity director position at the NF she was employed as the NF's receptionist and assisted with medical records and did not have a former training or background in activity director. During an interview on 08/12/2026 at 3:01 p.m., the Administrator revealed that the Activity Director was not licensed, and she was not sure where in the process of certification she was currently at. She stated that she was aware that the Activity Director did find a school, but she was not sure she had started classes. She stated that she would need to make sure she was enrolled online. She stated that currently she works with a regional corporate consultant who oversees the Activity Director's work. The Administrator stated that a certified Activity Director would have more knowledge of the process of State requirements. She stated that the facility had been without a certified Activity Director since 11/2025. Requested a policy for Activity Director from the Administrator on 08/12/2026. The administrator stated on 08/12/2026 at 2:40 p.m. that if she did not provide us with a policy, then she did not have one.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 2 (Resident #20, Resident #23) of 3 residents reviewed for infection control in that:1.The facility failed to ensure CNA C performed hand hygiene before applying clean gloves while providing incontinence care to Resident #20.2. LVN E did not change gloves from clean to dirty during ostomy care for Resident #23.This failure could lead to infection or illness. Findings included: 1.Record review of Resident #20's admission Record dated 08/12/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Relevant diagnoses included: hemiplegia and hemiparesis following cerebral infarction (when a blocked artery or blood clot stops blood and oxygen from reaching part of the brain, resulting in muscle weakness or paralysis on one side of the body), and unspecified urinary incontinence. Record review of Resident #20's Medicare 5-day MDS dated [DATE] reflected in section C0100: 0. No (resident is rarely/never understood), section GG0130: C. Toileting hygiene: 01. Dependent, section H0300. Urinary Continence: 3. Always incontinent, and H0400. Bowel Continence: 3. Always incontinent. Record review of Resident #20's Care Plan Report revealed: Problem: The resident has bladder incontinence r/t decreased mobility, CVA with left side hemiplegia. Date Initiated: 05/14/2024 Revision on: 07/22/2024, Intervention: Clean peri-area with each incontinence episode and Problem: The resident has bowel incontinence r/t CVA and Decreased mobility. Date Initiated: 08/01/2026 Revision on: 08/01/2026, Intervention: Provide peri-care after each incontinent episode. In an observation and interview on 08/10/2026 at 9:55 a.m., CNA C was observed performing incontinence care for Resident #20. CNA C cleaned the residents' buttocks, rolled soiled draw sheet under resident's hip, removed gloves, did not perform hand hygiene, applied new gloves and applied clean brief under resident. During an interview with CNA C on 08/11/2026 at 10:00 a.m., she stated she should have performed hand hygiene when changing gloves before applying the clean brief and that she was nervous. CNA C stated failing to do so may result in the resident getting an infection. In an interview with the DON on 08/12/2026 at 10:30 a.m., she said staff were expected to perform hand hygiene between glove changes and failing to do so may result in infection. The DON stated staff have received training on infection control and incontinent care. 2. Record review of Resident #23's admission Record dated 8/10/2026 reflected she was admitted on [DATE] with diagnoses of Dementia, and colostomy status. Record review of Resident #23's consolidated physician orders for August 2026 revealed she had an (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for ostomy, to check skin, around the stoma for redness and irritation, colostomy care every shift and as needed, empty colostomy pouch contents every shift, and as needed, Report changes in color, consistency, type and amount of colostomy drainage to medical provider and document in progress notes, every shift and as needed. Record review of Resident #23's Quarterly MDS dated [DATE] reflected that she had had a BIMS score of 4/15 (severe cognitive impairment), and ostomy. Record review of Resident #23's care plan dated 7/10/2026, reflected the resident has an alteration in gastro-intestinal status related to colostomy bag. Intervention was give medication as ordered. Monitor/document side effects and effectiveness. Observation on 8/10/2026 at 11:18 AM in Resident #23's room, during ostomy care. LVN E was observed removing the soiled dressing and emptying the pouch. Observed Resident #23's stoma had brown substance, that LVN E wiped off and placed in garbage bag. LVN E then affixed the pouch and cleaned the dressing without removing the soiled gloves, sanitizing his hands, and applying new, clean gloves. Interview on 8/10/2026 at 12:18 PM with DON stated the nurse policy and procedures they follow are from the [NAME], regarding ostomy procedure, had no mention of changing gloves between dirty and clean. Interview on 8/10/2026 at 12:19 PM with LVN E stated the stoma was soiled with feces, he wiped with a wipe and placed new ostomy bag on Resident #23. LVN E stated he was busy talking and he did not get gloves soiled or take the old (dirty) gloves off his hands. LVN E stated best practice was to change gloves between dirty and clean. Record review of policy titled, Hand Hygiene dated 10/24/22 read: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 3 of 8 (Resident #3, Resident #40 and Resident #56) residents whose records were reviewed for assessments. Nursing staff failed to code Resident #3 had musculoskeletal Other Fracture, exhibited behavioral symptoms, including physical behavioral symptoms toward others, and inaccurately documented active diagnoses on his MDS assessment. Nursing staff failed to code Resident #40 had falls, frequency of falls, and falls with no injury and with injury on her MDS assessment. Nursing staff failed to code Resident #56 had falls and musculoskeletal other fracture on her MDS assessment. These failures could place residents at risk of not identifying care areas and result in residents not receiving needed care and services. The findings included: 1. Record review of Resident #3's admission Record, dated 08/11/2026 revealed a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. Resident #3 was not listed as his own responsible party. Record review of Resident #3's Medical Diagnoses, undated and accessed 08/11/2026 at 5:15 p.m., revealed diagnoses including other specified fracture of unspecified pubis, subsequent encounter for fracture with routine healing (pelvic injury) being listed as principal diagnosis, major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest, Alzheimer's disease (most common cause of dementia), dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), and anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident #3's quarterly MDS, dated [DATE] and signed 06/09/2026 as completed, reflected a BIMS score of 00, indicating severe cognitive impairment. Resident #3 was documented as having no musculoskeletal Other Fracture and was documented as having not exhibited any behavioral symptoms, including physical behavioral symptoms toward others. Resident #3 was documented with active diagnoses of Alzheimer's Disease, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Psychotic Disorder. Record review of Resident #3's care plan, undated and accessed 08/11/2026 at 5:10 p.m., revealed . [Resident #3] has potential to be physically aggressive [related to] Dementia/confusion, Alzheimer's. yelling, kicking, hitting/pinching staff. and . uses antidepressant medication [related to] Depression. initiated 11/21/2025 and revised 08/10/2026 and . [Resident #3] has an alteration in musculoskeletal status r/t fracture of the Pubis [related to] fall. initiated 11/21/2025 2. Record review of Resident #40's admission Record, dated 08/12/2026, revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident #40 was not listed as her own responsible party. Record review Resident #40's Medical Diagnoses, undated and accessed 08/12/2026 at 3:34 p.m., revealed diagnoses including major depressive disorder, muscle wasting and atrophy, Parkinson's disease (a movement disorder of the nervous system that worsens over time.), and dementia. Record review of Resident #40's quarterly MDS Assessment, dated 07/06/2026 and signed 07/08/2026 as completed, reflected a BIMS score of 00, indicating severe cognitive impairment. Resident #40's functional limitations in range of motion were documented with impairment on both sides of upper and lower extremities, and functional abilities were documented as dependent on staff. Record review of Resident #40's care plan, undated and accessed 08/12/2026 at 3:36 p.m., revealed . [Resident #40] has impaired cognitive function/dementia or impaired thought process [related to] Dementia. has little or no activity involvement [related to] Physical Limitations and cognitive impairment initiated 04/22/2021. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions included 1 on 1 activities in room initiated 03/08/2024 and Encourage the resident's participation daily. 3. Record review of Resident #56's admission Record, dated 08/09/2026 revealed an [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Resident #56 was not listed as her own responsible party. Record review of Resident #56's Medical Diagnoses, undated and accessed 08/09/2026 4:20 p.m., revealed diagnoses including laceration of spleen, wedge compression fracture of T7-T8 vertebra (thoracic spine injury where the front of the vertebral body collapses into a wedge shape), subsequent, encounter for fracture with routine healing, age-related osteoporosis with current pathological fracture, fracture of upper end of right humerus, with routine healing, fracture of unspecified part of neck of right femur (refers to a break in the region connecting the femoral head to the femoral shaft.), depression (mental state of low mood), altered mental status (describing any change from a person's normal level of awareness, cognition, or behavior), type 2 diabetes (insulin resistance and high blood sugar levels), vitamin D deficiency (body does not have enough vitamin D, which is essential for healthy bones and muscles), unspecified cirrhosis of liver (liver is scarred and damaged), chronic kidney disease, stage 3 (kidneys have a moderate loss of function), cognitive communication deficit (condition where a person's ability to communicate effectively is impaired). Record review of Resident #56's quarterly MDS, dated [DATE] and signed 07/24/2026 as completed, reflected a BIMS score of 05, indicating severe cognitive impairment. Resident #56's functional abilities were documented as requiring dependent to substantial/maximal assistance. The falls with and without injury Resident #56 sustained during the current MDS look-back period, 07/15/2026 and the noted end date of the observation for the assessment, 07/22/2026 were not coded. Resident #56 was documented as having no falls with or without injury since prior assessment. Record review of Resident #56's quarterly MDS, dated [DATE] and signed 05/01/2026 as completed, reflected a BIMS score of 11, indicating moderate cognitive impairment. Resident #56 was documented as having no musculoskeletal Other Fracture. Resident #56's functional abilities were documented as requiring dependent to substantial/maximal assistance. Record review of Resident #56's care plan, undated and accessed 08/09/2026 at 5:44 p.m., revealed . [Resident #56] is dependent on staff etc., for meeting emotional, intellectual, physical, and social needs [related to] Physical Limitations. at risk for falls [related to] [history] of falls. unwitnessed fall in room [ROOM NUMBER]/16/026. unwitnessed fall in restroom [ROOM NUMBER]/12/2026. initiated 02/10/2026 and revised 07/27/2026. Record review of Resident #56's Hospital Discharge Report dated 07/25/2026, revealed Imaging Data CT abdomen pelvis and chest: Radiologist's impression: IMPRESSION: 1.Acute minimally displaced fractures of the left lateral eighth, ninth and 10th ribs. 2. Heterogeneity of the spleen with surrounding hyperdense fluid, concerning for splenic laceration with perisplenic hematoma. Discharge Plan Discharge. Patient Disposition: DC [discharge] to Another Hosp. Clinical Impression: Splenic laceration, Multiple rib fractures, Fall, Anemia, Chronic idiopathic thrombocytopenia, Chronic . Record review of Resident #56's #2434 Un-witnessed Fall incident report dated 07/16/2026 at 9:58 p.m., revealed Nursing Description: resident found on bathroom floor, sitting up against toilet. Resident Description: resident states, I don't not know how or why I fell. Description: head to toe assessment done, resident remains with same skin tears to left arm x 2, bandage changed and reapplied. neuros [neurological assessment] check reinitiated. Record review of Resident #56's #2433 Un-witnessed Fall incident report dated 07/1/2026 at 7:17 p.m., revealed Nursing Description: resident was on the floor in her room. Upon entering room noted resident laying supine on floor in between both beds. Also noted bleeding to Lt [left] arm. Resident Description: Resident stated she slipped after using the commode while she was on her way to lay down onto bed. Resident could not state how she slipped . Description: Head to toe and neuros (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[neurological assessment] assessed. Resident placed on bed x2 [2 person] assist. Noted 2 skin tears and 2 abrasions noted to Lt [left] arm. WC [wound care] provided to Lt [left] arm. Record review of Resident #56's #2432 Un-witnessed Fall incident report dated 07/16/2026 at 6:15 a.m., revealed Nursing Description: Heard a loud noise and went to Resident's room and found Resident sitting on the floor by her bedside table and bed, one shoe on and one shoe off with pull up at her thighs twisted and upside down. Resident Description: I was trying to go to the bathroom. Description: Resident assessed and noted skin tear to Lt. [left] elbow 2x0.5 [size]. Resident states did not hit head. Alert and oriented x 2 [oriented to person and place] . During an observation and interview on 08/12/2026 at 1:43 p.m., the MDS Nurse revealed that she was responsible for the accuracy of assessments. She stated that assessments were completed following new admission, significant change, quarterly, and discharge. She stated that assessments were for care provided to residents. She stated that assessments capture residents' care provided, medications, changes in conditions, behaviors, falls, ADL declines, psychosis, falls, etc. She stated that if assessments were inaccurate, it could impact a resident's care, and the nursing staff would not have a baseline of their care. The MDS Nurse was observed to review Resident #3's electronic medical record and stated that his quarterly MDS had several areas not coded accurately and should have been coded as having musculoskeletal Other Fracture, exhibited behavioral symptoms, including physical behavioral symptoms toward others and accurately coding active diagnoses listing either Alzheimer's Disease or Non-Alzheimer's Dementia. The MDS Nurse was observed to review Resident #40's electronic medical record and stated that her quarterly MDS inaccurately coded falls history, frequency, and number of falls with no injury and with injury. The MDS Nurse was observed to review Resident #56's electronic medical record and stated that her quarterly MDS was coded inaccurately for falls and musculoskeletal other fracture following her recent hospitalization. She stated that she would review Resident #3's, Resident #40's, and Resident #56's assessments and make corrections accordingly. During an interview on 08/12/2026 at 2:28 p.m., the DON revealed that she reviews and signs resident assessments. She stated the assessments were a story of the resident; it would paint a picture of the resident and their care. She stated the impact of inaccurate assessments could give staff members an inaccurate picture of the residents. She stated that assessment of information transfers over to care plans. She stated that the staff know the residents well and does not believe inaccurate assessments would have an impact on residents or their care. During an interview on 08/12/2026 at 3:01 p.m., the Administrator revealed that assessments report everything that occurs with the residents' care and the impact if not accurate or coded correctly would result in information being inaccurately reported to the State. She stated that inaccurate assessments would only affect the facility. Requested a policy for Assessment Accuracy from the Administrator on 08/11/2026 and 08/12/2026. The administrator stated on 08/12/2026 at 2:40 p.m. that if she did not provide us with a policy, then she did not have one.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to incorporate the recommendations from PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. for 1 of 3 (Resident #57) PASRR resident in that:Resident #57's PASRR II recommendations for a customized manual wheelchair (10/10/2025) and Occupational Therapy (8/4/2025)/Physical Therapy (7/28/2025) NFSS was submitted after 20 days. This could affect all residents on PASRR services and could result in residents on PASRR services not provided with DME or specialized services. The Findings:1.Record review of Resident 57's admission Record dated 8/9/2026 documented she was admitted on [DATE] and was discharged to the community on 3/3/2026. Resident #57 had a diagnosis is of Spina Bifida (a neural tube birth defect where the spinal column fails to close completely during the first month of pregnancy) with Hydrocephalus) (the abnormal buildup of cerebrospinal fluid in the brain's ventricles) and Cerebral Palsy (a group of permanent movement disorders that appear in early childhood). Resident #57's health insurance was Medicaid.Record review of Resident 57's discharge MDS dated [DATE] revealed she had a BIMS score of 15/15 (cognitively intact) and resident used a [NAME] wheelchair. Record review of Resident 57's care plan dated 3/3/2026 revealed she had been identified as having PASRR positive related to Spina Bifida. Interventions were customized manual wheelchair. Record review of Resident 57's PASRR II meeting dated 8/4/2025 revealed a customized manual wheelchair and OT and PT recommended. Record review of Resident #57's NFSS for customized wheelchair dated 10/2/2025 was denied on 10/10/2025 due to missing the required customized wheelchair signature page. Please have all required parties sign the signature page before 10/24/2025 The NFSS for customized wheelchair was denied on 10/24/2025 due to facility did not respond to request. Record review of Resident #57's NFSS for customized wheelchair dated 10/2/2025 was denied on 11/14/2025 due to the customized wheelchair assessment was over 30 days old and no longer valid. A new customized wheelchair request may be submitted. Record review of Resident #57's customized wheelchair receipt was dated 1/19/2026 and was signed by Resident #57 on 2/10/2026. 2.Record review of Resident #57's NFSS for Occupational Therapy dated 8/4/2025, revealed this was denied on 12/9/2025 due to date of assessment being over 30 days old and had passed the time period allotted for authorization. Record review of Resident #57's NFSS for Physical Therapy dated 8/4/2025 revealed due to assessment being over 30 days old and had passed the time period allotted for authorization. Interview on 08/12/2026 at 8:00 AM with the ADM stated they had no policy for PASSAR services and had no other comments. Interview on 8/12/2026 at 11:12 AM with the MDS nurse stated she was new and was not sure how to figure out [NAME] the PASARR specialized services worked and submission timelines. MDS nurse (responsible for PASRR residents and submitting NFSS) stated if residents did not receive the PASRR service recommendations, this would affect residents by not getting the services recommended. MDS was responsible for all the PASARR services for the residents at the facility. MDS nurse stated Resident #57 did receive her DME before she was discharged .Interview on 8/12/2026 at 4:15 PM with the DON stated residents with PASRR DME could be affected by residents not receiving their recommended services from PASSAR. Record review of policy Comprehensive care plan dated 10/24/2022 read, It is the policy of the facility to develop and implement a comprehensive person centered care plan for each resident, consistent with rights resident rights, that includes measurable objectives and time frames to meet a resident's (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy explanation and compliance guidelines; 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the residents' personal and cultural purposes in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 2. A comprehensive care plan will be developed within seven days after the completion of the comprehensive MDS assessment 3. A comprehensive care plan will be described, at a minimum the following the services that are furnished to and or maintaining delivers high flexibility physical, mental, and psychosocial well-being. Any specialized services or specialized rehabilitation services their nursing facility will provide as a result of PASARR recommendations.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure preadmissions screening for individuals with a mental disorder and individuals with intellectual disability for 1 of 6 (Resident #3) residents reviewed for PASARR accuracy. The MDS Nurse failed to accurately screen Resident #3 for mental illness upon admission to the facility. This failure could place the residents at risk of not receiving the necessary care and services. The findings included: Record review of Resident #3's admission Record, dated 08/11/2026 revealed a [AGE] year-old male admitted [DATE] and re-admitted [DATE]. Resident #3 was not listed as his own responsible party. Record review of Resident #3's Medical Diagnoses, undated and accessed 08/11/2026 at 5:15 p.m., revealed diagnoses including other specified fracture of unspecified pubis, subsequent encounter for fracture with routine healing (pelvic injury) being listed as principal diagnosis, major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest, Alzheimer's disease (most common cause of dementia), dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), and anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident #3's quarterly MDS, dated [DATE] and signed 06/09/2026 as completed, reflected a BIMS score of 00, indicating severe cognitive impairment. Resident #3 was documented with active diagnoses of Alzheimer's Disease, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Psychotic Disorder. Record review of Resident #3's care plan, undated and accessed 08/11/2026 at 5:10 p.m., revealed . [Resident #3] has potential to be physically aggressive [related to] Dementia/confusion, Alzheimer's. yelling, kicking, hitting/pinching staff. and . uses antidepressant medication [related to] Depression. initiated 11/21/2025 and revised 08/10/2026 and . [Resident #3] has an alteration in musculoskeletal status r/t fracture of the Pubis [related to] fall. initiated 11/21/2025. Record review of Resident #3's PASRR Level 1 Screening, dated 01/20/2024 and completed at the incoming nursing facility, revealed section C0090. Primary Diagnosis of Dementia: Is there evidence that dementia is the primary diagnosis for this individual (This must be listed in the medical record as the primary diagnosis by the physician) recorded as a Yes and section C0100. Mental Illness: Is there evidence or an indicator this is an individual that has a Mental Illness recorded as a No. Record review of Resident #3's electronic medical record on 08/11/2026 at 5:10 p.m., did not reveal a Mental Illness/Dementia Resident Review form 1012. Observation and interview on 08/10/2026 at 10:52 a.m. with Resident #3 revealed he was lying bed. Resident #3 was oriented to only his identity, but disoriented to place, time, and situation. Resident #3's cognition was severely impaired, and he was unable to respond to interview questions. During an observation and interview on 08/12/2026 at 1:43 p.m., the MDS Nurse revealed that she was responsible for PASARR Screening for MD & I. She stated that residents who have been found to be PASARR positive could be eligible for extra services. She stated that it was important for PASRR Level 1 Screenings to be accurate when she receives them from the incoming facility. She stated that she checks the PL1 Screening against the hospital paperwork received for residents to confirm accuracy. She stated that if PL 1 Screenings were not accurately completed upon admission, it could leave the resident without extra services they need or qualify for. The MDS Nurse was observed to review Resident #40's electronic medical record and stated that PASRR PL 1 was inaccurate at admission. She stated that dementia was not documented as the resident's primary diagnosis, thus rendering the PL 1 screening as positive. She stated that she believed that PASRR PL 1 was coded (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as ineligible as dementia was the primary diagnosis and stated that she does not see dementia or Alzheimer's listed as Resident #40's primary diagnoses, and this would be an error. She stated that she would be responsible for ensuring the medical diagnoses record reflects dementia as primary diagnoses and to secure physician documentation supporting PL1 ineligible screening. The MDS Nurse stated now that she was aware that PASARR PL1 Screening was inaccurate she will then move forward with redoing the PL1 Screening with accurate diagnoses and move forward with a positive PL1 Screening and notify the local authority for evaluation. During an interview on 08/12/2026 at 2:28 p.m., the DON revealed that if PASRR Screenings were inaccurate, the residents would not be getting all the services available that PASRR has to offer. She stated that if something in the community that was needed or wanted, like wheelchair, outings to the community; the eligible PASRR residents would fail to receive. She stated that Resident #3 does not have specialized services. She stated that Resident #3 does have behaviors, but they were manageable by the staff. During an interview on 08/12/2026 at 3:01 p.m., the Administrator revealed that the MDS Nurse should have reviewed diagnoses when reviewing PASARR Screenings provided by the hospitals. She stated that if a resident was PASRR positive MDS Nurse would continue the steps after. She stated that inaccurate PASARR Screenings could impact the services provided to the residents. She stated that nursing staff should make corrections. The Administrator stated that the plan of correction will be to ensure nursing staff reviews the PASARR Screenings for accuracy and not trust information from the hospital. Requested a policy for PASRR Screenings from the Administrator on 08/11/2026 and 08/12/2026. The administrator stated on 08/12/2026 at 2:40 p.m. that if she did not provide us with a policy, then she did not have one.		

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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 and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and 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 8 (Resident, #3 and Resident #25) residents in that: Resident #25 was not care planned for his full code status. Nursing staff failed review and revise Resident # 3's comprehensive person-centered care plan following recent behaviors prompting psychiatric assessment on 7/23/2026 that documented Resident #3 as unstable and direction to Employ use of redirection at this time. This failure could affect all residents and could result in residents not having their wants and needs identified and met. The Findings: 1. Record review of Resident #25's admission Record dated 8/12/2026 documented he was admitted on [DATE] with diagnoses of complete traumatic amputation of right foot, diabetes II, (a long-term health condition where your body does not make enough insulin or cannot use insulin the right way) and cognitive communications deficit. admission Record for #25's was documented he was a full code. Record review of Resident #25's consolidated physician orders for August 2026 documented he had an order for a full code (2/11/2026). Record review of Resident #25's admission MDS dated [DATE] documented his BIMS score was 13/15 (cognitively intact) and required a wheelchair. Record review of Resident #25's care plan dated 8/10/2026 revealed no care plan to address his code status. Interview on 08/12/2026 at 11:09 AM with the MDS nurse stated she was responsible for care plans. MDS nurse stated Resident #25's code status of Full Code should have been in his care plan. MDS nurse stated she missed the code status of Resident #25. She said the effect on residents was that they could get the wrong care. Interview on 8/12/2026 at 4:15 PM with the DON stated, residents not having a code status on their care plan, could affect residents by not having a code status. The DON stated the nurses can check the resident orders for code status. 2. Record review of Resident #3's admission Record, dated 08/11/2026 revealed a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. Resident #3 was not listed as his own responsible party. Record review of Resident #3's Medical Diagnoses, undated and accessed 08/11/2026 at 5:15 p.m., revealed diagnoses including other specified fracture of unspecified pubis, subsequent encounter for fracture with routine healing (pelvic injury) being listed as principal diagnosis, major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest, Alzheimer's disease (most common cause of dementia), dementia (syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), and anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life). Record review of Resident #3's quarterly MDS, dated [DATE] and signed 06/09/2026 as completed, reflected a BIMS score of 00, indicating severe cognitive impairment. Resident #3 was documented as having no musculoskeletal Other Fracture and was documented as having not exhibited any behavioral symptoms, including physical behavioral symptoms toward others. Resident #3 was documented with active diagnoses of Alzheimer's Disease, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Psychotic Disorder. Record review of Resident #3's care plan, undated and accessed 08/11/2026 at 5:10 p.m., revealed . [Resident #3] has potential to be physically aggressive [related to] Dementia/confusion, Alzheimer's. yelling, kicking, hitting/pinching staff. and . uses antidepressant medication [related to] Depression. initiated (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/21/2025 and revised 08/10/2026 and . [Resident #3] has an alteration in musculoskeletal status r/t fracture of the Pubis [related to] fall. initiated 11/21/2025. Record review of Resident #3's Psychiatry Subsequent Note dated 07/23/2026, revealed that visit from psychiatrist that [Resident #3] is unstable requiring psychiatric Assessment. As per collected information and interview, it appears that the patient is unstable. I feel the symptoms are occurring due to confusion. Ongoing medical stabilization, emotional support, and closer monitoring from our side would be good enough. Continue monitoring and document frequency of behaviors. Employ use of redirection at this time. Observation and interview on 08/10/2026 at 10:52 a.m. with Resident 3 revealed he was lying in bed. Resident #3 was oriented to only his identity, but disoriented to place, time, and situation. Resident #3's cognition was severely impaired and was unable to respond to interview questions. During an interview on 08/12/2026 at 11:16 a.m., LVN A revealed that care plans contained information on dietary needs activities, refusal of care, behaviors, falls, and other important information for resident care. She stated that if care plans were not updated with resident changes of condition, behaviors, and interventions, it could harm a resident's care. During an interview on 08/12/2026 at 11:50 a.m., LVN D revealed that care plans document resident's ADLs, wounds, fractures, cognition, behaviors, etc. and includes interventions to provide residents with specific care. She stated that the impact of not updating care plans frequently and with new behaviors and interventions could impact residents' care as staff would not know how to provide specific care for residents and this could injure them. During an interview on 08/12/2026 at 1:12 p.m., Social Services revealed that care plans documented advance directives, discharge planning, behavior changes, in-room activities, etc. for residents. She stated that the impact of care plans not being updated could leave staff not knowing what was going on with residents and their specific care. During an observation and interview on 08/12/2026 at 1:43 p.m., the MDS Nurse revealed that she was responsible for regularly updating care plans. She stated that care plans should include resident behaviors, ADLs, code status, in-room activities, and specific falls and interventions. She stated the impact of care plans not being updated would leave the floor staff not knowing what to do and what interventions would help residents. She stated that Resident #3's behavior should be documented on his care plan. The MDS Nurse was observed to review Resident #3's progress notes and care plan and stated that his recent behaviors documented on his progress notes should have been reviewed and should have been updated on his care plan. She stated that a revision to Resident #3's care plan should have taken place. She stated that she was working towards updating his care plan. She stated that updating Resident #3's care plan with recent behaviors would provide the nursing staff with guidance on the type of care he requires. She stated that Resident #3's care plan does have a goal and interventions regarding behaviors initiated on 11/21/2025. She stated that this goal had not been reviewed and revised following his most recent behaviors and stated that an IDT meeting should have triggered following three behavior incidents. She stated that the behaviors had been addressed during the morning nursing staff meetings; however, the care plan should have been revised to include behaviors and interventions. During an interview on 08/12/2026 at 2:28 p.m., the DON revealed that falls, activities, behaviors, 1:1 in-room activities should all be documented on the care plan. She stated that care plans were tailored to the residents and will list their specific goals and interventions. She stated that the impact of not updating care plans regularly would be a challenge to new staff as they would not know what type of care or specifics were needed for the residents. She stated that Resident #3 had a few behaviors recently, but his aggression was not out of anger it was out of confusion. She stated that the care plan could be updated. She stated that the nursing team had discussed each of his behaviors, but they were not being revised in the care plan. During an interview on 08/12/2026 at 3:01 p.m., the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator revealed that care plans should be updated frequently, should be updated with the change as they happen, new orders, and quarterly updates. She stated that if care plans were not updated or accurate, it would have an impact on the residents' care. She stated that failing to revise care plans could cause the nursing staff to miss something. She stated that care plans should be personalized and should include falls, activities, and behaviors. Record review of policy Comprehensive care plan dated 10/24/2022 read, It is the policy of the facility to develop and implement a comprehensive person centered care plan for each resident, consistent with rights resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy explanation and compliance guidelines; 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the residents' personal and cultural purposes in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 2. A comprehensive care plan will be developed within seven days after the condition of the comprehensive MDS assessment 3. A comprehensive care plan will be described, at a minimum the following the services that are furnished to tanning and or maintaining delivers high flexibility physical, mental, and psychosis well-being.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide activities based on the comprehensive assessment and care plan, designed to meet the interests of and support the physical, mental and psychosocial well-being of 2 of 8 (Resident #40 and Resident #56) residents who were reviewed for activities. The facility failed to consistently provide individualized activities and did not meet the needs of Resident #40 and Resident #56 on a weekly basis. This failure placed the residents at risk of becoming apathetic (marked indifference to the environment), isolated from others, having a depressed mood, boredom, loneliness, and a decreased quality of life. The findings included: 1. Record review of Resident #40's admission Record, dated 08/12/2026, revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Resident #40 was not listed as her own responsible party. Record review Resident #40's Medical Diagnoses, undated and accessed 08/12/2026 at 3:34 p.m., revealed diagnoses including major depressive disorder (serious mental disorder that negatively affects how you feel, think, act, and perceive the world.), muscle wasting and atrophy (Muscle atrophy is the wasting or thinning of muscle mass.), Parkinson's disease (a disorder of the nervous system that affects movement and gets worse over time.), and dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.). Record review of Resident #40's quarterly MDS Assessment, dated 07/06/2026 and signed 07/08/2026 as completed, reflected a BIMS score of 00, indicating severe cognitive impairment. Resident #40's functional limitations in range of motion were documented with impairment on both sides of upper and lower extremities, and functional abilities were documented as dependent on staff. Record review of Resident #40's care plan, undated and accessed 08/12/2026 at 3:36 p.m., revealed . [Resident #40] has impaired cognitive function/dementia or impaired thought process [related to] Dementia.has little or no activity involvement [related to] Physical Limitations and cognitive impairment initiated 04/22/2021. Interventions included 1 on 1 activities in room initiated 03/08/2024 and Encourage the resident's participation daily. Record Review of Resident #40's Activity Progress Notes dated 08/11/2026 and handwritten entries undated and accessed 08/11/2026 at 5:50 p.m., revealed 9 in-room activity entries were documented for the last 12 months: 11/10/2025, 11/26/2025, 12/29/2025, 01/29/2026, 03/02/2026, 04/27/2026, 06/20/2026, 07/20/2026, and 08/10/2026. Observation and interview on 08/09/2026 at 1:14 p.m. with Resident #40 revealed she was lying in bed. Resident #40's cognition was severely impaired and was non-interviewable. 2. Record review of Resident #56's admission Record, dated 08/09/2026 revealed an [AGE] year-old female admitted [DATE] and re-admitted [DATE]. Resident #56 was not listed as her own responsible party. Record review of Resident #56's Medical Diagnoses, undated and accessed 08/09/2026 4:20 p.m., revealed diagnoses including laceration of spleen, wedge compression fracture of T7-T8 vertebra (thoracic spine injury where the front of the vertebral body collapses into a wedge shape), subsequent, encounter for fracture with routine healing, age-related osteoporosis with current pathological fracture, fracture of upper end of right humerus, with routine healing, fracture of unspecified part of neck of right femur (refers to a break in the region connecting the femoral head to the femoral shaft.), depression (mental state of low mood), altered mental status (describing any change from a person's normal level of awareness, cognition, or behavior), type 2 diabetes (insulin resistance and high blood sugar levels), vitamin D deficiency (body does not have enough vitamin D, which is essential for healthy bones and muscles), unspecified cirrhosis of liver (liver is scarred and damaged), chronic kidney disease, stage 3 (kidneys have a moderate loss of function), cognitive communication deficit (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(condition where a person's ability to communicate effectively is impaired). Record review of Resident #56's quarterly MDS, dated [DATE] and signed 07/24/2026 as completed, reflected a BIMS score of 05, indicating severe cognitive impairment. Resident #56's functional abilities were documented as requiring dependent to substantial/maximal assistance. Record review of Resident #56's care plan, undated and accessed 08/09/2026 at 5:44 p.m., revealed . [Resident #56] is dependent on staff etc., for meeting emotional, intellectual, physical, and social needs [related to] Physical Limitations. with Interventions to Ensure that the activities the resident is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences. Invite the resident to scheduled activities. Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility. The resident needs 1: 1 bedside/in-room visits and activities if unable to attend out of room events. initiated 02/25/2026 and The resident has little or no activity involvement initiated and resolved date 06/12/2026. Record Review of Resident #56's Activities - Quarterly Participation Review dated 07/22/2026, revealed [Resident #56] participates in one on one and group activities. Progress Toward Residents Activity goals were documented as goals were met. Record Review of Resident #56's Activity Note dated 08/11/2026 and handwritten entries undated and accessed 08/11/2026 at 5:50 p.m., revealed 4 in-room activity entries were documented for the last 12 months: 01/26/2026, 05/14/2026, 07/02/2026, and 08/09/2026. Observation and interview on 08/09/2026 at 1:14 p.m. with Resident #56 revealed she was lying in bed. Resident #56's cognition was severely impaired and was non-interviewable. During an observation and interview on 08/11/2026 at 5:50 p.m., the Activity Director revealed that non-verbal and non-ambulatory residents who were unable to join in the group activities will be provided with in-room activities. She stated she documents activities in the resident's electronic medical record and will keep a handwritten log for each group and individual in-room activity provided to residents. She stated that the impact of not receiving activity services on a regular basis would cause a resident to become sad. She stated that all residents deserve attention and some sort of engagement in activities. The Activity Director stated that Resident #56 was provided with strictly in-room activities. The Activity Director reviewed Resident #40's and Resident #56's electronic medical record and handwritten activity logs and stated only nine entries had been documented for Resident #40 and only four entries had been documented for Resident #56 in a year period. She stated that she was unsure as to why few entries were documented for each resident and she was unable to locate additional entries. During an interview on 08/12/2026 at 10:37 a.m., CNA C stated that she believed that Resident #40 received daily activities in her room, but could not recall frequency, or which staff provided this service. She stated that Resident #56 was total care and believed that staff provided in-room activities for her, but she could not recall frequency. During an interview on 08/12/2026 at 10:56 a.m., MA N revealed that she was unsure if total care residents received in-room activities. During an interview on 08/12/2026 at 11:16 a.m., LVN A revealed that the Activity Director provides residents with bingo in the morning in the dining room and offers activities in-room. She stated that she had seen the Activity Director provide in-room activities to Resident #40, but she was not sure what activities were provided and could not recall how often or frequency of these activities. During an interview on 08/12/2026 at 11:50 a.m., LVN D revealed that the in-room activities were necessary for non-verbal and non-ambulatory residents. She stated that the impact of not receiving activities often could cause a resident depression and they would not feel safe. She stated that the Activity Director does visit the hall daily and sees how residents are doing but stated that she was not sure of the frequency of activities provided for Resident #40 and Resident #56. During an interview on 08/12/2026 at 1:12 p.m., Social Services revealed that the Activity Director (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided in-room activities to non-ambulatory residents. She stated that if residents did not receive in-room activities on a regular basis, it could cause them to be emotional and to withdraw. She stated she could not recall if Resident #40 and Resident #56 received in-room activities and could not provide information into the frequency. During an interview on 08/12/2026 at 1:43 p.m., the MDS Nurse revealed that she and the Activity Director were responsible for ensuring 1:1 in-room activities were appropriate for residents who are non-ambulatory, non-verbal, or refuse to engage in group activities. She stated she was not sure of the frequency of activities and stated that one in-room activity per month would not be appropriate to meet the residents' needs. She stated that three times per week would be an appropriate amount of time to provide in-room activities. She stated that if residents were offered only one in-room activity a month would be seen as isolation. She stated she could not recall the last time she had worked with the Activity Director to ensure activities were appropriate for residents and if activities were being provided. She stated that she was aware that Resident #40 was documented as 1:1 in-room activities on her care plan but could not recall the frequency of activities and stated she was unsure if activities were being provided for her. The MDS Nurse stated that prior to her recent hospital visit Resident #56 would come out of her room every now and then engage in group activities. She stated that Resident #56 now requires 1:1 in-room activities and believed they were provided by the Activity Director but stated she could not provide frequency of activities being provided but would begin working with the Activity Director to ensure activities and frequency of activities were being documented. During an interview on 08/12/2026 at 2:28 p.m., the DON revealed that 1:1 in-room activities should be provided to bedbound residents, but she was not sure of the regulations for activities and frequency. She stated that she was not familiar with what activities the Activity Director was providing for bedbound residents. During an interview on 08/12/2026 at 3:01 p.m., the Administrator revealed that in-room activities should be provided for residents if they were not participating in group activities. She stated that in-room activities should be provided often but stated that she was not familiar with the regulations on frequency and would need to look further into this. She stated that 9 in-room activities in a 12-month period were not sufficient as residents need the connection, and this could have an impact on the residents' mental health and cause them to get depressed and feel lonely. The Administrator stated that regional staff visited and checked in on activities, but in general she, as the Administrator, should have known and should have checked in with the Activity Director and the activities she provided for the residents and ensure it meets the needs of each resident. Requested a policy for Activities from the Administrator on 08/11/2026 and 08/12/2026. The administrator stated on 08/12/2026 at 2:40 p.m. that if she did not provide us with a policy, then she did not have one.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure a resident who was incontinent with bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #58) of 1 resident reviewed for catheter care. The facility failed to ensure Resident #58 had a leg strap to secure her indwelling urinary catheter tubing. This deficient practice could place residents at risk of complications and infection from movement at the insertion site. The findings included: Record review of Resident #58's admission Record dated 08/11/2026 reflected an [AGE] year-old female newly admitted on [DATE] with diagnoses of secondary malignant neoplasm (cancer that has spread from its original site to another area of the body), fracture of superior rim of left pubis (a break in the upper bone at the front of the pelvis), and dementia (loss of memory, language, problem-solving and other thinking abilities). Record review for Resident #58 indicated an Entry MDS dated [DATE], Admission/Medicare 5-day MDS in progress. Record review of Resident #58's Care Plan Report reflected: Problem: The resident has Indwelling Foley Catheter, Date Initiated: 08/06/2026, Revision on: 08/10/2026, and Goal: The resident will be/remain free from catheter-related trauma through review date, Date Initiated: 08/06/2026. The care plan did not reflect the need for a leg strap to secure the tubing. Record review of Resident #58's Order Summary Report indicated orders for: Indwelling Catheter: Size 16Fr with balloon 10cc (Dx: Peritoneal CA (affects the peritoneum, the thin tissue lining the belly and organs) every shift. Active 08/06/2026, and Check Indwelling Urinary catheter use securement device every shift for urinary retention, Use leg strap to secure Foley in place. Active 08/06/2026. Observation of catheter care on 08/11/2026 at 9:24 a.m. for Resident #58 revealed she had an indwelling urinary catheter and did not have a leg strap/securement device in place. During an interview with CNA B on 08/11/2026 at 9:40 a.m., CNA B stated the resident did not have her catheter tubing secured to her leg, but it should have been. CNA B stated the purpose of securing the catheter is to prevent pulling on the tubing which could cause it to come out and cause an infection if the catheter must be reinserted. CNA B stated that if the leg securement device is not in place, the charge nurse is notified to replace it. During an interview with LVN D on 08/11/2026 at 10:45 a.m., LVN D stated there is an order to check placement of urinary tubing securement device every shift. LVN D stated she does not know why Resident #58's securement device was not in place because she checks it at the beginning of the shift, so it must have come off for some reason. LVN D stated the possible consequences of not having the tubing secured could be bleeding, pain, or irritation to the residents if the catheter is pulled. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2026
NAME OF PROVIDER OR SUPPLIER Val Verde Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/11/2026 4:15 PM with ADM stated she did not have policy for catheter care. During an interview with DON on 08/12/2026 at 10:30 a.m., the DON stated it was her expectation that urinary catheter tubing be secured to prevent the catheter from being pulled or causing pain to the resident. DON stated Resident #58 had been having incontinent episodes, and the securement device probably came off, and the CNAs should be notifying the nurse if a securement device needs to be replaced. The DON stated there is no facility policy related to catheter care.		

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NAME OF PROVIDER OR SUPPLIER Val Verde Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Hermann Dr Del Rio, TX 78840	
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #35) of 7 residents reviewed for medication administration in that: The facility failed to accurately transcribe a physician-ordered medication onto Resident #35's Medication Administration Record. As a result, the medication was reflected on the MAR with an incorrect route of administration. This failure could place residents at risk of injury due to incorrect medication administration and inaccurate orders. Findings included: Record review of Resident #35's admission Record dated 08/11/2026, revealed the resident was an [AGE] year-old male, admitted to the facility on [DATE], with diagnoses of cerebral infarction (when a blocked artery or blood clot stops blood and oxygen from reaching part of the brain), dysphagia oropharyngeal phase (swallowing problems occurring in the mouth and throat), and gastrostomy status (a tube placed directly into the stomach through the abdomen). Record review of Resident #35's quarterly MDS submitted 08/04/2026 reflected in section C0100: 0. No (resident is rarely/never understood), section K Swallowing/Nutritional Status, K0520: B Feeding tube. Record review of Resident #35's Care Plan Report revealed: Problem: The resident requires tube feeding r/t stroke. Date Initiated: 02/26/2026, Revision on: 03/24/2026 with Goal: The resident will be free of aspiration through the review date. Date Initiated: 02/26/2026, Revision on: 03/16/2026. Record review of Resident #35's Order Summary Report indicated an order for Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain give 2 tablets to = 650 mg, active 07/29/2026, and NPO diet NPO texture, NPO (Nothing by Mouth) consistency, related to dysphagia following cerebral infarction, active 02/27/2026. During an observation of g-tube medication administration on 08/11/2026 at 6:55 a.m., Resident #35 did not receive acetaminophen, and all scheduled medications were administered through gastrostomy tube. Record review of Administration Record Report MAR dated 07/01/2026-07/31/2026 indicated that on 07/29/2026, Resident #35 received 650mg of acetaminophen at 7:02 a.m., with no other administered doses documented. During an interview LVN A on 08/11/2026 at 10:10 a.m., LVN A reviewed the order for Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain give 2 tablets to = 650 mg and stated the order instructions indicated to give the medication by mouth. LVN A stated Resident #35 is NPO and does not take anything by mouth. LVN A stated that she was the nurse who received the original order from the physician. LVN A stated she must have accidentally (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Val Verde Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Hermann Dr Del Rio, TX 78840	
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	marked the wrong route of administration when transcribing the order into PCC. LVN A stated she gave one dose of the medication on the day it was ordered, but she administered the medication through the gastrostomy tube because she is aware the resident has an order for NPO. If he were given a medication by mouth, he could choke and aspirate. LVN A stated that she would clarify the order with the physician and update the order with the correct administration route. During an interview with the DON on 08/12/2026 at 10:30 a.m., the DON stated the charge nurse receiving a physician order is responsible for transcribing the order into electronic medical record (PCC-point click care) right away. New orders are reviewed every morning by the nurse managers. DON stated the order was likely reviewed, but the incorrect route of administration was missed by the team. DON stated the possible consequences of administering medication orally when a resident is NPO status included choking or aspiration. Record review of policy Medication Reconciliation dated 04/10/23 read: 5. Daily Processes: b. Verify medication labels match physician orders and consider rights of medication administration each time a medication is given, and c. Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarifications as needed.		

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews and record reviews, the facility failed to ensure the Nurse Staffing Information. Data requirements. The facility must post the following information on a daily basis. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift and Resident census. Posting requirements. The facility must post the nurse staffing data of this section on a daily basis at the beginning of each shift. Data must be posted as follows: Clear and readable format. In a prominent place readily accessible to residents, staff, and visitors. Public access to posted nurse staffing data. Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater for 1 of 1 nursing home in that: The Nurse Staffing posting was not posted on the correct date, and for some nursing staffing posting the data of census and actual hours were missing. The Facility failed to ensure the retained 10 months of Nurse Staffing posting. This could affect all residents and visitors and could result in not having who was working for the day, was not available to public to view. The Finding: Observations on 8/09/2026 at 11:50 AM revealed the Nurse Staffing posting dated 8/7/2026 was missing the actual hours (this was posted on the wall). The Nurse Staffing posting was kept in a clear 8 by 11 folder posted on wall. There were 2 days of Nurse Staffing posting on the wall at a time. Observation on 8/09/2026 at 11:51 AM revealed the Nurse Staffing posting, dated 8/10/2026, had no actual hours and no census. The Nurse Staffing posting for 8/9/2026 was missing for the day. Interview on 8/11/2026 at 2:51 PM with ADON (person responsible for posting the Nurse Staffing posting), stated she posted the next day's Nurse Staffing posting before she left for the day. ADON stated the Nurse Staffing posting for 8/9/2026 was posted behind the 8/7/2026 Nurse Staffing posting. ADON stated she kept all the Nurse Staffing posting together, and some were behind each other. ADON stated no staff were responsible for ensuring the correct date for the Nurse Staffing posting. ADON stated they had retained 10 months of Nurse Staffing posting but will continue to look. No additional evidence was provided. Interview on 8/12/2026 at 8:00 AM with ADM stated there was no policy for Nurse staffing posting. Interview on 8/12/2026 at 4:15 PM with DON stated she did not believe having the correct information or missing Nurse Staffing posting could affect residents and visitors and residents could ask the charge nurse. Record review of Nurse Staffing posting from October to December 31, 2025, reflected they were missing the actual hours staff worked. Record Review of Nurse Staffing posting for January 2026, Nurse Staffing posting dated, 1/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28/2026, and 1/30-31/2026 reflected they were missing the actual hours staff worked. Nurse staffing posting for 1/29/2026 Nurse staffing posting sheet was missing. Record Review of Nurse Staffing posted for February 2/, 2, 5, 6, 8/2026 reflected they were missing the actual hours. For 2/9, 28/2026 the census was missing. Record Review of Nurse Staffing posted for March 3/1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30/2026 and 3/28, 29, 30/2026 reflected they were missing the census. Record Review of Nurse Staffing posted for May 5/23, 24, 25, 26, 28, 30, 31/2026 reflected they were missing the census. Record Review of Nurse Staffing posted June 6/17, 20, 21, 22, 24, 27, 28, 30/2026 reflected they were missing the census.		