STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675677	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Del Rio Nursing and Rehabilitation Center	301 W Martin St Del Rio, TX 78840

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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 exercise their rights as a resident of the facility and as a citizen or resident of the United States for 2 of 40 residents (Residents #93 and #94) reviewed for freedom of their rights. 1. On 4/17/2025 Resident #93 was admitted to the facility in the custody of the United States Marshal Service under armed guard supervision and shackled at the wrists, abdomen, and ankles. 2. On 4/28/2025 Resident #94 was admitted to the facility in the custody of the United States Marshal Service under armed guard supervision and shackled at the wrists, abdomen, and ankles. These failures could place residents at risk for physical restraints not required to treat medical symptoms. The findings included: 1. A record review of Resident #93's administration record dated 5/2/2025 revealed Resident #93 was a [AGE] year-old male admitted on [DATE] with diagnoses which included cerebral infarction (stroke) and epilepsy (seizures). A record review of Resident #93's care plan dated 4/18/2025 revealed, actual or at risk for skin impairment: cuffs to bilateral (left and right) wrists, ankles, and abdominal back area, . other: US Marshal's supervisory needs in Rome [SIC(ROOM)] at all times . resident is detained under the direct supervision of a United States marshals as per state and federal law enforcement court orders. Therefore, the resident must remain secured via law enforcement requirements such as the use of cuffs / shackle like device. Nursing to monitor for seeing this especially at the ankles, wrists, etcetera. Regarding the cuffs shackles in place. Nurse should notify the US Marshal's nurse case manager and assigned physician for any skin related condition. During an observation and interview on 4/29/25 at 3:44 PM revealed Resident #93 in his room lying in bed covered in blankets with 2 armed guards supervising him. Resident #93 pulled back his covers and demonstrated his cuffed hands, and ankles as well as an abdominal chain. Resident #93 refused to comment on his wishes for restraints and or medical needs for restraints. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A record review of Resident #94's administration record dated 5/2/2025 revealed Resident #94 was a [AGE] year-old male admitted on [DATE] with diagnoses which included chronic pulmonary disease and heart failure. A record review of Resident #94's care plan dated 4/29/2025 revealed, actual or at risk for skin impairment: cuffs to bilateral wrists, ankles, and abdominal back area, . other: US Marshall's supervisory needs in Rome [sic(room)] at all times . resident is detained under the direct supervision of a United States marshals as per state and federal law enforcement court orders. Therefore, the resident must remain secured via law enforcement requirements such as the use of cuffs / shackle like device. Nursing to monitor for seeing this especially at the ankles, wrists, etcetera. Regarding the cuffs shackles in place. Nurse should notify the US Marshal's nurse case manager and assigned physician for any skin related condition. During an observation and interview on 4/29/25 at 3:48 PM revealed Resident #94 in his room lying in bed with 2 armed guards supervising him. Resident #94 demonstrated his cuffed hands, and ankles as well as an abdominal chain. Resident #94 refused to comment on his wishes for restraints and or medical needs for restraints. During an interview on 4/29/25 at 3:50 PM LVN B stated she was the charge nurse for Residents #93 and #94. LVN B stated Residents #93 and #94 were prisoners under custody of the Marshals service and each one was guarded by 2 armed guards and each prisoner was restrained by hand cuffs, ankle cuffs and an abdominal chain. LVN B stated each one was admitted with the restraints and each one did not have any consents nor physician's orders for the restraints. LVN B believed the resident prisoners were restrained by the Marshals and not the facility. LVN B stated, [Resident #94] just arrived yesterday, and [Resident #93] has been here since 4/17/2025. LVN B stated she and other nurses checked on resident prisoners' skin under and around the restraints for skin integrity. LVN B stated, They never leave their rooms, except for showers which are provided late evenings when other residents are in their rooms. During an interview on 4/29/25 at 4:50 PM the Health Services Administrator for the (Local) Detention Facility stated Resident # 94 and Resident #93 were current prisoners under the custody of the U.S. Federal Marshal Service. The Health Services Administrator stated the prisoners had medical needs for health care and security and the facility accepted the prisoners for care with the armed guards and the prisoners restrained. The Health Services Administrator stated per the Department of Justice the prisoners were to be always shackled at the wrists and ankles and guarded by 2 guards armed with firearms. During an interview on 4/30/25 at 5:10 PM the Deputy U.S Marshal Detention Management Investigator stated Resident #94 and Resident #93 were current prisoners under the custody of the U.S. Federal Marshal Service. The Deputy Marshal stated the prisoners had medical needs for health care and security which the facility accepted the prisoners. The Deputy Marshal stated the prisoners were to be always shackled at the wrists and ankles and guarded by 2 guards armed with firearms. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/30/25 at 7:01 AM revealed Detention Guard C and Detention Guard D were in Resident #93's room guarding Resident #93. The detention guards stated Resident #93 was a prisoner of the U.S. Marshals Service and were to be always shackled and in certain situations like mealtime they would call the Marshal and request permission to undo 1 of the hand cuffs temporarily for the meal. During an observation and interview on 4/30/25 at 7:10 AM revealed Detention Guard E and Detention Guard F were in Resident #94's room guarding Resident #94. The detention guards stated Resident #94 was a prisoner of the U.S. Marshals Service and were to be always shackled and in certain situations like mealtime they would call the Marshal and request permission to undo 1 of the hand cuffs temporarily for the meal. During an interview on 5/2/2025 at 4:40 PM the Administrator and the DON stated Residents #93 and #94 were admitted for rehabilitation healthcare under the supervision of the U.S. Marshals Service and had the need to be restrained. The Administrator and the DON stated they believed the restraints were applied by the Marshals and not the facility. The Administrator and the DON stated the risks for residents was for residents to be restrained. The Administrator stated she would partner with the Marshal Service to safely discharge Residents #93 and #94. A record review of the facility's Restraint Management policy dated January 2024, revealed, Compliance Guidelines: The standard of practice at the community is to attain a home like environment; therefore, the community strives to be a restraint free environment. Physical or chemical restraints are not used for purpose of discipline or convenience, but only as required/ordered to treat the resident's medical symptoms. Resident Rights - Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

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F 0552 Level of Harm - Minimal harm or potential for actual harm 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, their treatments, for 1 of 8 residents (Resident #24) reviewed for antipsychotic medication administration. 1. Resident #24 was administered ziprasidone, an antipsychotic medication, in April 2025 without the resident's informed consent and understanding the medications potential side effects. The deficient practices could place residents at risk for side effects for which they did not consent. The findings included: A record review of Resident #24's admission record dated 5/2/2025 revealed an admitted [DATE] with diagnoses which included dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities which can interfere with activities of daily life) and anxiety. A record review of Resident #24's admission MDS assessment dated [DATE] revealed Resident #24 was an [AGE] year-old female admitted for long term care and was assessed with a BIMS score of 0 out of a possible 15 which indicated severe cognitive impairment. Resident #24 was assessed with trouble sleeping and difficulty concentrating on tasks. Resident #24 needed total assistance with most ADL's and could use a wheelchair. Further review revealed Resident #24 was documented as receiving high-Risk Drugs. Resident #24 was documented as receiving antipsychotic medication. A record review of Resident #24's care plan dated 2/1/2025 revealed, I have a self-care deficit - dementia . with psychotic disturbance . I use my wheelchair as a walker and refuse to use a regular walker, I ambulate without requesting assistance and refuse to be assisted by staff, I tend to refuse care at times such as brief changes, showers, and clothing changes from staff . I require psychotropic medications and I am at potential risk for side effects related to my medication regiment . my targeted behavior for the antipsychotic is: aggressive [sic(aggression)] towards others . monitor, document, report, to medical doctor as needed signs and symptoms of psychotropic drug complications; altered mental status, decline in mood or behavior, hallucinations, delusions, social isolation, A record review of Resident #24's physician's orders dated 4/29/2025 revealed the physician prescribed for Resident #24 to receive ziprasidone (an antipsychotic medication) 10 mg injections as needed every 8 hours . A record review of Resident #24's Consent for Antipsychotic or Neuroleptic Medication Treatment form dated 4/18/2025, revealed the form was signed by Resident #24's representative however the form lacked any information for risks and benefits. The form instructed, you may attach prepared documents that state the risks and benefits of the proposed major medical treatment, procedure, specified. however, all questions must be addressed on this forum. the probable clinically significant side effects and risks of the proposed treatment with antipsychotic or neuroleptic medications are indicated: . the need for, and benefits of, the proposed treatment with antipsychotic or neuroleptic medications is indicated: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/2025 at 1:19 PM Resident #24's representative stated she recalled receiving reports shortly after Resident #24's admission concerning Resident #24's aggressive behaviors towards peer residents and staff along with Resident #24's confused anxiety and refusals for medication and hygiene care which led to the physician's recommendation for a drug that could calm Resident #24. Resident #24's representative stated she signed a permission slip for Resident #24 to receive the drug but was unaware of any risks for side effects and believed the drug would be a pill and not an injection. Resident #24's representative stated she learned Resident #24 had received the drug multiple times since the end of April 2025 and believed the drug had helped Resident #24 but she now had concerns about the injection and the potential risks for side effects. During an interview on 5/1/2025 at 1:40 PM the ADON stated Resident #24 had a history of aggression towards peers and staff and had been prescribed ziprasidone on 4/29/2025 and had been administered the medication via an injection several times in April 2025. The ADON stated Resident #24's representative had consented for the medication administration and was documented on the Consent for Antipsychotic or Neuroleptic Medication Treatment form dated 4/18/2025. The ADON stated upon inspection of the document the form lacked any information for risks and benefits. The ADON stated the resident should be informed of the proposed medication's potential risks versus the intended benefits prior to the administration. The ADON stated she was unaware of how the information was not documented. During an interview on 5/2/2025 at 5:02 PM the Administrator and the DON stated the expectation for anti-psychotic medication administration was for the resident and or the resident's representative to receive informed consent prior to the drugs administration. The DON stated the risk to residents who did not receive informed consent could be receiving the medications without understanding the potential benefits versus the potential risks of the medications administered. The DON stated the system in place to ensure informed consents prior to medication administration was for the IDT to meet daily and review the medication orders and follow up with consents. A record review of the facility's Psychotropic Medications & Gradual Dose Reduction policy dated January 2023 revealed, The community is expected to make every effort to comply with state and federal regulations related to the use of psychotropic medications in the community to include diagnosis, targeted behavior or clinical indications for use, prescriber's specified dosage frequency and duration of therapy, consent must be received and noted in the medical record for any use of psychotropic medications. Additionally, the prescriber must provide specific rational for use, clinical indications for use, risks and/or benefits of therapy and informed consent as per defined content in the Texas 3713 form for all antipsychotic or neuroleptic drug therapy

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record review the facility failed to ensure that each resident was free from physical or chemical restraints imposed for purposes of discipline or convenience and that were not required to treat the resident's medical symptoms, for 2 0f 40 residents (Residents #93 and #94) reviewed for physical restraints. 1. On 4/17/2025 Resident #93 was admitted to the facility in the custody of the United States Marshal Service under armed guard supervision and shackled at the wrists, abdomen, and ankles. 2. On 4/28/2025 Resident #94 was admitted to the facility in the custody of the United States Marshal Service under armed guard supervision and shackled at the wrists, abdomen, and ankles. These failures could place residents at risk for physical restraints not required to treat medical symptoms. The findings included: 1. A record review of Resident #93's administration record dated 5/2/2025 revealed Resident #93 was a [AGE] year-old male admitted on [DATE] with diagnoses which included cerebral infarction (stroke) and epilepsy (seizures). A record review of Resident #93's care plan dated 4/18/2025 revealed, actual or at risk for skin impairment: cuffs to bilateral (left and right) wrists, ankles, and abdominal back area, . other: US Marshal's supervisory needs in Rome [SIC(ROOM)] at all times . resident is detained under the direct supervision of a United States marshals as per state and federal law enforcement court orders. Therefore, the resident must remain secured via law enforcement requirements such as the use of cuffs / shackle like device. Nursing to monitor for seeing this especially at the ankles, wrists, etcetera. Regarding the cuffs shackles in place. Nurse should notify the US Marshal's nurse case manager and assigned physician for any skin related condition. During an observation and interview on 4/29/25 at 3:44 PM revealed Resident #93 in his room lying in bed covered in blankets with 2 armed guards supervising him. Resident #93 pulled back his covers and demonstrated his cuffed hands, and ankles as well as an abdominal chain. Resident #93 refused to comment on his wishes for restraints and or medical needs for restraints. 2. A record review of Resident #94's administration record dated 5/2/2025 revealed Resident #94 was a [AGE] year-old male admitted on [DATE] with diagnoses which included chronic pulmonary disease and heart failure. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #94's care plan dated 4/29/2025 revealed, actual or at risk for skin impairment: cuffs to bilateral wrists, ankles, and abdominal back area, . other: US Marshal's supervisory needs in Rome [sic(room)] at all times . resident is detained under the direct supervision of a United States marshals as per state and federal law enforcement court orders. Therefore, the resident must remain secured via law enforcement requirements such as the use of cuffs / shackle like device. Nursing to monitor for seeing this especially at the ankles, wrists, etcetera. Regarding the cuffs shackles in place. Nurse should notify the US Marshal's nurse case manager and assigned physician for any skin related condition. During an observation and interview on 4/29/25 at 3:48 PM revealed Resident #94 in his room lying in bed with 2 armed guards supervising him. Resident #94 demonstrated his cuffed hands, and ankles as well as an abdominal chain. Resident #94 refused to comment on his wishes for restraints and or medical needs for restraints. During an interview on 4/29/25 at 3:50 PM LVN B stated she was the charge nurse for Residents #93 and #94. LVN B stated Residents #93 and #94 were prisoners under custody of the Marshals service and each one was guarded by 2 armed guards and each prisoner was restrained by hand cuffs, ankle cuffs and an abdominal chain. LVN B stated each one was admitted with the restraints and each one did not have any consents nor physician's orders for the restraints. LVN B believed the resident prisoners were restrained by the Marshals and not the facility. LVN B stated, [Resident #94] just arrived yesterday, and [Resident #93] has been here since 4/17/2025. LVN B stated she and other nurses checked on resident prisoners' skin under and around the restraints for skin integrity. LVN B stated, They never leave their rooms, except for showers which are provided late evenings when other residents are in their rooms. During an interview on 4/29/25 at 4:50 PM the Health Services Administrator for the (Local) Detention Facility stated Resident # 94 and Resident #93 were current prisoners under the custody of the U.S. Federal Marshal Service. The Health Services Administrator stated the prisoners had medical needs for health care and security and the facility accepted the prisoners for care with the armed guards and the prisoners restrained. The Health Services Administrator stated per the Department of Justice the prisoners were to be always shackled at the wrists and ankles and guarded by 2 guards armed with firearms. During an interview on 4/30/25 at 5:10 PM the Deputy U.S Marshal Detention Management Investigator stated Resident #94 and Resident #93 were current prisoners under the custody of the U.S. Federal Marshal Service. The Deputy Marshal stated the prisoners had medical needs for health care and security which the facility accepted the prisoners. The Deputy Marshal stated the prisoners were to be always shackled at the wrists and ankles and guarded by 2 guards armed with firearms. During an observation and interview on 4/30/25 at 7:01 AM revealed Detention Guard C and Detention Guard D were in Resident #93's room guarding Resident #93. The detention guards stated Resident #93 was a prisoner of the U.S. Marshals Service and were to be always shackled and in certain situations like mealtime they would call the Marshal and request permission to undo 1 of the hand cuffs temporarily for the meal. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/30/25 at 7:10 AM revealed Detention Guard E and Detention Guard F were in Resident #94's room guarding Resident #94. The detention guards stated Resident #94 was a prisoner of the U.S. Marshals Service and were to be always shackled and in certain situations like mealtime they would call the Marshal and request permission to undo 1 of the hand cuffs temporarily for the meal. During an interview on 5/2/2025 at 4:40 PM the Administrator and the DON stated Residents #93 and #94 were admitted for rehabilitation healthcare under the supervision of the U.S. Marshals Service and had the need to be restrained. The Administrator and the DON stated they believed the restraints were applied by the Marshals and not the facility. The Administrator and the DON stated the risks for residents was for residents to be restrained. The Administrator stated she would partner with the Marshal Service to safely discharge Residents #93 and #94. A record review of the facility's Restraint Management policy dated January 2024, revealed, Compliance Guidelines: The standard of practice at the community is to attain a home like environment; therefore, the community strives to be a restraint free environment. Physical or chemical restraints are not used for purpose of discipline or convenience, but only as required/ordered to treat the resident's medical symptoms. Resident Rights - Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50760 Based on interviews and record review, the facility failed to electronically transmit encoded, accurate, and complete MDS data to the CMS System, within 14 days, upon a resident's transfer, reentry, discharge, and death, for 1 of 8 residents (Resident #37) reviewed for transmitted MDS data to the CMS System. The facility failed to transmit a discharge MDS assessment to the CMS system for Resident #37. This failure could place residents at risk of not having their assessments transmitted timely which could cause a delay in treatment. The findings included: Record review of Resident #37's admission sheet documented an original admitted [DATE] with diagnoses which included type 2 diabetes mellitus, high blood pressure, and high cholesterol. Record review of Resident #37's discharge summary documented a discharge date of [DATE] to the resident's home. Record review of Resident #37's admission MDS assessment, dated 12/23/2024, documented a BIMS score of 14 which indicated no cognitive impairment. Further review of Resident #37's medical record revealed no other MDS assessment and or transmittal to the CMS system with a status of Discharge - ARD: 12/23/2024 116 days overdue. During an interview with the MDS Nurse on 5/02/25 at 1:23 PM, the MDS Nurse stated when a resident is discharged , they do a care plan meeting with the family to see what the plan is, and if the resident has the resources they need after discharge. The MDS Nurse stated when a resident is discharged , they must open a discharge MDS which is an assessment of the discharge they send to CMS with the discharge status of the resident. The MDS Nurse stated she must complete and submit the MDS discharge assessment. The MDS Nurse stated she signs each tab of the assessment, and then has the Regional Nurse Supervisor and the DON sign it. The MDS Nurse stated once all signatures are present, she sends the assessment to CMS. The MDS Nurse stated the discharge MDS assessment was probably not done because the resident left so soon; she missed it; and it was human error. During an interview with the Administrator on 5/02/25 at 4:40 PM, the Administrator stated her expectation for MDS assessments was when a resident is discharged , the MDS Nurse should process the discharge assessment to CMS and double check herself. The Administrator stated the harm in not processing the discharge MDS assessment was that CMS would be unaware that the resident was no longer residing in the facility. Record review of the facility policy titled Comprehensive Assessments, dated February 2017 and revised March 2023, noted assessments are conducted within fourteen days of the resident's admission to the community, when there has been a significant change in the resident's condition, quarterly, and annually (every twelve months).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50760 Based on observations, interviews, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 residents (Resident #93) reviewed for pharmacy services. The facility failed to ensure Resident #93's blood pressure results were documented in the electronic medical before administering a blood pressure medication per the physician's orders. This failure could place residents at risk of not receiving the intended effect of their prescribed medications and a decreased quality of life. The findings included: Record review of Resident #93's admission sheet dated 5/2/2025, documented a [AGE] year old male with an admitted [DATE] with diagnoses which included cerebral infarction (when blood flow to the brain is blocked or a blood vessel inside or on the surface of the brain bursts), seizure disorder, low blood pressure, depression, and anxiety. Record review of Resident #93's annual MDS assessment, dated 4/26/2025, documented no BIMS score for the resident. Under section 0C100 Should Brief Interview for Mental Status (0C200-0C500) be Conducted?, no answer was recorded. Record review of Resident #93's care plan with a creation date of 4/18/2025, documented the resident's refusal to follow care recommendations of the physician and clinical team with interventions including Provide education on options for care and reassure that choices will be respected. Provide education to me and or my family on the associated benefits of the recommended care and orders noted. Refer to Social Worker as indicated. Record review of Resident #93's hospital discharge summary, dated 4/13/2025, documented the resident's active medication list including an order for Midodrine 10mg, give 1 tablet by mouth three times a day, hold if systolic blood pressure greater than 100. Record review of Resident #93's MAR from April 2025 showed no documentation of Resident #93's blood pressure results before giving the resident's blood pressure medication. During an observation and record review of medication administration with the facility CMA on 5/01/25 at 7:45 AM, the CMA collected the blood pressure cuff and medications for resident #93 including the resident's blood pressure medication and proceeded to the resident's room to measure the resident's blood pressure and administer the medications. Review of the directions for the blood pressure medication on the electronic medication administration record included parameters to hold the medication pending the result of the blood pressure. The resident refused to have his blood pressure measured and refused all medications. The CMA returned to the medication cart to dispose of the refused medications, document the refusal, and alert the nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675677	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Del Rio Nursing and Rehabilitation Center	301 W Martin St Del Rio, TX 78840

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the CMA on 5/01/25 at 4:10 PM, the CMA stated she takes Resident #93's blood pressure before dosing and is aware of the parameter but she does not document the measurement of the blood pressure on the resident's electronic medical record. The CMA stated she does not document the results of Resident #93's blood pressure because there is nowhere to record it. The CMA stated she had not told anyone there was nowhere to record the blood pressure results. When asked why she had not told anyone there was nowhere to document blood pressure results, the CMA stated, well, I don't, but I give it correctly. During an interview with LVN A on 5/02/25 at 8:45 AM, LVN A stated if parameters are on the medication aide screen, results should be somewhere. LVN A stated she always takes the blood pressures of all residents with parameters, and we all write it in our brain, but that's not right. During an interview with the Regional Administrator, the Administrator, and the DON on 5/02/2025 at 4:40 PM, the Administrator stated her expectation was for staff to follow physician orders and document a resident's blood pressure results in the notes section of the electronic medical record. The Administrator stated her expectation was for staff to communicate with her if they could not find an area in the medical record to document blood pressure results. The Administrator stated there was no harm to the resident, because the Medical Director discontinued the order with parameters the day before on 5/01/2025 and reordered the medication with no parameters. Record review of the facility's policy titled Medication Administration, dated March 2019 and revised January 2024, documented if applicable and/or prescribed, take vital signs or tests prior to administration of the dose and administer medications as ordered by the physician.