

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2025
NAME OF PROVIDER OR SUPPLIER  Village Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  615 N Ware Rd McAllen, TX 78501	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301</b></p> <p>Based on interviews, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #1) of 8 residents reviewed for accuracy of assessments.</p> <p>The facility failed to ensure Resident #1 was coded in the MDS for a fall with major injury on 1/30/25.</p> <p>This failure could place residents at risk of receiving care and services to meet their needs.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 3/5/2025 reflected Resident #1 was admitted on [DATE] and she was [AGE] years old. Resident #1 had diagnoses of muscle weakness, unsteadiness on feet, other abnormalities of gait and mobility, and dementia (a progressive decline in cognitive functions, such as memory, thinking, problem-solving and decision-making).</p> <p>Record review of Resident #1's comprehensive care plan dated 1/24/25 reflected: Resident #1 had an actual fall with major injury, poor balance, and unsteady gait. She was sent to the ER for an evaluation and returned with a right rib fracture. Date Initiated: 01/30/2025.</p> <p>Record review of Provider Investigation Report revealed the facility reported the fall incident of Resident #1 to HHSC on 1/31/25. The resident was sent out to the ER for x-rays. The ER reported to the facility the resident had right rib fractures. A safety survey was conducted. Staff were in-serviced on abuse, neglect, and falls.</p> <p>Record review of Resident #1's Discharge MDS dated [DATE] revealed:</p> <p>1 fall since Admission/Entry or Reentry or Prior MDS Assessment with no injury.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/4/25 at 3:20 pm, LVN B said he completed the head-to-toe assessment after the fall. She did have a fall but did not recall the actual date. He said he heard a thump, and when he checked on the resident, she was getting herself back in bed. When LVN B asked Resident #1 what she was doing prior to the fall, Resident #1 said she was trying to unlock the door at the bottom. He said they did not know what she meant by that. He said when he felt the back of her head, she complained of pain. He stated they called the on-call provider, and he gave the order to send to the ER for further evaluation. He said we did not lock the doors on the residents. He said they would provide Resident #1 repeated reminders to use the call light and to use her walker, but she would not remember. He said he did not remember the interventions provided for that fall, but Resident #1 had at one point 1:1 redirecting, providing snacks, bed low position, and floor mats. He said he did frequent rounding for his residents. He said he recalled receiving in-services for abuse, neglect, and exploitation, and for falls .</p> <p>During an interview on 3/5/25 at 3:15 pm, MDS A said when she ran her Risk Assessment report, it showed Resident #1 had a fall but did not have an injury at the time of the incident. She said she went based on that report. She said Resident #1 was later sent out to the hospital, where they found the fractures. She said the fall with injury should have been updated and coded accurately on the MDS once they learned about the fractures. She said she just missed it. She said if the MDS was not documented accurately, the information that gets automatically transferred to other facilities would be inaccurate. The accepting facility would not be aware that Resident #1 had a prior fall with major injury, and it could cause more injury or harm to the Resident if not communicated. She said she modified the assessment and fixed the issue once she reviewed the documentation from the hospital.</p> <p>During an interview on 3/5/25 at 4:00 pm, the DON said Resident #1 had an unwitnessed fall on 1/30/25, and she was complaining of pain to the head. The DON said due to the fall being unwitnessed, the MD sent her to the hospital for a CT scan. She said in-services were conducted for abuse, neglect, and exploitation which included injury of unknown origin. She said a falls in- service was also conducted once we ensured it was a fall. She said depending on what was involved with a fall, we included transfer training or get the therapist involved. She said Resident #1's fall happened due to self-transferring at night. She said Resident #1 understood when we instructed her on the use of the call light for assistance with transfers, but she would not remember to use the call light due to her diagnosis of dementia, bipolar, and schizophrenia. She said fall in-services were done any time there was an incident, a change of condition that involved an injury, or for a fall and included the reason of what happened to try and improve on the care. The DON said the Risk Assessment report showed no injury due to the head CT scan results were negative for injury, and the initial complaint was related to pain to the head. She said the fall with major injury should have been caught and coded accurately on the MDS. She said the outcome of the coding did not affect the care Resident #1 received when she returned to the facility because the care plan was being followed to provide her care and the MD was aware of her status.</p> <p>During an interview on 3/5/25 at 5:10 pm, the Administrator said Resident #1 had a fall and was sent out to the hospital where they found she had rib fractures. He said we want to ensure our facility was accurate in our reporting for the MDS. He said the fall was reported, we just forgot to include it involved an injury. He said he felt it would not affect the care Resident #1 needed for the fall. He said it was more a technical error.</p> <p>Record review of CMS's RAI Version 3.0 Manual dated 10/2024 reflected section:</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>J1800: Any falls since admission/entry or reentry or Prior to Assessment .</p> <p>Steps for Assessment .</p> <p>3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.</p> <p>Coding instructions:</p> <p>Code 1, yes if the resident has fallen since the last assessment. Continue to number of falls since admission/entry or reentry or prior to assessment.</p> <p>J1900: Any falls since admission/entry or reentry or Prior to Assessment.</p> <p>Coding instructions for J1900C:</p> <p>Code 1, one: if the resident had one major injurious fall since admission/entry or reentry prior assessment .</p> <p>Coding Tip</p> <p>If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Internet Quality Improvement and Evaluations System (iQIES), the assessment must be modified to update the level of injury that occurred with that fall.</p> <p>Definitions .</p> <p>Major Injury</p> <p>Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.</p>