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	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Rafael Nursing and Rehabiliation	3050 Sunnybrook Rd Corpus Chrisit, 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately to the appropriate State Agency, but no later than 2 hours after the allegation was made, for 1 of 5 Residents (Resident #1) reviewed for reporting allegations of abuse and/or neglect. The facility failed to report Resident #1's fall with a major injury on 06/01/25 in which Resident #1 sustained a left hip fracture. State Agency was not notified of the fall with injury. This failure could result in placing residents at increased risk for not receiving a proper or thorough investigation. The findings included: Record review of Resident #1's face sheet dated 07/31/25 revealed an [AGE] year-old female with an original admission date of 01/12/23 and a current admission date of 06/05/25. Pertinent diagnoses included Displaced Intertrochanteric Fracture of Left Femur (a common hip fracture which occurs in the upper part of the femur which typically required surgical intervention); Other Abnormalities of Gait and Mobility, Dementia (a decline in cognitive function which affects daily life, memory, reasoning, and language skills), Alzheimer's Disease (the most common form of dementia, characterized by problems with memory, thinking, and behavior), and Blindness to the Left Eye. Record review of Resident #1's care plan initiated 06/15/2023 and revised 07/25/25 revealed resident was at risk for falls related to gait and balance problems. Interventions included anticipate and meet the resident's needs, follow facility fall protocol, and evaluate and treat as ordered. Resident #1's care plan initiated 01/16/2023 and revised 01/03/2025 revealed Resident was an elopement risk as evidenced by wandering; interventions included distracting Resident #1 from wandering by offering diversions, structured activities, food, conversation, television, books, and/or listening to the radio in her room. Other interventions included Resident #1 would be redirected when wandering into other residents' rooms or as needed, and Resident #1 would reside in memory care unit for safety. Resident #1's care plan also included the actual fall on 06/01/25 with serious injury. It was initiated on 06/03/25. Interventions included determine and address causative factors of the fall. Record review of Resident #1's Quarterly MDS assessment dated [DATE] section C, cognitive patterns, revealed a BIMS score of 00 (severe cognitive impairment). This MDS revealed no falls since admission, entry, reentry, or prior assessment. Record review of Resident #1's Quarterly MDS assessment dated [DATE] section C, cognitive patterns, revealed a BIMS score of 0 (severe cognitive impairment). This MDS revealed fall with major injury requiring surgical intervention. There was no provider investigation or internal investigation for the fall of the unsupervised Resident #1 done by the facility, so there was no review done of a provider or facility investigation. Record review of Resident #1's Fall Risk Evaluation dated 03/04/25 revealed Resident #1 wanders; no falls in past 3 months; regularly incontinent; balance problem while standing/walking. Resident was considered High Risk for falls. Record review of Resident #1's progress note dated 06/01/25, written by LVN-I, revealed a male resident came out of his room and said there was a woman in his room on the floor. Resident #1 was found on her left side, and two CNAs were called to room for assistance. There was a small hematoma to left brow. Resident #1 was in severe pain to left thigh. Staff assisted Resident #1 into wheelchair and assisted her to bed. Left leg was shorter than right leg. Record review of Resident #1's Hospital Summary - Orthopedic Discharge Instructions dated 06/05/25 revealed Resident #1 underwent open reduction with internal fixation (surgical procedure to repair broken bones) on 06/02/25. Pertinent information included per [family member], [Resident #1] was found in another resident's room and had fallen. The Assessment and Plan portion of the hospital summary revealed unwitnessed fall. The Hospital Diagnoses portion of the hospital summary revealed unwitnessed fall. In an interview on 07/30/25 at 3:35 PM LVN-I stated she had not seen Resident #1 fall. She stated it was an unwitnessed fall, and Resident #2 had found Resident #1 on the floor in his room. LVN-I stated Resident #1 had severe pain with facial grimacing and moaning, and when she assessed Resident #1 she was noted to have had some bruising as well as a deformity in which one leg was noted to be longer than the other leg. She stated two CNAs assisted her with getting Resident #1 up and to the wheelchair, then to the bed in her room, then notified provider and EMS. LVN-I stated she notified the facility on-call number (the afterhours number to be notified) of the fall like she was supposed to, as well as documented the fall in Resident #1's chart. In an interview on 07/30/25 at 3:48 PM ADON-A stated Resident #1 had not had any other recent falls since 09/04/24 in which she had wandered into another resident's room and had a fall. She also stated she only knew what she had read about the fall from LVN-I's progress note as an investigation had not been done. ADON-A stated she had

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have evidence that all alleged violations were thoroughly investigated and measures were taken to prevent further potential abuse, neglect, exploitation or mistreatment in accordance with State law, and if the alleged violation was verified appropriate, corrective action must have been taken for 1 (Resident #1) of 5 residents reviewed for abuse, neglect, and/or misappropriation. The facility failed to do a thorough investigation to include interviewing Resident #1, as well as other residents or staff which may have been involved in or witnessed the incident. This failure placed residents at risk of not having their allegations investigated thoroughly or timely. The findings included: Record review of Resident #1's face sheet dated 07/31/25 revealed an [AGE] year-old female with an original admission date of 01/12/23 and a current admission date of 06/05/25. Pertinent diagnoses included Displaced Intertrochanteric Fracture of Left Femur (a common hip fracture which occurs in the upper part of the femur which typically requires surgical intervention); Other Abnormalities of Gait and Mobility, Dementia (a decline in cognitive function which affects daily life, memory, reasoning, and language skills), Alzheimer's Disease (the most common form of dementia, characterized by problems with memory, thinking, and behavior), and Blindness to the Left Eye. Record review of Resident #1's Quarterly MDS assessment dated [DATE] section C, cognitive patterns, revealed a BIMS score of 0 (severe impairment). Record review of Resident #1's care plan initiated 06/15/2023 and revised 07/25/25 revealed resident was at risk for falls related to gait and balance problems. Interventions included anticipate and meet the resident's needs, be sure call light was within reach, follow facility fall protocol, and evaluate and treat as ordered. Record review of Resident #1's care plan initiated 01/16/23 and revised 01/03/25 revealed resident was an elopement risk related to dementia, as evidenced by wandering around unit and into other residents' rooms. Interventions included distract resident from wandering, evaluate and screen quarterly for memory unit, redirect when wandering into other residents' rooms, and Resident #1 would reside in memory care unit for safety. Record review of Resident #1's care plan initiated 06/03/2025 revealed resident had an actual fall on 06/01/25. Interventions included continue post fall follow up x 72 hours, determined and addressed causative factors, and physical therapy to consult for strength and mobility. Record review of Resident #1's fall risk dated 03/04/25 revealed Resident #1 had a balance problem while standing and/or walking. Record review of Resident #1's progress noted dated 06/01/25, written by LVN-I, revealed a male resident came out of his room and said there was a woman in his room on the floor. Resident #1 was found on her left side, and two CNAs were called to room for assistance. The skin check was done, and there was a small hematoma to left brow. Resident #1 was in severe pain to left thigh. Staff assisted Resident #1 into wheelchair and assisted her to bed. Left leg was shorter than right leg. Record review of Resident #1's progress noted dated 06/01/25 revealed Resident #1's family member called to let the facility know Resident #1 had a hip fracture, and they were waiting to speak with Orthopedic Doctor regarding options. Record review of Resident #1's Hospital Summary - Orthopedic Discharge Instructions dated 06/05/25 revealed Resident #1 underwent open reduction with internal fixation (surgical procedure to repair broken bones) on 06/02/25. Pertinent information included per [family member], [Resident #1] was found in another resident's room and had fallen. The Assessment and Plan portion of the hospital summary revealed unwitnessed fall. The Hospital Diagnoses portion of the hospital summary revealed unwitnessed fall. In an interview on 07/30/25 at 3:35 PM LVN-I stated she had not seen Resident #1 fall. She stated it was an unwitnessed fall, and another (male) resident had found her on the floor in his room. The male resident came out of his room and notified staff there was a woman in the floor in his room. She stated Resident #1 was having severe pain with facial grimacing and moaning. LVN-I stated she assessed Resident #1, and she was noted to have had some bruising, as well as a deformity in which one leg was noted to be longer than the other leg. She then had two CNAs assist her with getting Resident #1 up and to the wheelchair, then to the bed in her room, and notified provider and EMS. LVN-I stated severe pain and a deformity with the hip and leg could mean an injury or possible fracture, and the resident should not have been moved because movement could possibly have made the injury worse. She stated she notified the facility on-call of the fall, as well as documented it. In an interview on 07/30/25 at 3:48 PM ADON-A stated Resident #1's fall on 06/01/25 with a hip fracture was the most recent fall, and she had not had any other recent falls. ADON-A stated she was informed another resident walked in and found Resident #1 on the floor in his room. She stated she only knew what she had read about

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility failed to enforce the post-fall assessment policy leading to Resident #1 being moved from the floor to her wheelchair, and from her wheelchair to her bed after a fall while having severe pain and an obvious hip and leg deformity. The failure could affect residents currently residing in the facility, resulting in them not receiving the needed care to maintain optimal health and placing them at risk for injury or deterioration in their condition. The findings included: Record review of Resident #1's face sheet dated 07/31/25 revealed an [AGE] year-old female with an original admission date of 01/12/23 and a current admission date of 06/05/25. Pertinent diagnoses included Displaced Intertrochanteric Fracture of Left Femur (a common hip fracture which occurs in the upper part of the femur which typically requires surgical intervention); Other Abnormalities of Gait and Mobility, Dementia (a decline in cognitive function which affects daily life, memory, reasoning, and language skills), Alzheimer's Disease (the most common form of dementia, characterized by problems with memory, thinking, and behavior), and Blindness to the Left Eye. Record review of Resident #1's Fall Risk Evaluation dated 06/05/25 revealed a history of 1-2 falls in the past 3 months, regularly incontinent, requires use of assistive devices, and Resident #1 was considered high risk for potential falls. Record review of Resident #1's Quarterly MDS assessment dated [DATE] section C, cognitive patterns, revealed a BIMS score of 0 (severe cognitive impairment). Record review of Resident #1's care plan initiated 06/15/2023 and revised 07/25/25 revealed resident was at risk for falls related to gait and balance problems. Interventions included anticipate and meet the resident's needs, be sure call light was within reach, follow facility fall protocol, and evaluate and treat as ordered. Record review of Resident #1's care plan initiated 01/16/23 and revised 01/03/25 revealed resident was an elopement risk related to dementia, as evidenced by wandering around unit and into other residents' rooms. Interventions include distract resident from wandering, evaluate and screen quarterly for memory unit, redirect when wandering into other residents' rooms, and Resident #1 would reside in memory care unit for safety. Record review of Resident #1's care plan initiated 06/03/2025 revealed resident had an actual fall on 06/01/25. Interventions included continue post fall follow up x 72 hours, determined and addressed causative factors, and physical therapy to consult for strength and mobility. Record review of Resident #1's fall risk dated 03/04/25 revealed Resident #1 had a balance problem while standing and/or walking. Record review of Resident #1's progress noted dated 06/01/25, written by LVN-I, revealed a male resident came out of his room and said there was a woman in his room on the floor. Resident #1 was found on her left side, and two CNAs were called to room for assistance. The skin check was done, and there was a small hematoma to left brow. Resident #1 was in severe pain to left thigh. Staff assisted Resident #1 into wheelchair and assisted her to bed. Left leg was shorter than right leg. Record review of Resident #1's progress noted dated 06/01/25 revealed Resident #1's family member called to let the facility know Resident #1 had a hip fracture, and they were waiting to speak with Orthopedic Doctor regarding options. Record review of Resident #1's Hospital Summary - Orthopedic Discharge Instructions dated 06/05/25 revealed Resident #1 underwent open reduction with internal fixation (surgical procedure to repair broken bones) on 06/02/25. Pertinent information included per [daughter], [Resident #1] was found in another resident's room and had fallen. The Assessment and Plan portion of the hospital summary revealed unwitnessed fall. The Hospital Diagnoses portion of the hospital summary revealed unwitnessed fall. In an interview on 07/30/25 at 3:35 PM LVN-I stated she had not seen Resident #1 fall. She stated it was an unwitnessed fall, and another (male) resident had found her on the floor in his room. The male resident came out of his room and notified staff there was a woman on the floor in his room. She stated Resident #1 was having severe pain with facial grimacing and moaning. LVN-I stated she assessed Resident #1, and she was noted to have had some bruising, as well as a deformity in which one leg was noted to be longer than the other leg. She then had two CNAs assist her with getting Resident #1 up and to the wheelchair, then to the bed in her room, and notified provider and EMS. LVN-I stated severe pain and a deformity with the hip and leg could mean an injury or possible fracture, and the resident should not have been moved because movement could possibly have made the injury worse. In an interview on 07/30/25 at 3:48 PM ADON-A stated Resident #1's fall on 06/01/25 with a hip fracture was the most recent fall, and she had not had any other recent falls. ADON-A stated she was informed another resident walked in

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure residents received adequate supervision to prevent accidents and/or hazards as possible for 1 of 5 residents (Resident #1) reviewed for supervision, accidents, and hazards. The facility failed to keep Resident #1 free from accident and/or hazards when she fell on [DATE] which caused her to sustain a left hip fracture by not providing the necessary monitoring and supervision for Resident #1 with known history of behaviors of wandering into other resident rooms. The three staff assigned to supervise the secure unit were at the nurse's station distracted and engaged in personal conversation when Resident #1 wandered out of her room and into another resident's room. An IJ was identified on 08/20/25. The IJ template was provided to the facility on [DATE] at 3:22 PM. While the IJ was removed on 08/21/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because new procedures implemented to prevent future errors were still in process. This failure could place residents at risk for injuries and a decline in health.The findings included: Record review of Resident #1's face sheet dated 07/31/25 revealed an [AGE] year-old female with an original admission date of 01/12/23 and a current admission date of 06/05/25. Pertinent diagnoses included Displaced Intertrochanteric Fracture of Left Femur (a common hip fracture which occurs in the upper part of the femur which typically required surgical intervention); Other Abnormalities of Gait and Mobility, Dementia (a decline in cognitive function which affects daily life, memory, reasoning, and language skills), Alzheimer's Disease (the most common form of dementia, characterized by problems with memory, thinking, and behavior), and Blindness to the Left Eye. Record review of Resident #1's care plan initiated 06/15/2023 and revised 07/25/25 revealed Resident #1 was at risk for falls related to gait and balance problems. Interventions included anticipate and meet the resident's needs, follow facility fall protocol, and evaluate and treat as ordered. Resident #1's care plan initiated 01/16/2023 and revised 01/03/2025 revealed Resident #1 was an elopement risk as evidenced by wandering; interventions included distracting Resident #1 from wandering by offering diversions, structured activities, food, conversation, television, books, and/or listening to the radio in her room. Other interventions included Resident #1 would be redirected when wandering into other residents' rooms or as needed, and Resident #1 would reside in the memory care unit for safety. Resident #1's care plan also included the actual fall on 06/01/25 with serious injury. It was initiated on 06/03/25. Interventions included determine and address causative factors of the fall. Record review of Resident #1's Quarterly MDS assessment dated [DATE], section C, cognitive patterns, revealed a BIMS score of 00 (severe cognitive impairment). This MDS revealed no falls since admission, entry, reentry, or prior assessment. Record review of Resident #1's Quarterly MDS assessment dated [DATE], section C, cognitive patterns, revealed a BIMS score of 00 (severe cognitive impairment). This MDS revealed fall with major injury requiring surgical intervention. There was no provider investigation or internal investigation for the fall of the unsupervised Resident #1 done by the facility, so there was no review done of a provider or facility investigation. Record review of Resident #1's Fall Risk Evaluation dated 03/04/25 revealed Resident #1 wanders; no falls in the past 3 months; regularly incontinent; balance problem while standing/walking. Resident was considered a high risk for falls. Record review of Resident #1's progress note dated 06/01/25, written by LVN-I, revealed a male resident came out of his room and said there was a woman in his room on the floor. Resident #1 was found on her left side, and two CNAs were called to the room for assistance. The skin check was done, and there was a small hematoma to the left brow. Resident #1 was in severe pain to left thigh. Staff assisted Resident #1 into the wheelchair and then assisted her to bed. Left leg was noted to be shorter than the right leg. Record review of Resident #1's Hospital Summary - Orthopedic Discharge Instructions dated 06/05/25 revealed Resident #1 underwent open reduction with internal fixation (surgical procedure to repair broken bones) on 06/02/25. Pertinent information included per family member, [Resident #1] was found in another resident's room and had fallen. The Assessment and Plan portion of the hospital summary revealed unwitnessed fall. The Hospital Diagnoses portion of the hospital summary revealed unwitnessed fall. Record review of the Staffing Schedule for the locked unit revealed a census of 26 and the following staff: 05/31/25 revealed 6AM - 6PM had 2 CNAs and an LVN (from 6AM-1:30PM) and another LVN (from 1:30PM-12AM). 6Pm - 6AM had 2 CNAs and an LVN (from 12AM-6AM).06/01/25 revealed 6AM - 6PM had 2 CNAs and an LVN (from 6AM-1:30PM) and another LVN (from 1:30PM-6PM). 6PM - 6AM had 2 CNAs and an LVN 06/02/25 revealed 6AM - 6PM had 2 CNAs and 2