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	01/16/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 44748 Based on observation, interviews, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 of 5 resident's (Residents #1) reviewed for accidents/supervision in that: CNA B failed to have a second staff assist her with care for Resident #1 and Resident was left unattended and rolled off her bed during incontinent care on 06/12/24. This failure could place residents at risk for injuries related to falls. The findings were: Record review of Resident #1's Face Sheet dated 06/16/21 documented a [AGE] year-old female with diagnoses including Cerebral Palsy (abnormal brain development that affect's a person's ability to control their muscles), muscle wasting, Parkinson's (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), seizures, Alzheimer's, heart failure, and mild intellectual disabilities. She was her own self representative. Record review of Resident #1's comprehensive MDS dated [DATE] documented a BIMS score of 8, indicating she was moderately cognitively intact. Further, Resident #1's level of assistance with Activities of Daily Living (ADLs) was dependent on staff for showering, and transfers. Resident #1 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) for eating, toileting, bed mobility, personal hygiene, dressing, oral hygiene, and 2-person assistance with bed mobility and mechanical lifting. She was always incontinent of bladder and bowel. Resident #1's quarterly functional abilities dated 03/20/24 indicated she was dependent on staff of all ADL's. Record review of Resident #1's interim functional abilities and goals dated 06/17/24 indicated she was impaired on both sides of her upper and lower body, she required substantial/maximal assistance with self-care-eating, oral and personal hygiene, toileting, shower/bathing, all dressing and footwear, and mobility-roll left and right. She was dependent for chair/bed-to-chair transfers and utilizing her manual wheelchair. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's annual Care Plan dated 11/14/24 indicated the resident had an ADL self-care performance deficit r/t Parkinson's, cerebral palsy, mild intellectual disabilities, anoxic (lack of oxygen) brain damage, seizure disorders, contractures to upper and lower extremities. Date Initiated and revised: 01/09/21. Interventions included Roll left and right- (Dependent), BED MOBILITY: The resident is total dependent of (X2) staff for repositioning and turning in bed. Date Initiated: 01/09/21. Revision on 03/03/21. The resident is at risk for falls related to gait/balance problems, incontinence, poor communication/comprehension through the review date, Date Initiated: 01/09/21. Psychoactive drug use , unaware of safety needs Date Initiated: 01/09/21, Revision on: 11/26/24. Interventions included review information on past falls and attempt to determine cause of falls. Record possible root causes and remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team as to causes. Date Initiated: 01/09/21. The resident had an actual fall on 6/12/24 with minor injury. Date initiated and revision on 06/19/24. Interventions included Record, Monitor/document /report PRN (as needed) x 72 hours to physician for signs or symptoms: Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro-checks x 72 hours. Wing Mattress in place. Date Initiated: 06/19/24. Record review of Resident #1's fall risk evaluation dated 03/25/24 documented a score of 15 indicating she was a high fall risk. Resident #1's fall risk evaluation dated 06/12/24 (the same day she fell from her bed) documented a score of 7 indicating she was a low fall risk. Record review of the facility provider investigation report dated 06/19/24 revealed Resident #1 had a diagnosis of Cerebral Palsy and Intellectual Disability Disorder (IDD). She was obese. She lived in a nursing home. She was supposed to have 2 staff assigned for ADL's. On 6/13/24, only one staff was cleaning her up/changing bed sheets, and Resident #1 fell from her bed when staff rolled her to the side. This caused injury to legs and back. Resident #1 went to a local hospital for x-ray with no breaks noted, but still had some pain and soreness. This has happened in the past which is why she had 2 staff assigned for changing/bathing and used a mechanical lift. Staff should have asked for assistance from an additional staff. Checked and released from the hospital. Expectation/Desire for resolution: staff need to follow Resident #1's plan to have 2 staff assist with ADL's. Record review of the facility incident reports dated 06/01/24-06/30/24 indicated Resident #1 experienced an un-witnessed fall on 06/12/24 at 4:05 pm. During a phone interview with the complainant/case worker on 01/15/25 at 12:29 pm, she said Resident #1 told her how she fell and was complaining of ankle pain, (resultant to the fall) because staff was providing incontinent care in bed with one staff member. Resident #1 told her she was bruised, had pain in her ankle and back, and they gave her Tylenol for her pain. Resident #1 told her that 2 staff was required and was in her orders. The Case Worker said the facility did not prevent it (the fall) because they were not following orders. She said she nor Resident #1 knew the names of the staff. She said Resident #1 was able to use her call light and kept it in her right, contractured hand and could press the button with her thumb. In an interview with ADON C on 01/15/25 at 4:15 pm, he said the resident should have had 2 staff for incontinent care. He said he recalled when he was informed that Resident #1 rolled out of bed. He said CNA B no longer worked at the facility and was suspended for the incident then terminated because she admitted to performing incontinent care alone. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #1 on 01/16/25 at 11:10 am she stated she remembered falling out of bed in June 2024. She could not remember which side of the bed she fell from. She said it made her mad and she was still mad because they were supposed to use two people and they did not. She remembered having to go to the hospital and being in pain. In an interview with CNA E on 01/16/25 at 11:55 am, she said she mainly worked on the 100 hall and had worked at this facility for [AGE] years. She said she knew Resident #1 very well. She said CNA B went in to change Resident #1 by herself and she fell . She said the next thing she knew, there was an ambulance picking Resident #1 up. She said she heard other staff members saying CNA B thought she had enough room on the bed to turn her by herself. She said she did not really know what was going on at first because she was showering another resident at the time. She said Resident #1 was and is a 2-person assist for everything. She said she did not know why CNA B did not find or ask anyone for help. She said CNA B wasn't very talkative. She said Resident #1 returned to the facility later the same night. She asked Resident #1 if she was ok the next day and she gave her a hug and Resident #1 said ow, and that her right side hurt. CNA E said she did not notice any bruising at that time. She said Resident #1 was hurting for several days. She said Resident #1 was afraid to turn on the shower bed. Resident #1 required reassurance from herself and her partner CNA (whoever it was on her shift). She said Resident #1 had never been able to help turn, even with 1/4 rails-she has not had them for a very long time. CNA E said when Resident #1 did, we would put her hand on it because it made her feel like she was helping. She said she thought Resident #1 had gotten better. CNA E said Resident #1 had no family but had a case worker. She said staff knew which residents required 2-person assists by looking at their charts and care plans on the kiosk. She said Resident #1 always had a scoop mattress. She said once Resident #1 got moving to turn, she would just keep going because of her weight and contractures. She said she had not heard of any other falling incidents since. CNA E said it was important to know what they were getting into (the resident's needs) not only for their safety but the resident's safety too. She said the CNA's had skills checkoffs every few months. She said ADON C did the monitoring. He would say, I want to see you wash your hands, or I want to see you do peri care. She said she had not witnessed any type of abuse in the past year. She said staff were in-serviced over ANE (abuse, neglect and exploitation) probably 2-3 times per month. She said the ADM was the abuse coordinator. If she witnessed abuse she would intervene, make sure resident was safe, report to the ADM, then have a nurse assess. If you see resident to resident altercation, you intervene and separate and call the nurse or the ADM. They are typically taken to their rooms, and from there they are assessed by the nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with ADON D on 01/16/25 at 1:05 pm, she said she recalled the incident in June 2024. She said before and after the incident the resident told her she fell off the bed and hit her head and wanted to go to the hospital. She said the resident could not move enough by herself to fall out of bed. She said she spoke to the CNA B who told her the resident fell out of bed. She said CNA B was suspended pending the investigation. She said she and ADON C typically conducted suspensions, and they suspended CNA B for not doing what she was supposed to, meaning performing incontinent care without another staff member. ADON D said the facility educated staff on kardex's and checking the kardex's to make sure if the residents were a 1- or 2-person assist to prevent harm to the resident. She said they had monthly mandatory in-services with different topics with all staff attending. She said they held the monthly mandatory in-services over a period of 2 days so both shifts got the education. She said Resident #1 requested to be sent to the ER. She said if Resident #1 hit her head, they would start the neuro checks regardless for the required 72 hours. She said the process for evaluating if a resident needed to transfer, they call the doctor to let them know they were transferring a resident and there should be an order for it. She said there was no order for the transfer. She said the resident returned to the facility at 11:04 pm the same day. She said this was a witnessed fall because CNA B was in the room. She said the nurse documented it as an unwitnessed fall, but it didn't make sense because CNA B told her she was in the room. emergency room record requested at this time. In an interview with ADON D on 01/16/25 at 2:33 pm, she said the emergency room records were not in Resident #1's chart. She said the receptionist was supposed to scan hospital, emergency room , any kind of transfer notes. She said each nurse's station had a box for documents including after hours, and she and/or ADON C checked the documents for appointments, new orders, etc., then took them to the receptionist to scan in. During a phone interview with LVN F on 01/16/25 at 2:08 pm, she said she knew Resident #1 . She recalled when she fell out of bed and that was the only time she had ever fallen out of bed. She said CNA B told her that she rolled the resident onto her side and left her to go out of the room to get something and when she came back, the resident had already fallen. She asked her what happened after she assessed Resident #1, and the resident told her CNA B left and then she fell , and CNA B was in there by herself. She said CNA B was terminated because of the incident. She said Resident #1 was crying and upset and she had worked with her for a long time. She said Resident #1 was credible. She said the facility sent her out just to make sure she was ok. She said she did not think Resident #1 hit her head. She said she took care of Resident #1 the next day and did not recall any bruising. She said she did not recall if the resident was in pain. She recalled the resident did not break anything. Attempted phone interview with CNA B on 01/16/25 at 11:48 am, -left voice message with call back number. 2nd attempt for phone interview with CNA B on 01/16/25 at 2:30 pm. Left message. Record review of the facility policy revised March 2018, titled, Activities of Daily Living (ADL), Supporting: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement-Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. 5. A resident's ability to perform ADLs will be measured using clinical tools, including the MDS. Functional decline or improvement will be evaluated in reference to the Assessment Reference Date and the following MDS definitions: e. Total Dependence - Full staff performance of an activity with no participation by resident for any aspect of the ADL activity. 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. Record review of the facility policy revised April 2021, titled, Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.

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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. 48633 Based on observation, interview and record review the facility failed to ensure that drugs and biologicals were stored behind a closed and locked door in a secured unit (Hall 300) in one of 3 medication rooms. The medication door was left open on hall 300.This failure could place residents at risk of access and ingestion of medication in the medication room. Findings were: Observation on 1/8/2025, at 4:23 p.m., revealed the medication room door was open and unlocked. The medication door was unlocked for 5 minutes until LVN A exited a room and returned to the nurses station (medication room door located inside of nurses ' station). The refrigerator door was locked, and the discontinued tub of medications were locked. No medication was immediately accessible including over the counter medications without a key to the refrigerator and the tub of medications. During an interview on 1/8/2025 at 4:28 p.m., LVN A verbalized she was in a room helping a resident with sit to stand equipment. She verbalized she thought she shut and locked the door of the medication room before leaving the area. LVN A stated it was proper process to close and lock the door to the medication room at all times. She also stated all the medication in the medication room were locked in the refrigerator or in the discontinued medication lock box of the medication room and all other medications are stored and locked in the 300 hall cart. During an interview on 1/8/2024 at 4:33 p.m., the Director of Nursing (DON) stated it was the expectation of the facility for all staff to keep all the medication doors closed and locked. The DON stated LVN A should have closed and locked the medication room door before leaving the area. During an interview on 1/10/2025 at 1:47 p.m., the Administrator stated LVN A is received corrective action to include 1:1 in-servicing on the medication policy. It is the policy of the facility to keep all medication rooms closed and locked. The Administrator also stated they added a pneumatic door (a door that uses compressed air to open and close) and lock that cannot be unlocked on the medication room door in the 300 hall. A review of the medication policy dated 2001 Medpass (revised November 2020) revealed #1 Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity control. Only persons authorized to prepare, and administer medications have access to locked medication, #2 The nursing staff is responsible for maintaining medication storage, and preparation areas in a clean, safe and sanitary manner, and #6 Compartments, including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes containing drugs and biologicals are locked when not in use.