STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675717	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Rafael Nursing and Rehabilitation Center	3050 Sunnybrook Rd Corpus Christi, TX 78415

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48633 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences for one of one residents reviewed for call lights. The facility did not ensure Resident #1's call light was with in reach. This failure could place residents at risk for illness due to cross contamination in the kitchen and left a resident without access to staff and at risk for falling. Findings included: Record review of a face sheet dated 9/4/2024 indicated Resident #1 was a [AGE] year old who was admitted on [DATE] with diagnoses of Hemiplegia and hemiparesis of the left side following a cerebral infarction affecting the left non-dominant side (a stroke causing weakness or total paralysis of the left side of the body), Vascular Dementia (a progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), lack of coordination, and abnormalities of gait and ambulation (walking). Review of a quarterly MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 10 which indicated moderate cognitive impairment. Record review of Resident #1's care plan, undated revealed, Resident #1 has functional limitation in range of motion of extremities, to encourage the resident to use the call light, and the resident needs the assistance of 1-2 staff members for transfers (from bed to wheelchair and return from wheelchair to bed). The care plan also revealed the resident is at risk for falls and interventions include ensuring the call light is within reach. On 9/4/2024 at 2:42 pm, observation of Resident #1 in her room in her wheelchair with the door closed and no call light within reach (call light was attached to side of bed.) The resident stated she was uncomfortable and wanted to go to bed. On 9/4/2024 at 3:22 pm, during an interview with LVN A she stated, anything could have happened with Resident #1 being in the room by herself with no call light, she could have thrown herself down in the floor and hurt herself. LVN B stated I was on break, but next time I will check on her before I go on break. The aides should know what to do. I am unsure who left her in the room without her call light. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/2024 at 11:50 am, during a second interview with LVN A, she stated, the other nurse (LVN B) took the resident to her room and tried to get an aide to help her but got sidetracked and left Resident #1 alone in the room without the call light. On 9/5/2024 at 11:58 am, during an interview with LVN B, she stated, Resident #1 asked if she could go to bed, I rolled her to her room, there wasn't an aide immediately available, but I left the room to get one and got sidetracked with a critical lab result of another patient. Next time I will hand the resident the call light. The resident was not in the room very long, maybe 3 minutes. On 9/5/2024 at 12:06 pm, during an interview with the DON, he stated Resident #1 should not have been left without her call light, she is usually left in the living area with nursing staff observing her until an aide is available or a nurse can help put the resident to bed. LVN B is a new staff member and is learning the residents and she has been counseled/re-educated on this matter. On 9/5/2024 at 12:31 pm, during an interview with the Administrator, he stated Resident #1 should not have been left without her call light. The nurse (LVN B) was transporting the resident back from eating lunch and got sidetracked. The expectation was for all staff to leave the call light within reach of the resident. They have counseled the staff member about this concern and instructed her on the right things to do. Record review of nursing in-service dated 9/4/2024 included the topic of ensuring call lights are always within the reach of residents with 25 staff members in attendance to include LVN B.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48633 Based on observation, interview, and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for one of one kitchens reviewed for safety. The kitchen vent was drpiping condensation from the ceiling to the surface beneath the area creating slipping hazards and possible contamination during food prepartation. This failure could place residents at risk for illness due to cross contamination in the kitchen and left a resident without access to staff and at risk for falling. Findings included: Observation and interview on 9/4/2024 at 11:51 am, revealed the kitchen area the ceiling ventilation was dripping onto the floor space very near a table. During the interview of the Kitchen Manager, she stated I didn't notice it was dripping, but there is no cross contamination due to the water not being directly over the food preparation area. The Kitchen Manager also stated, all residents are served out of the kitchen except one resident that has a feeding tube. During an interview with the Maintenance Director on 9/5/2024 at 3:00 pm, he stated the dripping from the ceiling could cause cross contamination into the food. He also stated he was unaware of the condensation dripping from the vent. The Maintenance Director stated the kitchen staff usually inform him of items needing repairs as well as performing daily and weekly observations of items needing repairs. He stated there was a work order book available for staff to report needed repairs. Record review of the Maintenance work orders dated 8/1/2024-9/5/2024 indicated no work orders placed or completed for ventilation system in the ceiling of the kitchen area. On 9/5/2024 at 12:31 pm, during an interview with the Administrator, he stated I was not aware of the condensation leaking from the vent in the kitchen. We are working to get it rubberized which should fix the issue. This could have been a slipping hazard, but I don't think cross contamination is an issue because food should be covered and there is not a table directly beneath the dripping from the vent. On 9/6/2024 at 8:45 am, during an interview with the Assistant Director of Nurses, she stated, the kitchen serves all but one resident that is on NPO (nothing by mouth) status and has a feeding tube.