STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uvalde Healthcare and Rehabilitation Center	535 N Park St Uvalde, TX 78801

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 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews, and record reviews the facility failed to ensure residents had the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers, for 1 of 16 residents (Resident #14) reviewed for advance education for medication benefits versus risks. The facility administered medroxyprogesterone, a type of hormone (progestin), from June 2023 to March 2024 to Resident #14 without Resident #14 and/or Resident #14's representative receiving education on the rationale for the prescription, the benefits vs. the risks of medroxyprogesterone and offered options for treatment. An Immediate Jeopardy (IJ) was identified on 03/15/2024. The IJ was provided to the facility on [DATE] at 08:05 PM. While the IJ was removed on 03/18/2024, the facility remained out of compliance at a scope of isolated with a severity level of potential harm because of the facility's need to evaluate the effectiveness of their corrective actions. This failure denied the resident their right to participate in their care and treatment and placed other residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party or being aware of the benefits and risks of the medications prescribed. The findings included : A review of Resident #14's admission record dated 03/14/2024, revealed an admitted [DATE] with diagnoses which included dementia, psychotic disturbance, mood disturbance, anxiety, and alcohol use. The admission record revealed Resident #14 had two representatives. A record review of Resident #14' quarterly MDS assessment revealed Resident #14 was a [AGE] year-old male admitted for long term care assessed with a BIMS score of 5 which indicated severe cognitive impairment . A record review of Resident #14's physicians orders, dated 03/14/2024, revealed the physician prescribed medroxyprogesterone (a hormone which help other hormones start and stop the menstrual cycle) 10 mg once a day at bedtime. (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: 675532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
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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 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #14's medication Administration Records for June, July, August, September, October, November, December 2023, and January, February, March 2024 revealed Resident #14 was receiving medroxyprogesterone daily. Record review of Resident #14's medical record revealed no evidence Resident #14 and or his representatives received any education on the rationale for the prescription, benefits vs risks, or potential adverse reactions of the prescribed medroxyprogesterone. A record review of the National Library of Medicine's website, https://www.ncbi.nlm.nih. gov/books/NBK559192/ , Medroxyprogesterone .Last Update: June 30, 2022 revealed, Continuing Education Activity: This article highlights medroxyprogesterone .This activity discusses the mechanism of action, adverse effects, monitoring, and contraindications for medroxyprogesterone. Also, it highlights the important role that providers play in administering medroxyprogesterone and regularly monitoring patients for side effects . Off-Label Indications: Paraphilia/hypersexuality . Both genders reported experiencing changes in breast and sexual function . Patients currently using medroxyprogesterone for paraphilia/hypersexuality, LFTs (liver function tests), CBC (complete blood count), serum testosterone (male hormone), LH, FSH (a lab for decreased functional activity of the gonads (ovaries or testes)), and glucose require regular monitoring. Also, if serum testosterone shows a marked decrease, consider an annual bone scan. A record review of Resident #14's medical records revealed no evidence Resident #14 received monitoring and or lab studies for the potential adverse effects of the female hormone medroxyprogesterone he was prescribed and administered for 9.5 months. During an interview on 03/13/24 at 02:29 PM LVN K stated she had been the charge nurse for Resident #14. LVN K stated Resident #14 had a history of aggressive sexual harassment behaviors towards staff and Resident s. LVN K stated Resident #14 had been prescribed medroxyprogesterone. LVN K stated the medication aide had administered Resident #14's medroxyprogesterone. LVN K stated there had been no monitoring measures for testosterone levels or breast tenderness . During an interview on 03/14/2024 at 03:00 PM Dr. Y stated he was the primary care physician for Resident #14. Dr. Y stated he had received reports from nursing staff, in June of 2023, that Resident #14 was developing unwanted sexual behaviors towards staff, and he prescribed medroxyprogesterone, a hormone prescribed to reduce Resident #14's unwanted sexual harassment behaviors. Dr. Y stated he had trust and faith the nursing staff would have advised Resident #14 and his representatives of the new medication to include rationale for the prescription, risks versus benefits, and potential adverse reactions. Dr. Y stated since June 2023 he had not received any reports from the nursing staff for any signs and or symptoms of adverse effects from the medroxyprogesterone . (continued on next page)

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F 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/15/2024 at 02:44 PM Resident #14's 2 representatives stated Resident #14 occasionally had behaviors where he would become upset and would be calmed by the facility when offered non-alcoholic beer, he doesn't know the difference, and the representatives would call and further calm Resident #14. Resident #14's representatives stated Resident #14 was not able to receive education on the rationale, benefits vs risks of any prescribed medications. Resident #14's representatives stated they were unaware of Resident #14's inappropriate sexual behaviors towards female residents. Resident #14's representatives stated they were not informed Resident #14 was prescribed and administered a hormone to reduce his sexual inappropriate behaviors. Resident #14's representatives stated they had not received any education on the rationale, benefits vs risks of the prescribed medroxyprogesterone, and stated We have no idea what the drug is and what it does. The facility called us today to schedule a meeting next week, but they did not report to us any information on any drugs and or past sexual behaviors. During an interview on 03/18/24 at 02:20 PM LVN N stated she was the charge nurse who reported in June 2023 Resident #14's sexual harassment behaviors and received from Dr. Y the order for medroxyprogesterone. LVN N stated she had not clarified Resident #14's medroxyprogesterone order for monitoring for adverse effects of the medroxyprogesterone, breast tenderness and or laboratory test for monitoring Resident #14's testosterone blood levels, because it did not occur to her. LVN N stated she had not consulted with Resident #14 and or his representatives to provided informed consent to include the rationale for the medroxyprogesterone, the benefits versus the risk, and the potential adverse effects of the medroxyprogesterone prior to the administration of the medroxyprogesterone. LVN N stated not having provided Resident #14 the opportunity to receive education for benefits vs risks of medroxyprogesterone would deny him his right to participate in his plan of care and to consent or refuse the care. During an interview on 03/18/24 at 03:50 PM the MDS Nurse stated a review of Resident #14's medical record revealed no evidence for laboratory studies for testosterone, no monitoring for adverse effects medroxyprogesterone, no evidence for education for benefits vs risks of medroxyprogesterone, no care plan summaries to reveal Resident #14 and or the representatives received education for benefits vs risks of medroxyprogesterone. The MDS Nurse stated not having provided Resident #14 the opportunity to receive education for benefits vs risks of medroxyprogesterone would deny him his right to participate in his plan of care and to consent or refuse the care. During an interview on 03/18/2024 at 05:20 PM the Administrator stated the policy and expectation was for residents to receive informed consent prior to the initial dose of any medication and or treatment. The Administrator stated going forward he would ensure residents received from the physician and or nursing staff the rational for the new prescription and or treatment, the risks versus benefits, and potential adverse reactions. The Administrator stated not having provided Resident #14, or any resident, the opportunity to receive education for benefits vs risks of a medication and or treatment would deny their rights to participate in their plan of care and to consent or refuse the care. During an interview on 03/18/2024 at 05:31 PM the ADON stated a review of Resident #14's medical record revealed no evidence for laboratory studies for testosterone, no monitoring for adverse effects medroxyprogesterone, no evidence for education for benefits vs risks of medroxyprogesterone, no care plan summaries to reveal Resident #14 and or representatives received education for benefits vs risks of medroxyprogesterone. The ADON stated not having provided Resident #14 the opportunity to receive education for benefits vs risks of medroxyprogesterone would deny him his right to participate in his plan of care and to consent or refuse the care. (continued on next page)

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F 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's Resident Participation - Assessment/Care Plans policy dated February 2021, revealed, the Resident/representatives right to participate in the development and implementation of his or her plan of care includes the right to: participate in the planning process; identify individuals to be included in the planning process; request meetings; request revisions to the plan of care; participate in the establishing his or her goals and expected outcomes of care; participate in the type, amount, frequency, and duration of care; receive the services and or items included in the care plan; be informed, in advance, of changes to the plan of care; refuse, request changes to and or discontinued care or treatment offered or proposed; be informed, in advance by the physician more professionals, of the risks and benefits of the care or treatment proposed . The following Plan of Removal submitted by the facility was accepted on 03/17/2024 at 07:08 AM. POR Verification Problem: F552 Failure to ensure resident had the right to be informed of, and participate in, his or her treatment Interventions: o Resident #14's Responsible Party was notified, according to progress notes, again of orders for Resident #14 to be prescribed medroxyprogesterone. Record review of progress note, dated 03/17/2024 at 1:12 PM, reflected that the MDS Coordinator, spoke with Resident #14's responsible parties to include educating on risk vs benefits of medroxyprogesterone. The progress notes further revealed that the responsible party voiced their understanding of the medication and its side effects and agreed that it was beneficial for the resident to remain on the medication. Interview on 3/18/2024 at 1:06 PM, the Administrator stated that Resident #14's responsible party was notified of the orders for medroxyprogesterone on 3/17/2024. o Resident #14's care plan was updated to reflect responsible party's notification of the medication being prescribed. Record review of the care plan, dated 3/15/2024, reflected Problem: Resident #14 is taking hormone medroxyprogesterone with Approach: Education provided to family as to risk vs benefit of medication. o Any new medication or treatment that Resident #14 (or any other resident) is prescribed will be assessed by nurse staff for a minimum of 72 hours. Record review of Resident #14 progress notes reflected an assessment of adverse reactions by nursing staff on medications. Interview on 3/18/2024 at 1:09 PM, the Administrator stated the assessments of adverse reactions of the new medication or treatments for Resident #14 were in the progress notes. (continued on next page)

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F 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees, 10 were nurses. A sample of 8 nurses, 5 on day shift and 3 on night shift , were interviewed to confirm receiving in-services and training on recognizing the side effects of the medication Medroxyprogesterone. o The need for education regarding adverse effects, risks vs. benefits, etc. of treatment before treatment begins, was identified, and in-servicing has begun by administrator; in-servicing will be completed by the end of business on 3/17/2024. This in-service is to include all nurses, and any nurse not in-serviced will not be allowed to perform duties until they are in-serviced. Interview on 3/17/2024 at 3:15 PM, the MDS Coordinator revealed that nursing staff who had not been in-serviced would be allowed to perform duties until they had been in-serviced. Record review of document titled In-Service Training, dated 3/15/2024, with the topic The Importance of Reporting Events to Physicians and Emergency Contacts revealed 7 of 11 nursing staff as having completed the in-service. o The following in-services were initiated on 3/14-16/2024: All available nursing staff will begin being in-serviced on 3/15/2024. Any nursing staff member not present or in-serviced, will not be allowed to assume their duties until in-serviced. Administrator/Designee to ensure that in service training has been done for all nurse staff. o All Nurse Staff) nurses, CNA, MA) o Abuse/Neglect o The importance of reporting events to physicians and responsible parties A record review of the facility's employee roster dated, 03/16/2024 revealed 71 employees. 57% of employees, 44 of the 74, were interviewed to confirm receiving in-services for IJ F552 The Right to Participate in Their Care. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees, 10 were nurses. A sample of 8 nurses, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F552 The Right to Participate in Their Care. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees 17 were CNAs. A sample of 8 CNAs, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F552 The Right to Participate in Their Care. Record review of document titled Staff in-service, dated 3/15/2024, with the topic Abuse/Neglect Inservice revealed 46 of 71 staff signed off as having completed the in-service. Interview on 3/17/2024 at 3:15 PM, the MDS Coordinator revealed that not all staff reported to physicians or emergency contacts, and that only 11 nurses would be responsible with reporting any events to physicians and emergency contacts. (continued on next page)

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F 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a document titled In-Service Training, dated 3/15/2024, with the topic The Importance of Reporting Events to Physicians and Emergency Contacts revealed 7 of 11 nursing staff signed off as having completed the in-service. Record review of document titled Staff in-service, dated 3/15/2024, with the topic Any staff who is turning off the lights and shutting the doors to any room shall check the room for any other persons prior to turning off the lights and shutting the door. Further review of this in-service revealed 49 of 71 staff signed off as having completed the in-service. Interview on 3/17/2024 at 12:30 PM, LVN N revealed that the in-service consisted of abuse and neglect prevention, complaints, when and where to file grievances and who to report grievances to. Interview on 3/17/2024 at 12:33 PM, CNA J stated that the in-service consisted of ensuring no residents are locked in shower rooms and monitoring showers and reporting to nursing staff. Interview on 3/17/2024 at 12:34 PM, CNA I stated that the in-service she received detailed ensuring that grievances are recognized and reported. Interview on 3/17/2024 at 1:35 PM, CNA P stated the in-service detailed abuse, neglect, exploitation, and discussing any of these concerns with the administrator. Interview on 3/17/2024 at 2:04 PM, LVN K stated her most recent in-service consisted of abuse and neglect training, to include specifics about what is abuse and neglect, changes in conditions, and when to notify family and physicians. Interview on 3/17/2024 at 3:00 PM, LVN R stated the in-service she had most recently consisted of ensuring residents' complaints were recognized and grievances were filed. Interview on 3/17/2024 at 4:13 PM, CNA O stated the in-service they completed on 3/15/2024 consisted of reporting grievances and who to give them to. Interview on 3/17/2024 at 4:23 PM, LVN T stated the most recent in-service was about abuse and neglect and reporting any abuse or neglect to supervisors, as well as reporting to physicians. Monitoring: o DON/Designee will perform a weekly audit of EMR to ensure that resident and/or responsible parties are being notified and educated with regard to any treatment changes, including but not limited to, any possible adverse effects, risks and benefits, or any alternative treatments that might be available BEFORE any changes are made Record review reflected a facility activity report, detailing each residents EMR, signed as Reviewed by the Administrator and DON on 3/16/2024. Interview on 3/18/2024 at 10:36 AM, the Administrator stated that the DON would be performing a weekly audit of the EMR. (continued on next page)

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F 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o This weekly audit will be monitored on an ongoing weekly basis, to be integrated into the normal work routine of the nurse management team. Initial audit to be performed on 3/16/2024 by DON/Designee. Interview on 3/18/2024 at 10:36 AM, the Administrator stated that the DON will be performing a weekly audit of the EMR. Record review reflected a facility activity report, detailing each residents EMR, signed as Reviewed by the Administrator and DON on 3/16/2024. o The QAPI committee will review findings monthly for no less than 90 days and makes changes as needed Interview on 3/18/2024 at 10:36 AM, the Administrator stated that during QAPI they will follow a template relating to the deficiencies and discuss any changes or suggestions relating to any changes in care for residents with all members of the QAPI committee. An Immediate Jeopardy (IJ) was identified on 03/15/2024. The IJ was provided to the facility on [DATE] at 08:05 PM. While the IJ was removed on 03/18/2024, the facility remained out of compliance at a scope of isolated with a severity level of potential harm because of the facility's need to evaluate the effectiveness of their corrective actions.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for 2 of 18 residents (Residents #14 and #23) reviewed for physician notification of changes. 1 . The facility failed to inform Resident #14's physician when Resident #14 made sexual lewd comments towards female residents and entered Resident #23's shower room while she was showering on 02/06/2024 and again on 03/12/2024 and unsuccessfully attempted to enter Resident #23's shower room on 02/15/2024. 2. The facility failed to inform Resident #23's physician when Resident #14 entered Resident #23's shower room while she was showering on 02/06/2024, again on 03/12/2024, and unsuccessfully attempted to enter Resident #23's shower room on 02/15/2024. An Immediate Jeopardy (IJ) was identified on 03/15/2024. The IJ was provided to the facility on [DATE] at 08:05 PM. While the IJ was removed on 03/18/2024, the facility remained out of compliance at a scope of isolated with a severity level of potential harm because of the facility's need to evaluate the effectiveness of their corrective actions. This failure denied residents and their physicians accurate and timely assessments so the physician could intervene with care. The findings included : 1. A record review of Resident #14's admission record dated 03/14/2024, revealed an admitted [DATE] with diagnoses which included dementia, psychotic disturbance, mood disturbance, anxiety, and alcohol use. Resident #14's admission record revealed Resident #14 had two representatives. A record review of Resident #14' quarterly MDS assessment revealed Resident #14 was a [AGE] year-old male admitted for long term care assessed with a BIMS score of 5 which indicated severe cognitive impairment . A record review of Resident #14's care plan dated 03/14/2024 revealed, Resident has episodes of inappropriate behaviors AEB (As Evidenced By) disrobes in public areas, sexual innuendos/gestures . Problem Start Date: 06/26/2023 . Behavioral episodes will be reduced to less than daily over the next 90 days . Monitor and chart behaviors and report to MD . A record review of Resident #14's nursing progress notes revealed LVN A documented on 06/07/2023, Resident urinated in shower room. Redirected resident to room and told resident that was not appropriate. Resident resting in bed . we'll continue to monitor. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of Resident #14's nursing progress notes revealed the DON documented on 08/18/2023, Resident sitting in dining room having non-alcoholic beverage. Activity director states that he was having a behavior issue earlier. He kept signaling to female resident to go to shower with him to shower . asked him to stop, he replied she wants to. Resident was redirected and asked to stop behavior . A record review of Resident #14's nursing progress note dated 08/28/2023 revealed LVN A documented, . resident had sexual behaviors this evening was blowing kisses and saying I love you to this writer when providing care - when resident started rubbing his private area through shorts, he was told that was inappropriate and this writer lowered the bed, close the curtain, and stepped out of room. call light within reach. A record review of Resident #14's nursing progress note dated 09/19/2023 revealed LVN AA documented, resident is showing sexual behaviors with aides, continues to tell aides to touch him down there, stating that he likes it, and throws kisses, blinking his eye. A record review of Resident #14's nursing progress note dated 02/06/2024 revealed LVN A documented, this writer was paged to station 1 where this resident was standing in the middle of the shower room while there was already a female resident using it (Resident #23). This resident refused to leave the Shower room after being told several times there was a female showering. The resident did not leave until an aide agreed to shower him in a different room once she was done with her round. A record review of Resident #14's nursing progress note dated 02/15/2024 revealed LVN A documented, resident came to station one and started calling this writer a 'pendeja' ([NAME] -a derogatory name in Spanish) and demanding that this writer take him into the shower (in Spanish) writer told resident to go back to his room and would let his nurse know. Difficult to redirect. resident kept shaking shower door handle on station 1 after being told several times there was a female resident using the shower. this is not the first-time resident becomes aggressive. resident does not belong to station one but will still come to this station to yell and demand to be showered. A record review of Resident #14's nursing progress note dated 03/12/2024 revealed LVN A documented, ad 0015 (15 minutes past midnight) Resident (#14) walked into station one shower while a female Resident (Resident #23) was using it and refused to leave. Resident (#14) became angry when asked to leave and walked to 700 hall and started opening several rooms - Resident (#14) kept stating he wanted to leave the facility (Spanish speaking). Resident (#14) was cussing and doing sexual gestures to staff. Resident (#14) was repeatedly told that was inappropriate and to stop. Resident (#14) replied I don't give a F*** I'm leaving (Spanish speaking). Resident (#14) walked to front hallway and started shaking door handles and running shoulder into door to force it open. Resident (#14) went to front door and pushed it open - this writer and CNA we're trying to hold it closed as resident repeatedly pushed on it. This writer called [Resident #14] representative and she was able to talk resident down. Resident stated to representative he wanted to be showered - [Resident #14's] representative was told tomorrow is Resident's shower day. [Resident #14's] representative was still on the phone while Resident (#14) was making sexual gestures to staff and was made aware. [Resident #14's] representative told Resident (#14) she would come to facility tomorrow to speak with him . attempted to call the DON and the ADON no answer. called the administrator made aware. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of Resident #14's medical record, on 03/14/2024, revealed no evidence for providing the physician with reports where Resident #14 had increased sexual harassment behaviors towards residents since June 2023. During an interview on 03/13/24 at 04:15 PM the BOM stated Resident #23 had complained in early February about Resident #14 trying to get into her shower room. The BOM stated the previous DON reported Resident #14 attempted to enter the room and was unsuccessful and redirected, I did not know [Resident #14] entered [Resident #23's] shower room. During an interview on 3/14/24 at 03:00 PM, Dr. Y stated he was the primary care physician for Resident #14 and, over the span of several months, had received multiple reports Resident #14 was sexually inappropriate with staff . Dr. Y stated he continued with resident #14's drug regiment to allow time for the therapies to progress. Dr. Y stated he had not received any reports Resident #14 was sexually inappropriate toward any resident. Dr. Y stated, I would have recalled a report of him getting in a female resident's shower. Dr. Y stated, if he had received such a report, he would have ordered for a 1 to 1 staff level of supervision for Resident #14 and ordered a psychiatric evaluation. The medical director stated he had received reports of Resident #14's inappropriate sexual behaviors however the reports were limited to staff harassment and not resident harassment. The reports were incomplete and lacking the scope of Resident #14's behaviors towards female residents. Dr. Y stated he was concerned for the behavior towards residents and would have considered further interventions for Resident #14's safety and the safety of residents. During an interview on 03/15/2024 at 09:30 AM Resident #14 stated he was wanting beer, a dance party, and a sexual partner. He stated, I have not been drunk, had sex in a long time .there are no dances here and they only have church! Resident #14 stated he enjoyed female CNAs assisting him with showers and they didn't shower him when he demanded. Resident #14 denied he was in any females shower room. 2. A record review of Resident #23's admission record, dated 03/14/2024, revealed an admitted [DATE] with diagnoses of dementia (not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), mood disturbance and anxiety. A record review of Resident #23's quarterly MDS assessment, dated 02/12/2024, revealed Resident #23 was an [AGE] year-old female admitted for long term care assessed with a BIMS score of 10 which indicated moderate cognitive impairment. A record review of Resident #23's care plan, dated 03/14/2024, revealed Resident #23 had a history of rejecting care and or limited permission for assessments and therapies. Further review revealed interventions avoidance of over-stimulation and avoidance of aggressive peer residents. During an interview on 03/13/2024 at 02:30 PM Resident #23 stated she felt unsafe due to Resident #14's sexual harassment behaviors (attempts to get in the shower with her) and now wished to avoid showers and stay in her room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 N Park St Uvalde, TX 78801	

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/13/24 at 04:30 PM Resident #23 stated on several occasions a man got into the shower with her, to which she would yell and scream at him until staff intervened and re-directed him away. Resident #23 stated she had increased anxiety and insomnia due to the fear of resident #14 entering her room and or shower. A record review of Resident #23's medical record, on 03/14/2024, revealed no evidence for providing the physician with reports where Resident #14 had increased sexual harassment behaviors towards Resident #23 since February 2024. During an interview on 03/14/24 at 08:28 AM the Medical Director stated he was unsure if he received a report from the nursing staff that Resident #23 was involuntary secluded in the shower. The medical Director stated if he had he could have assessed resident for psychiatric evaluation. During an interview on 03/15/2024 at 02:00 PM the Medical Director stated he was Resident #23's physician, and he was unaware Resident #14 had on 2 occasions entered Resident #23's shower room. The Medical Director stated had he known he may have assessed Resident #23 for anxiety and may have intervened with a psychiatric evaluation. The physician stated at a minimum he would have expected a report from nursing for Resident #14's sexual harassment behaviors and Resident #23's potential anxiety and fear. During an interview on 03/18/24 at 03:50 PM the MDS Nurse stated a review of Resident #14's medical record revealed no evidence for reports to the physician that Resident #14 was having sexual harassment behaviors towards residents . During an interview on 03/18/2024 at 05:20 PM the Administrator stated the policy and expectation was for nursing staff to timely report to Resident's physicians any changes in residents' health status to include increased and or decreased behaviors and or responses to therapies. The Administrator stated nursing staff should have reported to the physician and himself Resident #14's sexual harassment episodes towards residents. The Administrator stated nursing staff had not reported Resident #14 had made sexual harassment behaviors towards residents. During an interview on 03/18/2024 at 05:31 PM the ADON stated a review of Resident #14's and Resident #23's medical record revealed no evidence for reports to the residents' physicians for any of Resident #14's sexual harassment episodes towards residents and or Resident #23. A record review of the facility's Accidents and Incidents - Investigating and Reporting, dated July 2017, revealed, all accidents or incidents involving residents, employees, visitors, vendors, etcetera, occurring on our premises shall be investigated and reported to the Administrator .the following data, as applicable, shall be included on the report of incident accident form; the date and time the accident or incident took place; the nature of the injury illness; where the accident or incident took place; the names of witnesses and their accounts of the accident or incident; the injured person's account of the accident or incident; the time the injured person's attending physician was notified, as well as the time the position responded and his or her instruction . An Immediate Jeopardy (IJ) was identified on 03/15/2024 at 08:05 PM and presented to the Administrator, a plan of removal was requested. The following Plan of Removal submitted by the facility was accepted on 03/17/2024 at 07:08 AM. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Plan of Removal Verification Problem: F580 Notification of physicians and responsible parties Interventions: o Responsible parties of both Resident #14 and Resident #23 notified of incident as of 3/16/2024. Record review of Resident #23's progress note dated 3/15/2024 at 11:43 AM, made by the Worker reflected, SW spoke with resident today, via a Spanish translator, and asked if she had any lingering emotional distress or anxiety related to the 2/6/24 incident and if so does she want to be seen by psych. services/counseling. Resident stated she is o.k. and did not want any type of counseling/psych. services. SW also had a conversation with her MPOA regarding the incident on 2/6/24 and asked if she wanted resident to have counseling/psych. services and she stated no she doesn't want that for resident at this time as resident seems fine. SW let her know that counseling/psych. services is available if she ever changes her mind and that she may always speak to SW as needed. Record review of a progress note dated 3/15/2024 at 6:21 PM reflected the Social Worker, and Administrator spoke with Resident #14's RP of the resident's incidents. Interview on 3/18/2024 at 1:10 PM, the Administrator stated that each incident was discussed with Resident #14's responsible parties. The Administrator then confirmed Resident #23's responsible party had been notified of the incidents. The Administrator also confirmed the medication and its adverse effects were discussed with Resident #14's responsible parties. Record review of Resident #14's Progress Note, dated 3/17/2024 at 1:12 PM and written by the MDS Coordinator reflected that education was provided to the RP of risks vs benefits of taking the medication medroxyprogesterone and went on to list risks and benefits. o Evidence of deficiencies in notification of physicians and responsible parties was found to exist in the facility. Interview on 3/18/2024 at 10:55 AM, the Administrator stated that the evidence of deficiencies in notification were found during the survey process and no other evidence of deficiencies in notification were found during the facilities audit after notification of the initial deficiencies. o The following in-services were initiated on 3/14-16/2024: All available staff will begin being in serviced on 3/15/2024, to be completed on or before 3/16/2024. Any staff member not present or in-serviced by this time will not be allowed to assume their duties until they have been in serviced. Administrator/Designee to ensure that in-service training has been done for all staff. O All Staff o Abuse/Neglect o Incident reporting, to include behaviors, to Admin/Physicians o The importance of reporting events to physicians and responsible parties (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's all discipline employee roster dated, 03/16/2024 revealed 71 employees. 57% of employees, 44 of the 71, were interviewed to confirm receiving in-services for IJ F580 Reporting Change of Condition to Physician. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees, 10 were nurses. A sample of 8 nurses, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F580 Reporting Change of Condition to Physician. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees 17 were CNAs. A sample of 8 CNAs, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F580 Reporting Change of Condition to Physician. Record review of document titled Staff in-service, dated 3/15/2024, with the topic Abuse/Neglect Inservice revealed all disciplines, 46 of 71 staff signed off as having completed the in-service. Interview on 3/17/2024 at 3:15 PM, the MDS Coordinator stated that not all staff report to physicians or emergency contacts, and that only 11 nurses would be responsible with reporting any events to physicians and emergency contacts. Record review of document titled In-Service Training, dated 3/15/2024, with the topic The Importance of Reporting Events to Physicians and Emergency Contacts revealed 7 of 11 nursing staff signed off as having completed the in-service. Record review of document titled Staff in-service, dated 3/15/2024, with the topic Any staff who is turning off the lights and shutting the doors to any room shall check the room for any other persons prior to turning off the lights and shutting the door. Further review of this in-service revealed 49 of 71 staff signed off as having completed the in-service. Interview on 3/17/2024 at 12:30 PM, LVN N revealed that the in-service consisted of abuse and neglect prevention, complaints, when and where to file grievances and who to report grievances to. Interview on 3/17/2024 at 12:33 PM, CNA J stated that the in-service consisted of ensuring no residents are locked in shower rooms and monitoring showers and reporting to nursing staff. Interview on 3/17/2024 at 12:34 PM, CNA I stated that the in-service she received detailed ensuring that grievances are recognized and reported. Interview on 3/17/2024 at 1:35 PM, CNA P stated the in-service detailed abuse, neglect, exploitation, and discussing any of these concerns with the administrator. Interview on 3/17/2024 at 2:04 PM, LVN K stated her most recent in-service consisted of abuse and neglect training, to include specifics about what is abuse and neglect, changes in conditions, and when to notify family and physicians. Interview on 3/17/2024 at 3:00 PM, LVN R stated the in-service she had most recently consisted of ensuring residents' complaints were recognized and grievances were filed. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 3/17/2024 at 4:13 PM, CNA O stated the in-service they completed on 3/15/2024 consisted of reporting grievances and who to give them to. Interview on 3/17/2024 at 4:23 PM, LVN T stated the most recent in-service was about abuse and neglect and reporting any abuse or neglect to supervisors, as well as reporting to physicians. Monitoring o DON/Designee will perform a weekly audit of EMR (electronic medical record) to ensure that physicians and responsible parties are being notified with regard to any scenarios outlined in, but not limited to, CMS F580, to include medication changes, changes in condition, and critical labs. Record review reflected a facility activity report, detailing each residents' EMR, signed as Reviewed by the Administrator and DON on 3/16/2024. Interview on 3/18/2024 at 10:36 AM, the Administrator stated that the DON will be performing a weekly audit of the EMR. o Facility will be monitoring this by weekly EMR audits. Nurses will chart items in progress notes, and flagged on 24 hour report which will be discussed Monday - Friday by IDT. Interview on 3/18/2024 at 10:36 AM, the Administrator stated that they will be discussing the 24-hour report during the morning meeting to see if there need to be any changes made to any care for the residents based on what is on the 24 hour report. o The QAPI committee will review findings monthly for no less than 90 days and makes changes as needed Interview on 3/18/2024 at 10:36 AM, the Administrator stated that during QAPI they followed a template relating to the deficiencies and discussed any changes or suggestions related to any changes in care for residents with all members of the QAPI committee. An Immediate Jeopardy (IJ) was identified on 03/15/2024. The IJ was provided to the facility on [DATE] at 08:05 PM. While the IJ was removed on 03/18/2024, the facility remained out of compliance at a scope of isolated with a severity level of potential harm because of the facility's need to evaluate the effectiveness of their corrective actions.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews, the facility failed to ensure Residents had the right to be free from abuse, neglect, and involuntary seclusion for 3 (Resident #23, #43, and #1) of 16 residents reviewed for abuse and neglect. 1. The facility failed to ensure Resident #23 was not neglected when she was left in a dark, locked, shower room alone. 2. The facility failed to protect Resident #23 from abuse by allowing a male resident access to her while in the shower. 3. The facility failed to protect Resident #1 when she wandered into Resident #43's room and Resident #43 hit her (Resident #1) on the head. An Immediate Jeopardy (IJ) was identified on 03/14/2024 at 08:05 PM. While the IJ was removed on 03/18/2024 at 07:26 PM, the facility remained out of compliance at a scope of isolated with potential harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions. This failure denied residents their rights for freedom from abuse, neglect, and involuntary seclusion. The findings included: A record review of Resident #23's admission record, dated 03/14/2024, revealed an admitted [DATE] with diagnoses of dementia (not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), mood disturbance, anxiety, and Onchocerciasis with glaucoma (a disease where a parasite destroyed parts of the eye). A record review of Resident #23's quarterly MDS assessment, dated 02/12/2024, revealed Resident #23 was an [AGE] year-old female admitted for long term care assessed with a BIMS score of 10 which indicated moderate cognitive impairment. Section G of the MDS assessment revealed resident #23 used a wc independently and was Setup or clean-up assistance - for transfers and showers. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of Resident #23's care plan, dated 03/14/2024, revealed Resident #23 had a history of rejecting care and or limited permission for assessments and therapies. Further review revealed interventions for avoidance of over-stimulation and avoidance of aggressive peer residents and, Problem Start Date: 07/17/2020 .ADLs (activities of daily life) . Presents with alteration in ADL self-performance & mobility R/T hx (related to history) of Rhabdomyolysis (damaged muscle tissue releases its proteins and electrolytes into the blood. These substances can damage the heart and kidneys and cause permanent disability or even death) & failure to thrive, Dementia, stiff left shoulder, muscle weakness, lack of coordination, muscle wasting and atrophy AEB (as evidenced by) requires staff assistance with all ADL's . Approach Start Date: 01/21/202 1; Resident requires supervision and set up by staff with showers. A record review of Resident #23's nursing notes revealed LVN K documented on 02/06/2024 at 01:12 AM, an incident where Resident #23 was in the shower room bathing alone. LVN K documented she heard screams and shouts and discovered Resident #23 in the darkened shower room and on the floor. LVN K also documented Resident #23 was locked in the shower by another LVN (LVN A) who was re-directing Resident #14 from entering the shower room, while unknowing Resident #14 was in the shower, resident (#23) propel self in wheelchair to shower room. Another Resident (#14) wanting to take a shower and kept wanting to go in shower. Staff (LVN A) unknowing that resident was in shower turned light off and locked door so that other resident would not go into the shower by himself. Resident (#23) calling for help from the shower room and was sitting on the floor. asst. x2 to wheelchair. moving all extremities, refused writer to take vitals and/or check head. resident wanted to be left alone so that she could take her shower. Resident (#23) upset because she could hear other Resident (#14) wanting to go into shower. took other Resident to 200 hall shower room and showered. A record review of the facility's incident reports from June 2023 to March 2024 revealed no evidence for the incident on 02/06/2024 where Resident #23 was showering and Resident #14 attempting to enter the shower room while Resident #23 was bathing. During an interview on 03/13/2024 at 02:30 PM Resident #23 stated she felt unsafe due to Resident #14's sexual harassment behaviors (attempts to get in the shower with her). During an interview on 03/13/24 at 04:30 PM Resident #23 stated on several occasions a man got into the shower with her, to which she would, pull the shower curtain closed, yell and scream at him until staff intervened and re-directed him away. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/13/24 at 02:29 PM LVN K stated she and LVN A were the charge nurses on 02/06/2024 from 06:00 PM to 06:00 AM. LVN K stated Resident #23 had a preference to bathe herself in the shower room early in the mornings around midnight to 01:00 AM. LVN K stated Resident #23's routine was she would gather her clothes and bathing supplies and self-ambulate in her wheelchair to the shower room. LVN K stated on 02/06/2024 around 01:00 AM screams and shouting were heard coming from the shower room. LVN K stated she ran to the shower room and discovered Resident #23 in the dark on the floor. Resident #23 was upset and claimed she was locked in the shower with the lights off. LVN K stated Resident #23 stated she fell in the dark attempting to get out of her wheelchair trying to get to the light switch or door. LVN K stated she spoke with LVN A and learned Resident #14 was attempting to get into the shower room with Resident #23 when LVN A redirected Resident #14 away and LVN A did not recognize Resident #23 was in the shower room. LVN A turned off the light and locked the shower room door to prevent Resident #14 from entering. LVN K stated she had not initiated an incident report for any of Resident #14's sexual harassment incidents towards peer Residents, did not document on the 24 hour reports the sexual harassment behaviors towards peer residents. During an interview on 03/15/24 at 10:59 AM LVN A stated on the early morning of 02/06/2024 around midnight Resident #14 entered the shower room while Resident #23 was showering; although LVN A did not know Resident #23 was in the shower room. LVN A stated she heard Resident #23 in the shower room and entered and redirected him out and away from the shower room and turned off the shower room light and locked the door. LVN A stated she did not check for other residents in the shower room and did not see Resident #23 possibly due to the shower curtain was pulled shut. LVN A stated she had not initiated an incident report for any of Resident #14's sexual harassment incidents towards peer Residents, did not document on the 24 hour reports the sexual harassment behaviors towards peer residents. A record review of Resident #14's admission record dated 03/14/2024, revealed an admitted [DATE] with diagnoses which included dementia, psychotic disturbance, mood disturbance, anxiety, and alcohol use. A record review of Resident #14's quarterly MDS assessment revealed Resident #14 was a [AGE] year-old male admitted for long term care assessed with a BIMS score of 5 which indicated severe cognitive impairment. During an interview on 03/18/2024 at 05:20 PM the Administrator stated the policy and expectation was for facility staff to ensure residents were supported in their rights to be free from abuse and or neglect, including Resident #23's rights for safety. The Administrator stated he expected a report for all incidents involving resident #23 being secluded and harassed by resident #14 in her shower room. The Administrator stated not having provided any Resident, supports for ensuring their rights could have placed residents at risk for abuse, neglect, exploitation, and or mistreatment. 3. A record review of Resident #43's admission record dated 03/15/2024 revealed an admitted [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.). A record review of Resident #43's quarterly MDS assessment, dated 02/21/2024, revealed Resident #43 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 05 out of a possible 15 which indicated severe cognitive impairment . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of Resident #43's care plan dated 03/15/2024 revealed Resident #43 had a history of physical aggression towards staff and peer residents in areas of increased stimulation. Resident #43's care plan revealed interventions for monitoring for early signs of aggression and encouragement to attend social activities. A record review of Resident #1's admission record revealed an admitted [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.). A record review of Resident #1's quarterly MDS assessment, dated 02/06/2024, revealed Resident #1 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 99 which indicated Resident #1 could not participate in the assessment and may be severely cognitively impaired . A record review of Resident #1's care plan dated 03/15/2024 revealed Resident #1 had a history of unsafely wandering in her wheelchair. Further review revealed interventions which included, .Avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents) . Remove resident from other resident's rooms and unsafe situations . A record review of Resident #43's nursing progress notes revealed LVN N documented on 01/01/2024 at 10:35 AM, Resident (#43) in his room watching television (Resident #1) wandered into his room via wheelchair was asked to leave she did not - then he hit her in head just above left ear - resident is forgetful at times - and does not like people going into his room re-educated on importance of not hitting people and keeping his hands to himself - verbalized understanding stated she shouldn't be in my room. A record review of Resident #1's nursing progress notes revealed LVN N documented on 01/01/2024 at 10:32 AM, Resident (#1) propelling self in and out of other residents room went into room (Resident #43's room) was in room and she would not leave and (Resident #42) hit in head just above left ear - no apparent injuries noted resident moved from area and placed in main dining room to participate in activities. A record review of the Texas Unified Licensure Information Portal on 03/18/2024 revealed no evidence for reporting the alleged incident of abuse on 01/01/2024 between Residents #43 and #1. A record review of the facility's incidents and accidents log for the review dates of June 2023 through March 2024 revealed no reporting for the 01/01/2024 alleged peer to peer physical abuse between Resident #1 and Resident #43. During an interview on 03/12/2024 at 10:10 AM LVN N stated on 01/01/2024 at around 10:00 am Resident #1, who was pleasant and confused wandered into Resident #43's room when he began yelling at Resident #1 to get out of his room. LVN N stated she received a report from the CNA who saw Resident #43 hit Resident #1 on the side of the head. LVN N stated she assessed both residents for injuries and or pain and none were evidenced. Resident #43 was counseled and redirected to not hit anyone and Resident #1 was redirected to the living room to participate in activities. LVN N stated she had not generated an incident report, nor documented the incident on the 24-hour report but had documented the incident on the residents nursing progress notes. LVN N stated she had not reported the incident to the physician since there was no injuries . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/15/24 at 10:10 AM the DON stated the facility policy and her expectations were for all allegations of abuse, neglect, exploitation and or mistreatment were to be reported to the abuse, neglect, and exploitation prevention coordinator, the Administrator, herself (the DON), and document on the facility's incident report, and the 24-hour report. The DON stated record reviews of the incident reports and 24-hour reports failed to evidence the allegation of abuse on 01/01/204 for Resident #43's aggressive behavior towards Resident #1 therefore the facility leadership was unaware of the incident and failed to report and investigate the incident . During an interview on 03/15/24 at 11:00 AM the Administrator stated the facility policy, and his expectations were for all allegations of abuse, neglect, exploitation and or mistreatment were to be reported to the abuse, neglect, and exploitation prevention coordinator, (himself), and documented on the facility's incident report, and the 24-hour report. The Administrator stated record reviews of the incident reports and 24-hour reports failed to evidence the allegation of abuse on 01/01/204 for Resident #43 aggressive behavior towards Resident #1 therefore the facility leadership was unaware of the incident and failed to report and investigate the incident . A record review of the facility's Abuse / Neglect policy dated 01/08/2003, revealed, The Resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents should not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff, of other agencies serving the Resident, family members or legal guardians, friends, or other Residents . the facility will provide and ensure the promotion and protection of Resident rights. It is each individuals' responsibility to recognize, report, and promptly follow-up abuse or neglect allegations, suspicion of abuse or neglect, and situations that may constitute abuse or neglect to any Resident in the facility . An Immediate Jeopardy (IJ) was identified on 03/15/2024 at 08:05 PM and presented to the Administrator, a plan of removal was requested. The following Plan of Removal submitted by the facility was accepted on 03/17/2024 at 07:08 AM. Plan of Removal Verification Problem: F600 Sexual Inappropriateness allegation Interventions: Resident #14 placed in 1:1 observation and continues currently Record review of Resident #14's Orders reflected, One on one care d/t behaviors. with a start date of 3/14/2024. Observation and interview on 03/16/2024 at 11:25 AM revealed CNA M was assigned to monitor Resident #14 and has monitored him most of the day. She stated she must document on a sheet of paper every 15 minutes. During an observation on 03/16/2024 at 04:00 PM revealed Resident #14 was asleep in his bedroom while CNA M monitored Resident #14 for safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 N Park St Uvalde, TX 78801	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 03/16/2024 at 5:10 PM revealed resident #14 in the dining room being observed by staff while eating a meal. Record review of Resident #14's 1 to 1 documentation sheet, dated 03/16/2024, revealed Resident #14 was continuously monitored for safety and documented every 15 minutes. Interview on 3/18/2024 at 12:49 PM, the Administrator stated that Resident #14 is on 1:1 observation and will continue to be pending further evaluation by physician for effectiveness and necessity. Immediate psychiatric services via telehealth initiated on 3/14/2024 Record review of psychiatric evaluation dated 3/14/2024 at 06:06 PM. Record review of consolidated orders dated March 2023 revealed to be evaluated and treated by Psychiatric Services as needed, dated 3/14/2024. Record review of revealed Resident #14 RP verbally consented over the phone on 3/14/2024 to resident receiving psychiatric services. Interview on 3/18/2024 at 10:59 AM, the Administrator stated that Resident #14 had been seen by psychiatric services. Record review of Progress Note, dated 3/14/2024, reflected that Resident #14 was seen by a psychiatric NP with plan based on residents' diagnosis. STAT CBC, CMP, BMP, TSH, Ammonia level, and UA ordered by Primary Care Provider on 3/14/2024 Record review of Resident #14's orders reflected STAT CBC, CMP, UA ordered by the resident's physician on 3/14/2024. Record review of Resident #14's orders reflected Draw blood for TSH and Ammonia level ordered by the resident's physician on 3/15/2024. Record review of Resident #14's lab drawn on 3/14/2024 reflected CBC UA CMP, TSH and Ammonia with no recommendations signed Administrator/DON on 3/17/2024. New order for Sertraline, ordered by psychiatric services NP on 3/14/2024 Record review of telephone order dated 3/14/2024, start date for 3/22/2024 Sertraline 50 mg, 1 tablet once a day, oral for insomnia, ordered by the resident's PCP. Record review of telephone order dated 3/14/2024, start date 3/14/2024, end date 3/21/2024 for Sertraline 25 mg 1 tablet once a day by mouth with diagnosis of insomnia, ordered by the resident's PCP. Record review of telephone order dated 3/16/2024, start date 3/16/2024, with no end date for Risperidone 1 mg 1 tablet twice a day by mouth with diagnosis of anxiety disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of telephone order dated 3/16/2024, start date 3/16/2024, with no end date for Melatonin 5 mg 2 tablets once daily at bedtime with diagnosis of insomnia. Psychiatric services to be offered to Resident #23 in order to provide for any mental or emotional anguish created by any interactions with Resident #14 Record review of progress note dated 3/16/2024 at 4:29 PM, LVN K spoke with Resident #23's RP regarding the incident on 2/6/2024 as well as the incident on 3/12/2024. Record review of progress note dated 3/15/2024 at 11:43 AM revealed the Social Worker, spoke with Resident #23 who declined psychiatric services. Further review of the progress note revealed the Social Worker spoke with the MPOA regarding the incident on 2/6/2024 and the MPOA stated she did not want the resident to receive psychiatric services at this time. Abuse and Neglect prevention in-service for all facility staff initiated and completed by Admin/DON/Compliance Nurse on 3/14/2024 A record review of the facility's employee roster dated, 03/16/2024 revealed 74 employees. 57% of employees, 44 of the 74, were interviewed to confirm receiving in-services for IJ F600. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 74 employees, 10 were nurses. A sample of 8 nurses, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F600. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 74 employees 17 were CNAs. A sample of 8 CNAs, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F600. Interview on 3/17/2024 at 12:30 PM, LVN N revealed that the in-service consisted of abuse and neglect prevention, complaints, when and where to file grievances and who to report grievances to. Interview on 3/18/2024 at 12:54 PM, the Administrator stated most staff have been in-serviced and those who have not will be in-serviced before resuming duties. The following in-services were initiated on 3/14/2024: All available staff will be in-serviced by close of 3/15/2024 mandatory staff meeting, to be held at 1400 . Any staff member not present or in-serviced at close of mandatory meeting, will not be allowed to assume their duties until in-serviced. Administrator/Designee to ensure that in-service training has been done for all staff. oAll Staff Abuse/Neglect Abuse/Neglect Reporting Who to Report Abuse/Neglect to Incident reporting, to include behaviors, to Admin/Physicians. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's employee roster dated, 03/16/2024 revealed 71 employees. 57% of employees, 44 of the 74, were interviewed to confirm receiving in-services for IJ F600, Prevention and Reporting of Abuse, Neglect, and Exploitation. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees, 10 were nurses. A sample of 8 nurses, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F600, Prevention and Reporting of Abuse, Neglect, and Exploitation. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees 17 were CNAs. A sample of 8 CNAs, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F600, Prevention and Reporting of Abuse, Neglect, and Exploitation. Record review of document titled Staff in-service, dated 3/15/2024, with the topic Abuse/Neglect Inservice revealed 46 of 71 staff signed off as having completed the in-service. Interview on 3/17/2024 at 3:15 PM, the MDS Coordinator revealed that not all staff report to physicians or emergency contacts, and that only 11 nurses would be responsible with reporting any events to physicians and emergency contacts. Record review of document titled In-Service Training, dated 3/15/2024, with the topic The Importance of Reporting Events to Physicians and Emergency Contacts revealed 7 of 11 nursing staff signed off as having completed the in-service. Record review of document titled Staff in-service, dated 3/15/2024, with the topic Any staff who is turning off the lights and shutting the doors to any room shall check the room for any other persons prior to turning off the lights and shutting the door. Further review of this in-service revealed 49 of 71 staff signed off as having completed the in-service. Interview on 3/17/2024 at 12:30 PM, LVN N revealed that the in-service consisted of abuse and neglect prevention, complaints, when and where to file grievances and who to report grievances to. Interview on 3/17/2024 at 12:33 PM, CNA J stated that the in-service consisted of ensuring no residents are locked in shower rooms and monitoring showers. Interview on 3/17/2024 at 12:34 PM, CNA I stated that the in-service she received detailed ensuring that grievances are recognized and reported. Interview on 3/17/2024 at 1:35 PM, CNA P stated the in-service detailed abuse, neglect, exploitation, and discussing any of these concerns with the administrator. Interview on 3/17/2024 at 2:04 PM, LVN K stated her most recent in-service consisted of abuse and neglect training, to include specifics about what is abuse and neglect. Interview on 3/17/2024 at 3:00 PM, LVN R stated the in-service she had most recently consisted of ensuring residents complaints were recognized and grievances were filed. Interview on 3/17/2024 at 4:13 PM, CNA O stated the in-service they completed on 3/15/2024 consisted of reporting grievances and who to give them to. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 3/17/2024 at 4:23 PM, LVN T stated the most recent in-service was about abuse and neglect and reporting any abuse or neglect to supervisors. Interview on 3/18/2024 at 12:54 PM, the Administrator stated most staff have been in-serviced and those who have not will be in-serviced before resuming duties. Monitoring Administrator/DON to review findings of psychiatric NP and ensure implementation of treatment plan if found to be necessary. DON to ensure care plans have been updated for resident #14 as well as resident #23. Record review of Progress Note, dated 3/14/2024, reflected that Resident #14 was seen by a psychiatric NP. Further review reveals the DON and Administrator signed the document as Reviewed on 3/14/2024. Interview on 3/18/2024 at 10:59 AM, the Administrator stated that Resident #14 had seen the psychiatric NP and that he and the DON had reviewed the findings. He further stated that he, along with the DON, reviewed the psychiatric services progress note and will continue to do so after any psychiatric services appointment. Administrator will work with social services to develop a plan of action to find suitable placement for resident #14 in order to provide a better, more appropriate level of care, to provide a safer environment for resident #14 as well as all others residing in the facility Interview on 3/18/2024 at 12:58 PM, the Administrator stated that the social worker has put in referrals for 3 places and continues to search for placement. The residents RP's have declined some placements for the resident. Record review of Resident #14's care plan revealed, Problem: Administrator issued 30 Day Discharge Notice has been issued effective from 3/15/24. with interventions of Social services to send referrals to facilities that will meet Resident #14's needs. Thirty-Day Notice of discharge to be issued to resident #14, resident #14's representative, and representative of long-term care ombudsman program on 3/15/2024 Record review of document titled 30 Day Discharge Notice reflected a 30 day discharge notification provided to the residents representative on 3/15/2024. Record review of email to Ombudsman reflected notification of 30-day discharge notice on 3/15/2024. Record review of Resident #14's care plan revealed, Problem: Administrator issued 30 Day Discharge Notice has been issued effective from 3/15/24. with interventions of Social services to send referrals to facilities that will meet Resident #14 's needs. Interview on 3/18/2024 at 1:04 PM, the Administrator stated the family was provided with a 30-day notice to Resident #14, and the ombudsman was provided with the 30-day notice as well. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The QAPI committee will review findings monthly for no less than 90 days and makes changes as needed Interview on 3/18/2024 at 10:36 AM, the Administrator stated that during QAPI they will follow a template relating to the deficiencies and discuss any changes or suggestions relating to any changes in care for residents with all members of the QAPI committee. An Immediate Jeopardy (IJ) was identified on 03/14/2024 at 08:05 PM. While the IJ was removed on 03/18/2024 at 07:26 PM, the facility remained out of compliance at a scope of isolated with potential harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions.

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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 41937

Based on interviews and record reviews the facility failed to ensure all alleged violations which involved abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately to the administrator of the facility and to other officials, including to the State Survey Agency, in accordance with State law through established procedures for 3 of 16 Residents (Residents #1, #23, and #43) reviewed for reporting of alleged Abuse, Neglect, exploitation, and or mistreatment.

1.The facility failed to ensure staff reported to the Administrator and or the state agency Resident #43's alleged physical aggression towards Resident #1.

2. The facility failed to report to the state agency that Resident #23 was left in a dark, locked, shower room alone and failed to report abuse by allowing a male resident access to her while in the shower.

These deficient practices could have placed residents at risk for abuse, neglect, exploitation, and or mistreatment.

The findings included:

1.A record review of Resident #43's admission record dated 03/15/2024 revealed an admitted [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.).

A record review of Resident #43's quarterly MDS assessment, dated 02/21/2024, revealed Resident #43 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 05 out of a possible 15 which indicated severe cognitive impairment .

A record review of Resident #43's care plan dated 03/15/2024 revealed Resident #43 had a history of physical aggression towards staff and peer residents in areas of increased stimulation. Resident #43's care plan revealed interventions for monitoring for early signs of aggression and encouragement to attend social activities.

A record review of Resident #1's admission record revealed an admitted [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.).

A record review of Resident #1's quarterly MDS assessment, dated 02/06/2024, revealed Resident #1 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 99 which indicated Resident #1 could not participate in the assessment and may be severely cognitively impaired .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #1's care plan dated 03/15/2024 revealed Resident #1 had a history of unsafely wandering in her wheelchair. Further review revealed interventions which included, .Avoid over-stimulation (e. g., noise, crowding, other physically aggressive residents) . Remove resident from other resident's rooms and unsafe situations . A record review of Resident #43's nursing progress notes revealed LVN N documented on 01/01/2024 at 10:35 AM, Resident (#43) in his room watching television (Resident #1) wandered into his room via wheelchair was asked to leave she did not - then he hit her in head just above left ear - resident is forgetful at times - and does not like people going into his room re-educated on importance of not hitting people and keeping his hands to himself - verbalized understanding stated she shouldn't be in my room. A record review of Resident #1's nursing progress notes revealed LVN N documented on 01/01/2024 at 10:32 AM, Resident (#1) propelling self in and out of other residents room went into room (Resident #43's room) was in room and she would not leave and (Resident #42) hit in head just above left ear - no apparent injuries noted resident moved from area and placed in main dining room to participate in activities. A record review of the Texas Unified Licensure Information Portal on 03/18/2024 revealed no evidence for reporting the alleged incident of abuse on 01/01/2024 between Residents #43 and #1. A record review of the facility's incidents and accidents log for the review dates of June 2023 through March 2024 revealed no reporting for the 01/01/2024 alleged peer to peer physical abuse between Resident #1 and Resident #43. During an interview on 03/12/2024 at 10:10 AM LVN N stated on 01/01/2024 at around 10:00 am Resident #1, who was pleasant and confused wandered into Resident #43's room when he began yelling at Resident #1 to get out of his room. LVN N stated she received a report from the CNA who saw Resident #43 hit Resident #1 on the side of the head. LVN N stated she assessed both residents for injuries and or pain and none were evidenced. Resident #43 was counseled and redirected to not hit anyone and Resident #1 was redirected to the living room to participate in activities. LVN N stated she had not generated an incident report, nor documented the incident on the 24-hour report but had documented the incident on the residents nursing progress notes. LVN N stated she had not reported the incident to the physician since there was no injuries . During an interview on 03/15/24 at 10:10 AM the DON stated the facility policy and her expectations were for all allegations of abuse, neglect, exploitation and or mistreatment were to be reported to the abuse, neglect, and exploitation prevention coordinator, the Administrator, herself (the DON), and document on the facility's incident report, and the 24-hour report. The DON stated record reviews of the incident reports and 24-hour reports failed to evidence the allegation of abuse on 01/01/204 for Resident #43's aggressive behavior towards Resident #1 therefore the facility leadership was unaware of the incident and failed to report and investigate the incident . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/15/24 at 11:00 AM the Administrator stated the facility policy, and his expectations were for all allegations of abuse, neglect, exploitation and or mistreatment were to be reported to the abuse, neglect, and exploitation prevention coordinator, (himself), and documented on the facility's incident report, and the 24-hour report. The Administrator stated record reviews of the incident reports and 24-hour reports failed to evidence the allegation of abuse on 01/01/204 for Resident #43 aggressive behavior towards Resident #1 therefore the facility leadership was unaware of the incident and failed to report and investigate the incident . 2. A record review of Resident #23's admission record, dated 03/14/2024, revealed an admitted [DATE] with diagnoses of dementia (not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), mood disturbance, anxiety, and Onchocerciasis with glaucoma (a disease where a parasite destroyed parts of the eye). A record review of Resident #23's quarterly MDS assessment, dated 02/12/2024, revealed Resident #23 was an [AGE] year-old female admitted for long term care assessed with a BIMS score of 10 which indicated moderate cognitive impairment. Section G of the MDS assessment revealed resident #23 used a wc independently and was Setup or clean-up assistance - for transfers and showers. A record review of Resident #23's care plan, dated 03/14/2024, revealed Resident #23 had a history of rejecting care and or limited permission for assessments and therapies. Further review revealed interventions for avoidance of over-stimulation and avoidance of aggressive peer residents and, Problem Start Date: 07/17/2020 .ADLs (activities of daily life) . Presents with alteration in ADL self-performance & mobility R/T hx (related to history) of Rhabdomyolysis (damaged muscle tissue releases its proteins and electrolytes into the blood. These substances can damage the heart and kidneys and cause permanent disability or even death) & failure to thrive, Dementia, stiff left shoulder, muscle weakness, lack of coordination, muscle wasting and atrophy AEB (as evidenced by) requires staff assistance with all ADL's . Approach Start Date: 01/21/202 1; Resident requires supervision and set up by staff with showers. A record review of Resident #23's nursing notes revealed LVN K documented on 02/06/2024 at 01:12 AM, an incident where Resident #23 was in the shower room bathing alone. LVN K documented she heard screams and shouts and discovered Resident #23 in the darkened shower room and on the floor. LVN K also documented Resident #23 was locked in the shower by another LVN (LVN A) who was re-directing Resident #14 from entering the shower room, while unknowing Resident #14 was in the shower, resident (#23) propel self in wheelchair to shower room. Another Resident (#14) wanting to take a shower and kept wanting to go in shower. Staff (LVN A) unknowing that resident was in shower turned light off and locked door so that other resident would not go into the shower by himself. Resident (#23) calling for help from the shower room and was sitting on the floor. asst. x2 to wheelchair. moving all extremities, refused writer to take vitals and/or check head. resident wanted to be left alone so that she could take her shower. Resident (#23) upset because she could hear other Resident (#14) wanting to go into shower. took other Resident to 200 hall shower room and showered. A record review of the facility's incident reports from June 2023 to March 2024 revealed no evidence for the incident on 02/06/2024 where Resident #23 was showering and Resident #14 attempting to enter the shower room while Resident #23 was bathing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/2024 at 02:30 PM Resident #23 stated she felt unsafe due to Resident #14's sexual harassment behaviors (attempts to get in the shower with her). During an interview on 03/13/24 at 04:30 PM Resident #23 stated on several occasions a man got into the shower with her, to which she would, pull the shower curtain closed, yell and scream at him until staff intervened and re-directed him away. During an interview on 03/13/24 at 02:29 PM LVN K stated she and LVN A were the charge nurses on 02/06/2024 from 06:00 PM to 06:00 AM. LVN K stated Resident #23 had a preference to bathe herself in the shower room early in the mornings around midnight to 01:00 AM. LVN K stated Resident #23's routine was she would gather her clothes and bathing supplies and self-ambulate in her wheelchair to the shower room. LVN K stated on 02/06/2024 around 01:00 AM screams and shouting were heard coming from the shower room. LVN K stated she ran to the shower room and discovered Resident #23 in the dark on the floor. Resident #23 was upset and claimed she was locked in the shower with the lights off. LVN K stated Resident #23 stated she fell in the dark attempting to get out of her wheelchair trying to get to the light switch or door. LVN K stated she spoke with LVN A and learned Resident #14 was attempting to get into the shower room with Resident #23 when LVN A redirected Resident #14 away and LVN A did not recognize Resident #23 was in the shower room. LVN A turned off the light and locked the shower room door to prevent Resident #14 from entering. LVN K stated she had not initiated an incident report for any of Resident #14's sexual harassment incidents towards peer Residents, did not document on the 24 hour reports the sexual harassment behaviors towards peer residents. During an interview on 03/15/24 at 10:59 AM LVN A stated on the early morning of 02/06/2024 around midnight Resident #14 entered the shower room while Resident #23 was showering; although LVN A did not know Resident #23 was in the shower room. LVN A stated she heard Resident #23 in the shower room and entered and redirected him out and away from the shower room and turned off the shower room light and locked the door. LVN A stated she did not check for other residents in the shower room and did not see Resident #23 possibly due to the shower curtain was pulled shut. LVN A stated she had not initiated an incident report for any of Resident #14's sexual harassment incidents towards peer Residents, did not document on the 24 hour reports the sexual harassment behaviors towards peer residents. A record review of Resident #14's admission record dated 03/14/2024, revealed an admitted [DATE] with diagnoses which included dementia, psychotic disturbance, mood disturbance, anxiety, and alcohol use. A record review of Resident #14's quarterly MDS assessment revealed Resident #14 was a [AGE] year-old male admitted for long term care assessed with a BIMS score of 5 which indicated severe cognitive impairment. During an interview on 03/18/2024 at 05:20 PM the Administrator stated the policy and expectation was for facility staff to ensure residents were supported in their rights to be free from abuse and or neglect, including Resident #23's rights for safety. The Administrator stated he expected a report for all incidents involving resident #23 being secluded and harassed by Resident #14 in her shower room. The Administrator stated not having provided any Resident, supports for ensuring their rights could have placed residents at risk for abuse, neglect, exploitation, and or mistreatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uvalde Healthcare and Rehabilitation Center	535 N Park St Uvalde, TX 78801

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	A record review of the facility's Abuse / Neglect policy dated 01/08/2003, revealed, The Resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents should not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff, of other agencies serving the Resident, family members or legal guardians, friends, or other Residents . the facility will provide and ensure the promotion and protection of Resident rights. It is each individuals' responsibility to recognize, report, and promptly follow-up abuse or neglect allegations, suspicion of abuse or neglect, and situations that may constitute abuse or neglect to any Resident in the facility .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 N Park St Uvalde, TX 78801	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to have evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated and prevented further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress, and report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken for 3 of 16 residents (Residents #1, #23 and #43) reviewed for investigation to prevent further potential abuse, neglect, exploitation, or mistreatment. 1. The facility failed to investigate and report the findings to the state agency for Resident #43's alleged physical aggression towards Resident #1. 2. The facility failed to investigate and report the findings to the state agency that Resident #23 was left in a dark, locked, shower room alone and failed investigate and report the findings of alleged abuse by allowing a male resident access to her while in the shower. These deficient practices could have placed residents at risk for abuse, neglect, exploitation, and or mistreatment. The findings included : 1. A record review of Resident #43's admission record dated 03/15/2024 revealed an admitted [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.). A record review of Resident #43's quarterly MDS assessment, dated 02/21/2024, revealed resident #43 was an [AGE] year-old male admitted for long term care and assessed with a BIMS score of 05 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #43's care plan dated 03/15/2024 revealed Resident #43 had a history of physical aggression towards staff and peer residents in areas of increased stimulation. Resident #43's care plan revealed interventions for monitoring for early signs of aggression and encouragement to attend social activities. A record review of Resident #1's admission record revealed an admitted [DATE] with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities.). A record review of Resident #1's quarterly MDS assessment, dated 02/06/2024, revealed resident #1 was an [AGE] year-old female admitted for long term care and assessed with a BIMS score of 99 which indicated Resident #1 could not participate in the assessment and may be severely cognitively impaired. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #1's care plan dated 03/15/2024 revealed Resident #1 had a history of unsafely wandering in her wheelchair. Further review revealed interventions which included, .Avoid over-stimulation (e. g., noise, crowding, other physically aggressive residents) . Remove resident from other resident's rooms and unsafe situations . A record review of Resident #43's nursing progress notes revealed LVN N documented on 01/01/2024 at 10:35 AM, Resident (#43) in his room watching television (Resident #1) wandered into his room via wheelchair was asked to leave she did not - then he hit her in head just above left ear - resident is forgetful at times - and does not like people going into his room re-educated on importance of not hitting people and keeping his hands to himself - verbalized understanding stated she shouldn't be in my room. A record review of Resident #1's nursing progress notes revealed LVN N documented on 01/01/2024 at 10:32 AM, Resident (#1) propelling self in and out of other residents room went into room (Resident #43's room) was in room and she would not leave and (Resident #42) hit in head just above left ear - no apparent injuries noted resident moved from area and placed in main dining room to participate in activities. A record review of the Texas Unified Licensure Information Portal on 03/18/2024 revealed no evidence for reporting the alleged incident of abuse on 01/01/2024 between residents #43 and #1. A record review of the facility's incidents and accidents log for the review dates of June 2023 through March 2024 revealed no reporting for the 01/01/2024 alleged peer to peer physical abuse between Resident #1 and Resident #43. During an interview on 03/12/2024 at 10:10 AM LVN N stated on 01/01/2024 at around 10:00 am Resident #1, who was pleasant and confused wandered into Resident #43 room when he began yelling at Resident #1 to get out of his room. LVN N stated she received a report from the CNA who saw Resident #43 hit Resident #1 on the side of the head. LVN N stated she assessed both residents for injuries and or pain and none were evidenced. Resident #43 was counseled and redirected to not hit anyone and Resident #1 was redirected to the living room to participate in activities. LVN N stated she had not generated an incident report, nor documented the incident on the 24-hour report but had documented the incident on the residents nursing progress notes. LVN N stated she had not reported the incident to the physician since there was no injuries. During an interview on 03/15/24 at 10:10 AM the DON stated the facility policy and her expectations were for all allegations of abuse, neglect, exploitation and or mistreatment were to be reported to the abuse, neglect, and exploitation prevention coordinator, the Administrator, herself (the DON), and documented on the facility's incident report, and the 24-hour report. The DON stated record reviews of the incident reports and 24-hour reports failed to evidence the allegation of abuse on 01/01/204 for Resident #43 aggressive behavior towards Resident #1 therefore the facility leadership was unaware of the incident and failed to report and investigate the incident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 N Park St Uvalde, TX 78801	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/15/24 at 11:00 AM the Administrator stated the facility policy, and his expectations were for all allegations of abuse, neglect, exploitation and or mistreatment were to be reported to the abuse, neglect, and exploitation prevention coordinator, (Himself), and documented on the facility's incident report, and the 24-hour report. The Administrator stated record reviews of the incident reports and 24-hour reports failed to evidence the allegation of abuse on 01/01/204 for Resident #43 aggressive behavior towards Resident #1 therefore the facility leadership was unaware of the incident and failed to report and investigate the incident. 2. A record review of Resident #23's admission record, dated 03/14/2024, revealed an admitted [DATE] with diagnoses of dementia (not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), mood disturbance, anxiety, and Onchocerciasis with glaucoma (a disease where a parasite destroyed parts of the eye). A record review of Resident #23's quarterly MDS assessment, dated 02/12/2024, revealed Resident #23 was an [AGE] year-old female admitted for long term care assessed with a BIMS score of 10 which indicated moderate cognitive impairment. Section G of the MDS assessment revealed resident #23 used a wc independently and was Setup or clean-up assistance - for transfers and showers. A record review of Resident #23's care plan, dated 03/14/2024, revealed Resident #23 had a history of rejecting care and or limited permission for assessments and therapies. Further review revealed interventions for avoidance of over-stimulation and avoidance of aggressive peer residents and, Problem Start Date: 07/17/2020 .ADLs (activities of daily life) . Presents with alteration in ADL self-performance & mobility R/T hx (related to history) of Rhabdomyolysis (damaged muscle tissue releases its proteins and electrolytes into the blood. These substances can damage the heart and kidneys and cause permanent disability or even death) & failure to thrive, Dementia, stiff left shoulder, muscle weakness, lack of coordination, muscle wasting and atrophy AEB (as evidenced by) requires staff assistance with all ADL's . Approach Start Date: 01/21/202 1; Resident requires supervision and set up by staff with showers. A record review of Resident #23's nursing notes revealed LVN K documented on 02/06/2024 at 01:12 AM, an incident where Resident #23 was in the shower room bathing alone. LVN K documented she heard screams and shouts and discovered Resident #23 in the darkened shower room and on the floor. LVN K also documented Resident #23 was locked in the shower by another LVN (LVN A) who was re-directing Resident #14 from entering the shower room, while unknowing Resident #14 was in the shower, resident (#23) propel self in wheelchair to shower room. Another Resident (#14) wanting to take a shower and kept wanting to go in shower. Staff (LVN A) unknowing that resident was in shower turned light off and locked door so that other resident would not go into the shower by himself. Resident (#23) calling for help from the shower room and was sitting on the floor. asst. x2 to wheelchair. moving all extremities, refused writer to take vitals and/or check head. resident wanted to be left alone so that she could take her shower. Resident (#23) upset because she could hear other Resident (#14) wanting to go into shower. took other Resident to 200 hall shower room and showered. A record review of the facility's incident reports from June 2023 to March 2024 revealed no evidence for the incident on 02/06/2024 where Resident #23 was showering and Resident #14 attempting to enter the shower room while Resident #23 was bathing. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 535 N Park St Uvalde, TX 78801	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/2024 at 02:30 PM Resident #23 stated she felt unsafe due to Resident #14's sexual harassment behaviors (attempts to get in the shower with her). During an interview on 03/13/24 at 04:30 PM Resident #23 stated on several occasions a man got into the shower with her, to which she would, pull the shower curtain closed, yell and scream at him until staff intervened and re-directed him away. During an interview on 03/13/24 at 02:29 PM LVN K stated she and LVN A were the charge nurses on 02/06/2024 from 06:00 PM to 06:00 AM. LVN K stated Resident #23 had a preference to bathe herself in the shower room early in the mornings around midnight to 01:00 AM. LVN K stated Resident #23's routine was she would gather her clothes and bathing supplies and self-ambulate in her wheelchair to the shower room. LVN K stated on 02/06/2024 around 01:00 AM screams and shouting were heard coming from the shower room. LVN K stated she ran to the shower room and discovered Resident #23 in the dark on the floor. Resident #23 was upset and claimed she was locked in the shower with the lights off. LVN K stated Resident #23 stated she fell in the dark attempting to get out of her wheelchair trying to get to the light switch or door. LVN K stated she spoke with LVN A and learned Resident #14 was attempting to get into the shower room with Resident #23 when LVN A redirected Resident #14 away and LVN A did not recognize Resident #23 was in the shower room. LVN A turned off the light and locked the shower room door to prevent Resident #14 from entering. LVN K stated she had not initiated an incident report for any of Resident #14's sexual harassment incidents towards peer Residents, did not document on the 24 hour reports the sexual harassment behaviors towards peer residents. During an interview on 03/15/24 at 10:59 AM LVN A stated on the early morning of 02/06/2024 around midnight Resident #14 entered the shower room while Resident #23 was showering; although LVN A did not know Resident #23 was in the shower room. LVN A stated she heard Resident #23 in the shower room and entered and redirected him out and away from the shower room and turned off the shower room light and locked the door. LVN A stated she did not check for other residents in the shower room and did not see Resident #23 possibly due to the shower curtain was pulled shut. LVN A stated she had not initiated an incident report for any of Resident #14's sexual harassment incidents towards peer Residents, did not document on the 24 hour reports the sexual harassment behaviors towards peer residents. A record review of Resident #14's admission record dated 03/14/2024, revealed an admitted [DATE] with diagnoses which included dementia, psychotic disturbance, mood disturbance, anxiety, and alcohol use. A record review of Resident #14's quarterly MDS assessment revealed Resident #14 was a [AGE] year-old male admitted for long term care assessed with a BIMS score of 5 which indicated severe cognitive impairment. During an interview on 03/18/2024 at 05:20 PM the Administrator stated the policy and expectation was for facility staff to ensure residents were supported in their rights to be free from abuse and or neglect, including Resident #23's rights for safety. The Administrator stated he expected a report for all incidents involving resident #23 being secluded and harassed by Resident #14 in her shower room. The Administrator stated not having provided any Resident, supports for ensuring their rights could have placed residents at risk for abuse, neglect, exploitation, and or mistreatment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uvalde Healthcare and Rehabilitation Center	535 N Park St Uvalde, TX 78801

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's A record review of the facility's Abuse / Neglect policy dated 01/08/2003, revealed, The Resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents should not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff, of other agencies serving the Resident, family members or legal guardians, friends, or other Residents .the facility will provide and ensure the promotion and protection of Resident rights. It is each individuals' responsibility to recognize, report, and promptly follow-up abuse or neglect allegations, suspicion of abuse or neglect, and situations that may constitute abuse or neglect to any Resident in the facility .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 26869 Based on observations, interviews and record reviews the facility failed to ensure must 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 1 (Resident #20) of 21 residents reviewed in that: Resident #20 did not have a care plan for his urinary catheter or where the pacemaker was located. The failure could place residents at risk of not receiving care as ordered and needed. The findings were: Record review of Resident #20's face sheet dated 3/13/2024 revealed he was admitted on [DATE], readmitted on ,d+[DATE] with diagnoses of personal history of malignant neoplasm of bladder (Non-muscle-invasive bladder cancer is cancer that has not reached the muscle wall of the bladder.), overactive bladder, retention of urine, personal history of urinary infections. Resident was [AGE] years old. Record review of Resident #20's Quarterly MDS dated on 12/13/2023 revealed Section C BIMs score was 11/15 (moderate cognitive impairment). Section H Bladder and Bowel reflected he had ostomy checked off., that included urostomy and colostomy. Observation on 3/11/2024 at 11:13 AM with Resident #20 revealed he was sitting in a wheelchair and had a catheter bag, tube, and privacy bag was over the catheter bag. Observation on 3/18/24 at 1:52 PM in Resident # 20's room revealed he had a pacemaker, ostomy, urostomy, urinary catheter bag and were clean. Interview on 3/14/24 at 12:32 PM with MDS stated no care plan for where pacemaker was, no ostomy/colostomy and tubing. The MDS nurse stated residents needed care plans so the staff could provide care. Record review of Resident #20's consolidated orders for March 2024 revealed no order for urinary catheter, colostomy, and urostomy, only the treatment. Orders for urostomy every day and every shift. Change colostomy dressing every 3 days May use 2-piece system (wafer and pouch). Stoma (a surgically made hole in the abdomen that allows body waste to be removed from the body directly through the end of the bowel into a collection bag.) powder. Stoma paste or ring seal if available. Skin prep. Adhesive wipes once daily dated on 10/6/2023. Order for pacemaker to left upper chest wall start date 3/12/2024. Order for urostomy output every shift started on 9/9/2023. Order for follow up appointment with physician office to check pacemaker dated for 4/25/2024. Order for Colostomy to left lower abdominal area every shift start date 3/12/2024. Order to change urostomy dressing every 4 days may use stoma powder, adhesive remover wipes, skin prep, wafer, and drainage pouch once a day started on 10/12/2023. Order Change colostomy dressing as needed may use 2-piece system, stoma paste or ring seal if available, skin prep, adhesive wipes as needed start date 9/9/2023. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 N Park St Uvalde, TX 78801	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's care plan dated on 9/16/22, last review 12/13/2024. The pacemaker dated 9/11/23 revealed changed serial number, next pacemaker checks 4/25/2024. Record review revealed the facility did not have a care plan for his urinary catheter (a urinary catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag.) or where the pacemaker (send electrical pulses to help your heart beat at a normal rate and rhythm) was located. Interview on 3/18/24 at 1:47 PM LVN N stated Resident #20 had a pacemaker, urostomy, ostomy and catheter. LVN N stated Resident #20's cardiologist next check for his pacemaker at office was 4/25/2024. LVN N stated the nurses did provide care/maintenance for the pacemaker, catheter and ostomy. Interview 3/18/24 at 1:59 PM with Resident #20 stated he had no issues with his pacemaker, urostomy or ostomy. Interview on 3/18/24 at 5:36 PM with RN R revealed it was important to have a care plan for the resident to make sure the staff followed their plan of care discussed with staff/family and residents. Record review of policy Care Plans, Comprehensive Person- Centered dated December 2016 revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops i=and implements a comprehensive, person-centered care plan for each resident. 2. The Care plan interventions are derived from a though analysis for the information gathered as part of the comprehensive assessment.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record reviews the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 21 (Resident #20) reviewed in that: Resident #20 did not have an order for his colostomy, urostomy, urinary catheter, or his pacemaker. The failure could place residents at risk of not receiving care as needed. The findings were: Record review of #20's face sheet dated 3/13/2024 revealed he was admitted on [DATE], readmitted on , d+[DATE], resident was [AGE] years old. with diagnoses of personal history of malignant neoplasm of bladder, overactive bladder, retention of urine, persona history of urinary infections. Record review of consolidated physician orders for March 2024 revealed colostomy ,since 9/9/2023 (An opening into the colon from the outside of the body. A colostomy provides a new path for waste material to leave the body after part of the colon has been removed.), ostomy, urinary catheter, (uses a tube (created out of your own intestines) to help you pass urine when your bladder has been removed or isn't working correctly) or his pacemaker, since 9/11/2023. The urostomy since 9/9/2023. Record review of Resident #20's Quarterly MDS dated on 12/13/2023 revealed Section C BIMs score was 11/15 (moderate cognitive impairment). Section H Bladder and Bowel reflected he had, and ostomy checked off, that included urostomy and colostomy. The MDS revealed in section I Active Diagnosis reflected he had a cardiac pacemaker. Observation on 3/11/2024 at 11:13 AM with Resident #20 revealed he was sitting in a wheelchair and had a catheter bag, catheter tubing, and privacy bag was over the catheter bag. Observation on 3/18/24 at 1:52 PM in Resident #20's room revealed he had a pacemaker, urostomy, colostomy, urinary catheter bag and were clean. Record review of Resident # 20 consolidated orders for March 2024 revealed no order for urinary catheter, colostomy, and Urostomy. Order for pacemaker to left upper chest wall start date 3/12/2024 (surveyor intervention). Orders for Urostomy every day and every shift. Change colostomy dressing every 3 days May use 2-piece system (wafer and pouch). Stoma powder. Stoma paste or ring seal if available. Skin prep. Adhesive wipes once daily dated on 10/6/2023. Order for urostomy output every shift started on 9/9/2023. Order for follow up appointment with physician office to check pacemaker dated for 4/25/2024. Order for Colostomy to left lower abdominal area every shift start date 3/12/2024. Order to change urostomy dressing every 4 days may use stoma powder, adhesive remover wipes, skin prep, wafer, and drainage pouch once a day started on 10/12/2023. Order Change colostomy dressing as needed may use 2-piece system, stoma paste or ring seal if available, skin prep, adhesive wipes as needed start date 9/9/2023. Facility had orders for treatment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 535 N Park St Uvalde, TX 78801	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's care plan dated on 9/16/22, last review 12/13/2024. The pacemaker dated 9/11/23 revealed changed serial number, next pacemaker checks 4/25/2024, colostomy/ostomy-9/16/22. Interview on 3/13/24 at 5:22 PM with the DON stated it was important to have an order resident needs such as colostomy, so the nursing staff could follow and provide care to residents. Interview on 3/18/24 at 1:47 PM LVN N stated Resident #20 had a pacemaker, urostomy, colostomy and catheter. LVN N stated Resident #20's cardiologist next check for his pacemaker at the office was 4/25/2024. LVN N stated she worked with ostomies and catheters before and was experienced. Interview 3/18/24 at 1:59 PM Resident #20 stated he had no issues with pacemaker, urostomy or colostomy and urinary catheter. Interview on 3/18/24 at 5:36 PM with RN R revealed it was detrimental to have a care plan for resident to make sure the staff followed the physicians' orders to provide residents with care. Record review of the policy Physician Services dated February 2021 revealed The medical care of each resident is supervised by a licensed physician. 2. Once a resident is admitted , orders for the residents' immediate care and needs can be provided by a physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2024
NAME OF PROVIDER OR SUPPLIER Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 N Park St Uvalde, TX 78801	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to ensure that Residents environments remained as free from accident and hazards as possible, and each resident received adequate supervision and assistive devices to prevent accidents for 2 of 16 residents (Residents #14 and #23) reviewed for environments free from accident and hazards. 1. The facility failed to check a shower room prior to turning off the shower room lights and locking the door; Resident #23 was in the shower room and left alone in a dark with the door locked and fell . 2. The facility failed to ensure storage rooms containing equipment to draw blood for lab work, such as needles and syringes, were secured. This failure could place residents at risk for involuntary seclusion and injuries as well as injuries from syringe needles. An Immediate Jeopardy (IJ) was identified on 03/14/2024 at 08:05 PM. While the IJ was removed on 03/18/2024 at 07:26 PM, the facility remained out of compliance at a scope of isolated with potential harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions. The findings included: 1. A record review of Resident #23's admission record, dated 03/14/2024, revealed an admitted [DATE] with diagnoses of dementia (not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities), mood disturbance, anxiety, and Onchocerciasis with glaucoma (a disease where a parasite destroyed parts of the eye). A record review of Resident #23's quarterly MDS assessment, dated 02/12/2024, revealed Resident #23 was an [AGE] year-old female admitted for long term care assessed with a BIMS score of 10 which indicated moderate cognitive impairment. A record review of Resident #23's care plan, dated 03/14/2024, revealed Resident #23 had a history of rejecting care and or limited permission for assessments and therapies. Further review revealed interventions for avoidance of over-stimulation and avoidance of aggressive peer residents and, Problem Start Date: 07/17/2020 .ADLs (activities of daily life) . Presents with alteration in ADL self-performance & mobility R/T hx (related to history) of Rhabdomyolysis (damaged muscle tissue releases its proteins and electrolytes into the blood. These substances can damage the heart and kidneys and cause permanent disability or even death) & failure to thrive, Dementia, stiff left shoulder, muscle weakness, lack of coordination, muscle wasting and atrophy AEB (as evidenced by) requires staff assistance with all ADL's . Approach Start Date: 01/21/202 1; Resident requires supervision and set up by staff with showers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of Resident #14's admission record dated 03/14/2024, revealed an admitted [DATE] with diagnoses which included dementia, psychotic disturbance, mood disturbance, anxiety, and alcohol use. A record review of Resident #14's quarterly MDS assessment revealed Resident #14 was a [AGE] year-old male admitted for long term care assessed with a BIMS score of 5 which indicated severe cognitive impairment. A record review of Resident #23's nursing notes revealed LVN K documented on 02/06/2024 at 01:12 AM, an incident where Resident #23 was in the shower room bathing alone. LVN K documented she heard screams and shouts and discovered Resident #23 in the darkened shower room and on the floor. LVN K also documented Resident #23 was locked in the shower by another LVN (LVN A) who was re-directing Resident #14 from entering the shower room, while unknowing Resident #14 was in the shower, resident (#23) propel self in wheelchair to shower room. Another Resident (#14) wanting to take a shower and kept wanting to go in shower. Staff (LVN A) unknowing that resident was in shower turned light off and locked door so that other resident would not go into the shower by himself. Resident (#23) calling for help from the shower room and was sitting on the floor. asst. x2 to wheelchair. moving all extremities, refused writer to take vitals and/or check head. resident wanted to be left alone so that she could take her shower. Resident (#23) upset because she could hear other Resident (#14) wanting to go into shower. took other Resident to 200 hall shower room and showered. A record review of the facility's incident reports from June 2023 to March 2024 revealed no evidence for the incident on 02/06/2024 where Resident #23 was showering and Resident #14 trespassed and intruded in her privacy and safety while bathing. During an interview on 03/13/2024 at 02:30 PM Resident #23 stated she felt unsafe due to Resident #14's sexual harassment behaviors (attempts to get in the shower with her). During an interview on 03/13/24 at 04:30 PM Resident #23 stated on several occasions a man got into the shower with her, to which she would, pull the shower curtain closed, yell and scream at him until staff intervened and re-directed him away. During an interview on 03/13/24 at 02:29 PM LVN K stated she and LVN A were the charge nurses on 02/06/2024 from 06:00 PM to 06:00 AM. LVN K stated Resident #23 had a preference to bathe herself in the shower room early in the mornings around midnight to 01:00 AM. LVN K stated Resident #23's routine was she would gather her clothes and bathing supplies and self-ambulate in her wheelchair to the shower room. LVN K stated on 02/06/2024 around 01:00 AM screams and shouting were heard coming from the shower room. LVN K stated she ran to the shower room and discovered Resident #23 in the dark on the floor. Resident #23 was upset and claimed she was locked in the shower with the lights off. LVN K stated Resident #23 stated she fell in the dark attempting to get out of her wheelchair trying to get to the light switch or door. LVN K stated she spoke with LVN A and learned Resident #14 was attempting to get into the shower room with Resident #23. LVN A redirected Resident #14 away and LVN A did not recognize Resident #23 was in the shower room. LVN A turned off the light and locked the shower room door to prevent Resident #14 from entering. LVN K stated she had not initiated an incident report for any of Resident #14's sexual harassment incidents towards peer Residents, did not document on the 24 hour reports the sexual harassment behaviors towards peer residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/15/24 at 10:59 AM LVN A stated on the early morning of 02/06/2024 around midnight Resident #14 entered the shower room while Resident #23 was showering; although LVN A did not know Resident #23 was in the shower room. LVN A stated she heard Resident #23 in the shower room and entered and redirected him out and away from the shower room and turned off the shower room light and locked the door. LVN A stated she and LVN B spoke and concluded the chain of events. LVN A stated she did not check for other residents in the shower room and did not see Resident #23 possibly due to the shower curtain was pulled shut. LVN A stated she had not initiated an incident report for any of Resident #14's sexual harassment incidents towards peer Residents, did not document on the 24 hour reports the sexual harassment behaviors towards peer residents. 2. Observation and interview on 3/11/2024 at 10:55 AM revealed the storage room behind Nurses Station 1 was unlocked and the door was open. Further observation revealed phlebotomy products in the storage room to include needles, syringes, and empty vials for collecting blood. The Administrator approached at this time, and stated to surveyor that the door should be closed and was unsure if the door should be locked. LVN K then approached and stated she was not sure whether the door should be closed or locked. During an observation and interview on 3/13/2024 at 02:45 PM revealed the storage room behind Nurses Station 2 was unlocked and the door was open. Further observation revealed phlebotomy products in the storage room to include needles, syringes, and empty vials for collecting blood. LVN N stated that she was not sure if the door should be locked, and that she had been told that day to ensure the door was closed. LVN N also stated that the needles and other phlebotomy equipment have always been in the storage room with the door opened and unlocked. During an observation on 03/14/2024 at 12:30 PM, the medical equipment storage room behind Nurses Station 1 was observed to have the door open with phlebotomy equipment visible from the hallway. There were no staff present for approximately 15 minutes while the surveyor observed. During an interview on 03/15/2024 at 05:15 PM, the DON stated the storage room doors behind each nursing station should be closed and was unsure if they should be locked. The DON stated the risk could include residents getting into storage rooms and hurting themselves. Record review of facility policy titled Storage of Medications stated, Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. A record review of the facility's Accidents and Incidents - Investigating and Reporting, dated July 2017, revealed, All accidents or incidents involving residents, employees, visitors, vendors, etcetera, occurring on our premises shall be investigated and reported to the Administrator .the following data, as applicable, shall be included on the report of incident accident form; the date and time the accident or incident took place; the nature of the injury illness; where the accident or incident took place; the names of witnesses and their accounts of the accident or incident; the injured person's account of the accident or incident; the time the injured person's attending physician was notified, as well as the time the position responded and his or her instruction . An Immediate Jeopardy (IJ) was identified on 03/15/2024 at 08:05 PM and presented to the Administrator, a plan of removal was requested. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following Plan of Removal submitted by the facility was accepted on 03/17/2024 at 07:08 AM. Plan of Removal Problem: F689 Inadequate supervision to prevent accidents allegation Interventions: Resident #23 insists on having her privacy during shower times; staff is to assist in setting up resident for self-showering to include, but not limited to, assisting with transfers to and from wheelchair to shower chairs. Record review of care plan dated 3/16/2024 for Resident #23 revealed Problem: [Resident #23] desires privacy/modesty during showers. With interventions including Staff monitoring showers will be stationed outside the shower room door in order to provide for residents desire for modesty and privacy., and Staff monitoring shower will provide security from any intrusion by other staff or residents seeking entrance to shower room. Further review of the care plan revealed, staff is to assist in setting up resident for self-showering to include but not limited to transferring to and from wheelchair to shower chair. Interview on 3/17/2024 at 5:03 PM, CNA L stated she works overnight shifts and was informed that during Resident #23's shower, she would need to assist the resident with anything she may need in setting up her showers. Interview on 3/18/2024 at 12:55 PM, the Administrator stated that they put in place measures to ensure resident #23's privacy during her showers to include a nursing staff member ensuring no one enters the room, assists the resident as necessary, and monitor. Resident #23's shower time will be monitored by a dedicated nursing staff member at all times while she is showering. Interview on 3/17/2024 at 5:03 PM, CNA L stated she works overnight shifts and was informed that during Resident #23's shower, she or another nursing staff member would be required to monitor during Resident #23's shower. Interview on 3/18/2024 at 12:55 PM, the Administrator stated that they put in place measures to ensure resident #23's privacy during her showers to include a nursing staff member monitoring during all times in which the resident is showering. Staff monitoring showers will be stationed outside the shower room door in order to provide for resident #23's desire for modesty and privacy. Interview on 3/17/2024 at 5:03 PM, CNA L stated she worked overnight shifts and was informed that during Resident #23's shower, she or another nursing staff member would be required to monitor by standing outside the shower room door while the resident was showering to provide privacy to the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 3/18/2024 at 12:55 PM, the Administrator stated that they put in place measures to ensure resident #23's privacy during her showers to include a nursing staff member stationed outside the shower room door. Staff monitoring Resident #23's showers will provide security from any intrusion by other staff or residents seeking entrance to shower room. Interview on 3/17/2024 at 5:03 PM, CNA L stated she worked overnight shifts and was informed that during Resident #23's shower, she or another nursing staff member would be required stand outside the shower room door while the resident was showering to provide privacy to the resident and ensure no other residents enter the shower room. Interview on 3/18/2024 at 12:55 PM, the Administrator stated that they put in place measures to ensure resident #23's privacy during her showers to include a nursing staff member stationed outside the shower room door. We have changed out the doorknobs to the showers, and they are now classroom style locks, which automatically lock from the outside, and cannot be locked from the inside. Residents do not have access to the keys to these locks. Resident #23 will not be able to enter the shower area without a staff member opening the door for her. Observation of Shower room near Nurses Station 1 (of 2) on 3/16/2024 at 5:02 PM revealed doorknobs to the shower room automatically lock from the outside. Further observation revealed the door cannot be locked from the inside. Observation on 3/16/2024 at 5:15 PM revealed Shower Room in 200 hall had doorknobs to the shower room that automatically lock from the outside. Further observation revealed that the doors cannot be locked from the inside. Observation on 3/16/2024 at 5:25 PM revealed all shower room doors at the facility no longer have keys that unlock the shower room door visible or available to residents. These tasks will be added to staff's ADL Flow Chart/POC, which will in turn be monitored by DON/ Designee Record review of Order, start date 3/17/2024 with no end date reflected Ensure Privacy during shower time as follows: 1. Dedicated nursing staff member to monitor and be stationed outside shower room door in order to provide modesty/privacy. 2. Ensure security from any intrusion by other staff or residents seeking entrance to shower room on Monday, Wednesday, and Friday between 6:00 PM and 6:00 AM. Record review of Medication Administration Record, dated 3/18/2024, reflected the above order, once daily on Monday, Wednesday, and Friday between 6:00 PM and 6:00 AM with a start date of 3/17/2024. All shower rooms to have LED night lights installed on 3/15/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 3/16/2024 at 5:07 PM of Shower Room near Nurses Station 1 (of 2) revealed night light mounted near shower that activates when absence of light is detected through a sensor in the light. Observation on 3/16/2024 at 5:16 PM of Shower Room in 200 hall revealed night lights mounted in the shower room that activate when the absence of light is detected through a sensor in the light. Interview on 3/16/2024 at 5:29 PM, the Maintenance Director revealed the LED night lights installed in both shower rooms contain an internal battery, so if the power to them fails or is disrupted, they will remain on so long as the battery is charged. The following in-services were initiated on 3/14-16/2024: All available staff will be in-serviced by close of 3/15/2024 mandatory staff meeting, to be held at 1400 . Any staff member not present or in-serviced at close of mandatory meeting, will not be allowed to assume their duties until in-serviced. Administrator will ensure that trainings have been completed by keeping an in-service log that spells out the names of the staff members who have had trainings and have signed off on their attendance of said trainings. oAll Staff Abuse/Neglect Abuse/Neglect Reporting Who to Report Abuse/Neglect to Incident reporting to Admin/Physicians Importance of staff checking shower rooms for residents before turning off lights and locking doors A record review of the facility's employee roster dated, 03/16/2024 revealed 71 employees. 57% of employees, 44 of the 74, were interviewed to confirm receiving in-services for IJ F689. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees, 10 were nurses. A sample of 8 nurses, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F689. A record review of the facility's employee roster dated, 03/16/2024 revealed of the 71 employees 17 were CNAs. A sample of 8 CNAs, 5 on day shift and 3 on night shift, were interviewed to confirm receiving in-services for IJ F689. Record review of document titled Staff in-service, dated 3/15/2024, with the topic Abuse/Neglect Inservice revealed 46 of 71 staff signed off as having completed the in-service. Interview on 3/17/2024 at 3:15 PM, the MDS Coordinator revealed that not all staff report to physicians or emergency contacts, and that only 11 nurses would be responsible with reporting any events to physicians and emergency contacts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of document titled In-Service Training, dated 3/15/2024, with the topic The Importance of Reporting Events to Physicians and Emergency Contacts revealed 7 of 11 nursing staff signed off as having completed the in-service. Record review of document titled Staff in-service, dated 3/15/2024, with the topic Any staff who is turning off the lights and shutting the doors to any room shall check the room for any other persons prior to turning off the lights and shutting the door. Further review of this in-service revealed 49 of 71 staff signed off as having completed the in-service. Interview on 3/17/2024 at 12:30 PM, LVN N revealed that the in-service consisted of abuse and neglect prevention, complaints, when and where to file grievances and who to report grievances to. Interview on 3/17/2024 at 12:33 PM, CNA J stated that the in-service consisted of ensuring no residents are locked in shower rooms and monitoring showers and reporting to nursing staff . Interview on 3/17/2024 at 12:34 PM, CNA I stated that the in-service she received detailed ensuring that grievances are recognized and reported and checking shower rooms for residents. Interview on 3/17/2024 at 1:35 PM, CNA P stated the in-service detailed abuse, neglect, exploitation, and discussing any of these concerns with the administrator. Interview on 3/17/2024 at 2:04 PM, LVN K stated her most recent in-service consisted of abuse and neglect training, to include specifics about what is abuse and neglect, changes in conditions, and when to notify family and physicians. Interview on 3/17/2024 at 3:00 PM, LVN R stated the in-service she had most recently consisted of ensuring residents' complaints were recognized and grievances were filed. Interview on 3/17/2024 at 4:13 PM, CNA O stated the in-service they completed on 3/15/2024 consisted of reporting grievances and who to give them to. Interview on 3/17/2024 at 4:23 PM, LVN T stated the most recent in-service was about abuse and neglect and reporting any abuse or neglect to supervisors, as well as reporting to physicians. Monitoring Psychiatric services to be offered to Resident #23 in order to provide for any mental or emotional anguish created by being left in shower room with lights off. Record review of progress note dated 3/16/2024 at 4:29 PM, LVN K spoke with Resident #23's RP regarding the incident on 2/6/2024 as well as the incident on 3/12/2024. Record review of progress note dated 3/15/2024 at 11:43 AM revealed the Social Worker, spoke with Resident #23 who declined psychiatric services. Further review of the progress note revealed the Social Worker spoke with the MPOA regarding the incident on 2/6/2024 and the MPOA stated she did not want the resident to receive psychiatric services at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The QAPI committee will review findings monthly for no less than 90 days and makes changes as needed. Interview on 3/18/2024 at 10:36 AM, the Administrator stated that during QAPI they will follow a template relating to the deficiencies and discuss any changes or suggestions relating to any changes in care for residents with all members of the QAPI committee. DON to ensure care plans have been updated for resident #23 to reflect that she will have staff monitoring her during shower times. Record review of care plan dated 3/16/2024 for Resident #23 revealed Problem: [Resident #23] desires privacy/modesty during showers. With interventions including Staff monitoring showers will be stationed outside the shower room door in order to provide for residents desire for modesty and privacy., and Staff monitoring shower will provide security from any intrusion by other staff or residents seeking entrance to shower room. Further review of the care plan revealed, staff is to assist in setting up resident for self-showering to include but not limited to transferring to and from wheelchair to shower chair. An Immediate Jeopardy (IJ) was identified on 03/14/2024 at 08:05 PM. While the IJ was removed on 03/18/2024 at 07:26 PM, the facility remained out of compliance at a scope of isolated with risk for potential harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective actions.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range, for 1 of 8 Residents (Resident #13) reviewed for nutritional status in that: The facility failed to initiate timely intervention to prevent weight loss when Resident #13 experienced continuous significant weight loss of -10.84% (13.8 pounds) between the dates 12/01/2023 and 01/04/2024. 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 #13's Face Sheet, dated 3/18/2024, reflected an [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including unspecified dementia (group of thinking and social symptoms that interferes with daily functioning), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and osteoporosis (A condition in which bones become weak and brittle). Record review of Resident #13's MDS assessment, dated 3/1/2024, reflected a BIMS score of 10, indicating moderate cognitive impairment. Further review reflected that Resident #13 required setup or clean-up assistance while eating and had no swallowing disorders. Record review of Resident #13's Care Plan, dated 2/28/2024, reflected Resident #13 had unplanned weight loss of over 10% in 6 months with a start date of 1/9/2024. Interventions listed included: registered dietician to review residents medical record and make recommendations with nursing staff to follow up . There is no evidence to suggest the care plan intervention was implemented, or that the dietitian reviewed the medical record with nursing staff. Record review of Resident #13's weight record reflected that on 12/01/2023, she weighed 127.3 lbs.; on 1/04/2024, she weighed 113.5 lbs.; on 2/06/2024 she weighed 102.5 lbs.; and on 3/5/2024 she weighed 100. 3 lbs. Record review of document, titled Communication between the Dietitian and Attending Physician reflected that on 1/16/2024, the facility's registered dietician recommended house shake qd @ lunch and snack bid b/t meals for Resident #13. Further review reflected that the resident's physician reviewed this document on 2/8/2024, 23 days after the recommendation from the dietitian. Record review of Resident #13's orders reflected a doctor's order for house shake daily for lunch and a snack between meals twice daily with a start date of 2/8/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/11/2024 at 12:35 PM, Resident #13 was observed in her room eating lunch. A house shake was on the resident's meal tray. Interview attempt was not successful, as the resident declined to speak to surveyor. Interview on 3/15/2024 at 5:00 PM, LVN W stated that the CNA's take weights of residents and usually tell nursing staff if the resident seems to be losing weight based on any other factors throughout the month and they would notify the doctor if the weight was a significant amount. Interview on 3/15/2024 at 5:15 PM, the DON stated that the LVN's should document dietary intake and keep track of weights and inform DON of any significant changes so they can inform the physician. The DON stated that if there is a significant weight loss and/or any dietary recommendations, the expectation is that the physician is informed within a week so that they can begin any dietary recommendations or orders the physician may recommend. The DON stated that the risk to residents for not acting quickly on dietary recommendations or significant weight loss could include not preserving nutritional status or being able to investigate the cause for the weight loss. Interview on 3/16/2024 at 11:25 AM, CNA M stated that CNA's weigh residents monthly and discuss with nursing staff if a resident seems to be eating less or if the resident looks like they have lost weight. CNA M stated they were not aware on the resident's weight loss status and would only know if they noticed significant weight loss based on the residents appearance. Record review of policy titled, Food and Nutritional Services, dated 10/2017, reflected, The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675532	A. Building B. Wing	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uvalde Healthcare and Rehabilitation Center	535 N Park St Uvalde, TX 78801

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record review the facility failed to ensure residents are free of any significant medication errors for 2 of 2 (#9, #47) residents reviewed in that: 1. Resident #9 was administered Midodrine (a blood pressure medication) 9 times in February and March 2024 above parameters when it should have been held. 2. Resident #47 was administered Midodrine more than 39 times (2/13/2024 to 3/9/2024) in February and March 2024 without parameters (orders from the physician to determine where to give the medication or not based upon the blood pressure). This failure could result in residents having risk of heart attacks, strokes, blood clots, and risk of hospitalization s. Findings include: 1. Record review of Resident #9's face sheet dated 3/15/2024 revealed he was admitted on [DATE] and readmitted on [DATE] with diagnosis of hypotension (low blood pressure). Record review of Resident #9's consolidated orders for March 2024 revealed he had an order for Midodrine tablet 2.5 milligrams, oral, special instructions: Hold if systolic blood pressure is greater than 110 mm/Hg (millimeters of mercury) medications is used to treat low blood pressure (hypotension), three times a day. Record review of Resident #9's Quarterly MDS assessment dated [DATE] revealed Section C Cognitive Pattern BIMS score was 8/15 (moderate cognitive impairment), and Section I Active diagnosis reflected he had a diagnosis of hypotension. Record review of Resident #9's care plan dated 3/16/2024 revealed he was diagnosed with Cardiovascular, disease and the intervention was to monitor vitals for hypotension. Record review of Resident #9's MAR revealed administered Midodrine tablet 2.5 mg, 1 tablet, oral three times a day, HOLD if systolic blood pressure is greater than 110mm/Hg medications is used to treat low blood pressure (hypotension), diagnoses hypotension with a start date of 1/9/2024. Record review of MAR legend revealed initial parenthesized meant not administered or not charted. These dates below did not have parenthesis and show they were administered. Resident #9's February and March 2024 MARs indicated the Midodrine was administered on Dated: 2/15/2024 at 7- 10 PM B/P was 112/65 and was administered by MA H. 2/17/2024 at 1-2 PM B/P was 123/65 and was administered by MA H. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 N Park St Uvalde, TX 78801	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/20/2024 at 7-10 PM B/P was 113/64 and was administered by MA H. 2/23/2024 at 1-2 PM B/P was 134/65 and was administered by MA H. 2/26/2024 at 1-2 PM BP was 116/68 and was administered by MA X. 2/28/2024 at 1-2 PM B/P was 142/76 and was administered by MA H. 2/29/2024 at 1-2 PM B/P was 141/67 and was administered by MA H. 3/2/2024 at 1-2 PM B/P was 128/80 and was administered by MA X. 3/6/2024 at 1-2 PM B/P was 120/63 and was administered by MA H. Interview on 3/14/2024 at 10 AM with CMA H stated the Midodrine should not be administered if B/P was greater than 110 for Resident #9. CMA H stated she did not remember administering the Midodrine when his B/P was above 110. CMA H stated Resident #9 did not have side effects. Interview on 3/15/24 at 04:19 PM at 4 PM with CMA H stated she did Administer the medications as ordered and within the parameters to Resident # 9. CMA stated she had not noticed any adverse side effects and would notify the nurse. Interview on 3/14/2024 at 10:25 AM with LVN N stated the Midodrine was for low blood pressure and the CMA's administered that medication. LVN stated the CMA's had not notified her of any side effects and any change of condition. Interview on 3/14/2024 at 10:37 AM with the DON stated Midodrine was administering for low blood pressure and should not be administered by staff if Residents have a high B/P. DON stated the nursing staff had not let her know about administering Midodrine when B/P was high. DON stated she had been working as a DON for a week. Interview on 3/14/2024 at 10:42 AM with CMA X stated she missed it the Midodrine and thought it was for another medication with parameters. CMA X stated Resident #9 did not have adverse effects. 2. Record review of Resident #47's face sheet dated 3/18/2024 revealed she was admitted on [DATE] with diagnoses of Malignancy in colon, and non-specific low blood pressure reading. Record review of #47's consolidated orders for March 2024 revealed midodrine tablet; 5 mg (milligrams); 2 tablets oral Special Instructions: Hold if systolic blood pressure is more than 120. Record review of Resident #47's Admission MDS assessment dated [DATE] revealed Section C Cognitive Patterns BIMs score was 11/15 (moderate cognitive impairment), and Section I Active Diagnoses was cancer, and non-specific low blood pressure reading. Record review of Resident #47's Care Plan for Cardiovascular, reflected resident was at risk for sign and symptoms of hypotension (low blood pressure)/hyper (high blood pressure) related to diagnoses of hypertension. The interventions were to monitor resident's blood pressure per physician orders, and abnormal readings. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #47's February and March 2024 MAR revealed CMA Z administered Midodrine tablet 5 mg, 2 tablets three times a day, for diagnoses of low blood pressure reading, with start date 2/3/2024-3/9/2024. Record review reflected from 2/13/2024 to 3/9/2024 no vitals were documented with the administering of the Midodrine medication. Interview on 3/15/24 at 4:22 PM with CMA Z stated Midodrine did not have parameters from 2/13/2024 to 3/9/2024 and she would administer Midodrine as ordered with no parameters. The CMA Z stated Resident #47 did not have any adverse effects. CMA Z stated Resident #47 had not been feeling well lately, since her health had declined. Interview on 3/16/24 at 1:08 PM DON stated the CMAs were trained to administer medications, and no nursing staff had notified her of adverse effects with residents taking Midodrine. The DON stated she was not sure of the process because she was a new DON. DON stated she did not have any formal training and started 3/1/2024. The DON stated CMAs were not able to assess residents and should notify the nurse to assess the resident with any change of conditions. The DON stated the CMAs can take vitals. The DON stated the risk of not ensuring the staff had followed physic orders for Midodrine, would be heart rate goes up, stroke, and heart attack. Attempted interview on 3/18/24 at 5:09 PM with MD. Left a message and did not receive a return call. Interview on 03/18/24 at 05:10 PM with LVN K stated she did not remember the Midodrine orders. LVN K stated in her recent training, now nurses were to administrator Midodrine medication. Interview on 3/18/24 at 5:36 PM with RN R stated Midodrine was to treat hypotension, and the medication raised the blood pressure. RN R stated residents on Midodrine risked fainting, dizziness, having sensations in lower extremities and elevated pulse. RN R stated the CMA's should be notifying the nurse if any change of condition with medications. Record review of policy dated April 2019 was documented Administering Medications, Medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles in locked compartments and permit only authorized personnel to have access to the keys for 1 of 8 resident rooms (Resident #41) reviewed for storage of drugs, in that: An over-the-counter dietary supplement was found on a nightstand in a resident's room. This failure could place residents at risk of medication misuse and diversion. The findings included: Record review of Resident #41's face sheet, dated 3/18/2024, revealed a [AGE] year-old resident admitted on [DATE] with diagnosis including hypertension (high blood pressure), and urinary tract infection. Record review of Resident #41's care plan did not reflect any information related to self-administering medications or supplements. Record review of Resident #41's MDS Assessment reflected a BIMS score of 12, indicating moderate cognitive impairment. Interview and Observation on 3/11/2024 at 10:39 AM revealed a blister pack of medication on Resident #41's nightstand. Further observation revealed a box of medication with identical blister packs inside of it, with the box reading, AZO Cranberry Urinary Tract Health. Resident #41's husband entered the room, and stated he was happy with the care at the facility and had brought in the blister pack of the medication due to his wife's predisposition to contract urinary tract infections. Resident #41's husband stated his wife was at physical therapy and was unable to be interviewed, and that he had not been told he was not able to bring her medication that she could keep bedside. Interview on 3/15/2024 at 5:00 PM, LVN W stated if they see medication in a resident room, they are required to remove them, tell the DON, and tell the physician. LVN W stated the risks to medications being in resident rooms could include side effects from other medications possibly interacting with the medication in the resident's room. LVN W stated it was likely that the medication was brought in by the resident's family member, and further stated that they ensure any medications are stored by discussing medications with residents and ensure resident family members are informed of the risks of residents having access to medications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Uvalde Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 535 N Park St Uvalde, TX 78801	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/15/2024 at 5:16 PM, the DON stated that supplements, vitamins, or any sort of over-the-counter medication should not be in resident rooms and if staff find them, they are to inform the DON so they can inform the physician. The DON stated risks of over-the-counter medication being unregulated by nursing staff could include accidental ingestion of medication a resident should not take. The DON stated that the staff regularly go in and out of resident rooms and are taught to ensure there are no hazardous items such as over-the-counter medication available to residents. Record review of the facility policy and procedure titled, Storage of Medication, revealed, Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 18 (Resident #101) residents in that: LVN T did not use hand hygiene between cleaning Resident #101's plate/tray and touching an unknown resident's dessert plate. This could affect all residents that use plates from kitchen and could result in bacteria and cross contamination. The findings were: Record review of Resident #101's face sheet dated 3/11/2024 revealed he was admitted on [DATE], readmitted on [DATE] with diagnoses of Parkinson's disease, (progressive disorder that affects the nervous system and the parts of the body controlled by the nerves. Symptoms start slowly. The first symptom may be a barely noticeable tremor in just one hand. Tremors are common, but the disorder may also cause stiffness or slowing of movement), diabetes II, osteoarthritis (type of degenerative joint disease that results from breakdown of joint cartilage and underlying bone) and pain. Observation on 3/11/24 at 12:53 PM revealed Resident # 101 sitting in his wheelchair in the main dining room. LVN T served Resident # 101 his food tray, placed food items in front of him, then went to the other side of the room to put down his tray and throw things away. Then LVN T went over to pick up an unknown resident's dessert plate, then left the dining room. LVN T did not use hand hygiene after putting unknown residents' tray down and picking up unknown resident's dessert plate. Interview on 3/11/24 at 1:04 PM with LVN T stated she had served food to Resident #101, threw the trash from his tray away, then lifted an unknown residents' dessert tray to see if they were in the dining area. LVN T stated she was helping to serve in the dining room, then went back to her station to wash her hands and return to the nurse's station. LVN T stated her hand sanitizer was in her pocket, but she did not use it between resident food items. LVN T stated she did not serve the dessert tray, since the resident was not in the dining room. Interview on 3/11/24 at 01:38 PM with DON stated staff should use good hand hygiene (washing/disinfecting hands in between resident food items), in between touching resident food trays. Interview on 3/12/24 at 9:03 AM with Administrator discussed hand hygiene with LVN T touching the dessert plate, without hygiene between resident care. The Administrator had no response the infection control observation. Interview on 3/12/24 at 9:21 AM with DON stated the risk of staff not using good hand hygiene was cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of policy Handwashing/Hand Hygiene dated August 2019 revealed The facility considers hand hygiene the primary means to prevent the spread of infections. Before and after eating or handling food, and before and after assisting a resident with meals.