STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675689	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Healthcare and Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** Based on observations, interviews, and record review, the facility failed to ensure residents remained free from accidents, hazards and each resident received adequate supervision and assistance while providing care for 1 of 5 residents (Resident #1) reviewed for accidents and supervision. The facility failed when CNA B did not provide Resident #1 adequate supervision while providing incontinent care on [DATE] at around 11:50 AM, which led to Resident #1 falling from his bed, resulting in a traumatic intracranial hemorrhage (brain bleed). The non-compliance was identified as past non-compliance. The Immediate jeopardy began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This deficient practice has the potential to affect all residents in the building by causing resident injuries, such as falls, fractures, and even death due to improper supervision. The findings included: Record review of Resident #1's face sheet dated [DATE] reflected an [AGE] year-old male with an original admission date of [DATE]. His relevant diagnoses included: unspecified dementia, syncope (fainting) and collapse, anxiety disorder, atrial fibrillation (abnormal heart rhythm), and adult failure to thrive. Record review of Resident #1's care plan dated [DATE] reflected Resident #1 required one staff assistance for toileting and one staff assistance for bed mobility to reposition and turn in bed. Resident #1 had mobility bars (x2) to aide in easy turning and repositioning while in bed. Record review of Resident #1's fall risk evaluation dated [DATE] reflected Resident #1 was at a high risk for falls with a score of 15 (indicated high risk). Record review of Resident #1's MDS dated [DATE] reflected Resident #1 had a catheter for urinary continence and was always incontinent for bowel continence. Resident #1 was dependent for toileting hygiene and roll left/right. Resident #1 had a BIMS score of 00 with severe cognitive impairment. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's skin evaluation dated [DATE] reflected Resident #1 noted with swelling to left side of forehead, with open area size 0.4x0.4x0.3 cm, small amount of sanguineous drainage, purple discoloration present. Left lateral side of head noted with open laceration size 1.3x0.2x0.4 cm, moderate amount of sanguineous drainage, slight purple discoloration surrounding laceration. Left anterior shoulder with skin abrasion, size 1x1x0.1 cm, small amount of sanguineous drainage, no swelling noted. Left forearm noted with abrasion, size 2x1x0.1 cm, small amount of sanguineous drainage, no swelling noted. Open areas were cleansed with normal saline and gauze, pat dry with gauze, covered with gauze and secured with tape. Resident tolerated well. Record review of Resident #1's hospital records dated [DATE] reflected Resident #1 was diagnosed with a traumatic intracranial hemorrhage. Family did not want further treatment. Family decided on palliative care. In an interview on [DATE] at 9:40 AM, CNA B said on [DATE] she was going to provide incontinent care for Resident #1. CNA B said Resident #1 was on his side, facing towards the wall, and she was standing behind him. CNA B said she did not remember if she moved him onto his side or if he was already positioned that way when she entered the room. CNA B said Resident #1 was able to move in bed. CNA B added that she was interrupted by CNA C who came into the room, called CNA B's name to ask for assistance with another resident. CNA B said she turned momentarily to respond and when she turned back, Resident #1 had already rolled off the bed and to the floor. CNA B added that although she was standing next to the bed she was not holding on to the resident or else he would not have fallen. CNA B said she turned her head quickly but it happened very fast, in a second, and she was not able to prevent Resident #1 from falling off the bed. CNA B said CNA C heard the fall and she told CNA C to call the nurse right away. CNA B said she stayed with Resident #1 until LVN A arrived to assess him. CNA B said she was in-serviced on falls, incontinent care, and safety before and after the fall on [DATE]. CNA B said they were told to not leave the resident alone with the bed high, to be careful, and to pay attention to the resident. In an interview on [DATE] at 10:00 AM, CNA C said she entered Resident #1's room on [DATE] to inform CNA B, who was performing incontinent care for Resident #1, that she needed help with another resident. CNA C said the curtain was closed for Resident #1's privacy, but CNA B opened the curtain a bit and CNA B told CNA C that okay, she would go help her right now. CNA C said CNA B was standing right next to Resident #1's bed, CNA B did not move away from the bed, and the curtain was not far from the bed. CNA C said CNA B just quickly told her okay and closed the curtain. CNA C said she did not see how Resident #1 was positioned in the bed. CNA C said she turned towards the door to exit the room when she heard a noise. CNA C said CNA B told her Resident #1 fell and to call the nurse. CNA C said she immediately notified LVN A and LVN A went to Resident #1's room. CNA C said she was in-serviced before and after the fall on [DATE] and was told to focus on what they are doing for peri care or other tasks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 10:30 AM, LVN A said he was notified by CNA C that Resident #1 had fallen so he went to his room to assess. LVN A said when he walked in, Resident #1 was lying on the floor on his left side and CNA B was kneeling next to him. LVN A said CNA B reported she was attending to Resident #1 on the bed when CNA C called her from the doorway so CNA B turned around to answer CNA C. LVN A said CNA B said when she turned back, Resident #1 was on the floor. LVN A said he and RN B completed a head to toe assessment and noted Resident #1 with a raised area to the left temporal side with minimal bleeding that was controlled. LVN A said he followed the protocol and notified the MD and RP . LVN A said Resident #1 was sent out to the hospital for further evaluation and treatment. LVN A said he was familiar with Resident #1 and knew he was fidgety at times and was able to move in bed. LVN A said he was in-serviced on falls, abuse/neglect, safe transfers, and incontinent care before and after the fall on [DATE]. LVN A said when they in-serviced them on peri care and other tasks, they were instructed to focus on the task at hand. LVN A said the staff could have focused on Resident #1 and not turned away from him. In an interview on [DATE] at 11:15 AM, RN B said he was called to Resident #1's on [DATE] for a fall. RN B said Resident #1 was in bed, awake, but not in distress. RN B said he assessed Resident #1's skin, cleansed the affected areas, and placed a temporary dressing. RN B said Resident #1 was immediately sent out to the hospital. RN B said he noted the details of the injuries in his documentation and recalled the injuries were on Resident #1's left side. RN B said he was in-serviced on falls, abuse/neglect, incontinent care, and safety, before and after the fall on [DATE]. In an interview on [DATE] at 5:25 PM, the DON said on [DATE], she was notified Resident #1 had fallen. The DON said when she walked towards Resident #1's room, the ambulance had arrived to transfer him to the hospital. The DON said CNA B explained that she was providing incontinent care and when CNA C called for her, CNA B turned quickly to answer CNA C, and when CNA B turned back, Resident #1 had fallen and was on the floor. The DON said CNA B explained it happened fast and she could not prevent Resident #1 from falling. The DON said Resident #1 was 1 person assist for incontinent care and bed mobility as Resident #1 could help move. The DON said Resident #1 had a raised area on his forehead with a small laceration, first aid was provided, and he was sent out to the hospital for further evaluation. The DON said the hospital diagnosed Resident #1 with a traumatic intracranial hemorrhage and the family opted out of surgical interventions. The DON said Resident #1 returned on [DATE] under palliative care and he expired on [DATE]. The DON said they in-serviced all staff on falls, abuse/neglect, safety to prevent falls, transfers, change of condition, and how to find information on the Kardex (documentation system with the plan of care information). The DON said they reviewed all residents' charts to ensure the bed mobility and ADL status reflected in the plan of care. The DON said interdisciplinary team or an assigned staff monitored the staff by conducting random spot checks of information and observed staff providing care. In an interview on [DATE] at 5:45 PM, the Administrator said on [DATE], he was notified that Resident #1 had fallen. The Administrator said he spoke to CNA B who explained that she was providing incontinent care for Resident #1 when CNA C called her name and said she needed help. The Administrator said CNA B explained she turned to tell CNA C she would be right there and when she turned back, Resident #1 was on the floor. The Administrator said they interviewed staff and investigated the fall. The Administrator said they in-serviced all staff on abuse/neglect, falls, safety, change of condition, and the Kardex. The Administrator said they reviewed all residents' Kardex information which included their level of care needs and they did not identify any errors. The Administrator said they had a QAPI meeting and followed the plan in place which included ongoing in-services/education, resident assessments, and random spot checks of knowledge with staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- dated [DATE] for week 4 with 5 staff 9. Record review of investigation dated [DATE] reflected Resident #1's fall was on [DATE]. Incident Summary noted: Resident #1 sustained a witnessed fall while receiving peri care by CNA B. Upon charge nurse entering Resident #1's room, Resident #1 noted lying on his left side next to the bed with CNA B by his side. Resident #1 was noted with a raised area to left temporal head with abrasions and moderate bleeding. Resident #1 was awake with eyes open and in no apparent distress. MD/RP made aware immediately and Resident #1 was sent to the hospital per MD orders. As per CNA B's interview, fall attributed to Resident #1 abruptly rolling to right side of bed and CNA B unable to brace his fall. No evidence of emotional distress and no signs of abuse/neglect during this incident. Bleeding and raised area to head was related to witnessed fall and Resident #1 used anticoagulant therapy as per MD orders. 10. Record review of the Kardex dated [DATE] reflected 100% current residents' information reviewed to ensure bed mobility and ADL status was reflecting on POC. No other current residents were identified with potential for injury. 11. Record review of new admissions dated [DATE] reflected new admissions reviewed and care plan initiated/updated appropriately for residents, including Resident #1's readmission on [DATE]. 12. Record review of the QAPI meeting dated [DATE] reflected fall during ADL care. The team met with the medical director. Goal: Staff would be knowledgeable of safety during ADL care according to established criteria and decrease in falls. Interviews with other CNAs/nurses revealed they were in-serviced on falls, safety, bed mobility, incontinent care, abuse/neglect, and level of care/Kardex information. On the following dates and times: [DATE] at 1:50 PM, CNA A [DATE] at 1:30 PM, CNA D [DATE] at 1:40 PM, CNA E [DATE] at 1:50 PM, LVN B [DATE] at 2:05 PM, CNA F [DATE] at 2:15 PM, CNA G (continued on next page)

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