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	10/27/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, for one resident (Resident #5) of three residents reviewed for skin irregularities. When Resident #5 was readmitted into the facility on [DATE], LVN E failed to complete a thorough and accurate head-to-toe assessment that included assessing what was under Resident #5's right arm dressing/bandage. This failure could compromise a resident's skin integrity, which could increase the risk for progressive skin complications. Record review of the Resident #5's admission Record dated 10/24/2025 revealed Resident # 5 was a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. Resident #5 was admitted with multiple diagnoses which included: cerebral infarction (stroke), muscle wasting and atrophy, intellectual disabilities, hemiplegia (paralysis of a limb) and hemiparesis (weakness of a limb). Record review of Resident #5's care plan date initiated 10/02/2025 revealed The resident has actual impairment to skin integrity of the Right antecubital fossa r/t Coban wrap. Goal: the resident's minor skin injury of the right antecubital fossa will be healed by the next review date. Interventions: encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, monitor the site for infection for 72hours. Record review of Resident #5's MDS Quarterly dated 10/13/2025 revealed, Resident #5 had a BIMS score of 15 which indicated intact cognition. Additionally, Resident #5 needed setup/cleanup assistance with the majority of his ADLs. Resident #5 was not coded for major skin irregularity or wounds. Record review of Resident #5's progress notes from 09/17/2025 through 09/25/2025 revealed no mention or assessment of Resident #5's arm. Record review of Resident #5's progress note dated 09/26/2025 at 15:32 (3:32PM) the LMSW documented LMSW spoke to resident to follow up with him regarding the Coban wrap left on his forearm. During an interview and observation on 10/24/2025 at 11:38AM Resident #5 stated he recalled an incident where a bandage was left on his arm for days and felt tight, however he could not recall the date of the incident. Resident #5 stated he had no concerns about the dressing issue and verbalized no concerns. Upon initial observation, Resident #5 had no visible sign of skin irregularities on his arms. During a phone interview on 10/24/2025 at 12:47PM the local area advocate ([NAME]) stated she was notified by a family member regarding a complaint that Resident #5 had a dressing on his arm for roughly 8 days without any clinical staff member assessing underneath the dressing. The [NAME] stated when she arrived in the facility on either 9/24/2025 or 9/25/2025, she entered Resident #5's room and saw Resident #5 with a neutral color dressing to elbow, with red discoloration to the very same area. The [NAME] stated while she spoke to Resident #5, he never exhibited any sign or symptom of distress and was very pleasant. The [NAME] stated she conversed with Resident #5 and found no immediate concerns for Resident #5 and left the facility. During an interview on 10/24/2025 at 1:43PM, LVN E stated while the administrator was present, that she requested the administrator to be present during the interview. LVN E stated when Resident #5 returned to the facility roughly after lunch around 12:30pm-1:30pm on 09/17/2025. LVN E stated she recalled Resident #5 entering the facility on a stretcher and noticed he had a beige colored dressing/covering on Resident #5's arm but could not recall which arm. LVN E stated she worked at least 4-5 days between 09/17/2025-09/24/2025 and asked on 09/17/2025 and 9/18/2025 to observe what was underneath the bandage/dressing, but Resident #5 was resistant to care. LVN E stated in-hindsight she should have advocated to see what was under the bandage/dressing as not only part of her professional scope of practice but also to ensure there were no negative or immediate concerns for skin irregularities. LVN E stated her concern with Coban dressings was if the dressing was too tight, there could be a loss of blood circulation, skin irritation, and/or possible wound, but reiterated Resident #5 never expressed or exhibited any sign or symptoms of distress or concern. LVN E stated she should have conducted a more thorough head-to-toe assessment to ensure there were no concerning irregularities; however verbalized Resident #5 did not exhibit or express anything of a compromising nature regarding any skin irregularities. LVN E stated going forward; she will advocate in a more assertive manner when conducting a head-to-toe assessment as a precautionary intervention, to ensure the well-being of all her patients. LVN E stated she attended an in-service regarding removing Coban dressing upon all assessments. LVN E stated roughly after 09/22/2025 she observed Resident #5 with slight redness to his forearm and reiterated going forward; she will complete

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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 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. Based on observation, interview and record review the facility failed to ensure that drugs and biologicals were stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access for 1 of 2 wound treatment carts on hall 100 reviewed for storage.The 100 hall wound care treatment cart was found unlocked.This failure could place residents at risk of access and ingestion of medications or supplies not intended for them and/or misappropriation. Findings were:Observation on 10/21/2025, at 11:24 a.m., a wound care treatment cart was found unlocked in front of the 100 hall nursing station. The observation of items inside the wound care cart included: betadine solution, hydrogen peroxide, triple antibiotic ointment, nystatin cream, diclofenac sodium gel, iodoform packing strips, lidocaine cream, and a variety of bandages used for wound care treatment.During an interview on 10/21/2025 at 11:30 a.m., LVN A verbalized the treatment cart was an extra cart and was not assigned to any staff member. LVN A verbalized she was unsure who used the cart last, but it is policy for the cart to be locked. LVN A stated if a resident accessed the items in the cart they could ingest or use the items in the cart. During an interview on 10/27/2025 at 9:50 a.m., the Director of Nursing (DON) stated it is the expectation of the facility for all staff to lock all carts including the wound care carts. The DON stated depending on the items in the cart the residents could have ingested or utilized the items in the cart. The DON stated the cart was not assigned to any staff member(s) as the cart was an extra wound care treatment cart.During an interview on 10/27/2025 at 9:55 a.m., the Administrator stated all carts should be locked and all items on the cart should be put away. The Administrator stated, depending on what is in the cart it would depend on what happens to a resident if they access a cart, but a resident could open an item and ingest it. The Administrator also stated it is not necessarily neglect or abuse, but it is against the policy and procedure to leave any carts unlocked.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.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure menus met the needs of residents in accordance with established national guidelines for 1 (R#1) of 4 residents reviewed for pureed diets.The facility provided R#1 with a whole hot dog when R#1 required a puree diet, leading to a choking incident on 10/16/25 that required the use of the Heimlich maneuver and resulted in anoxic brain injury. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 10/16/25 and ended on 10/17/25. The facility corrected the non-compliance before the investigation began.This failure could place residents that require specialized diets at risk of choking, hospitalization, and death.Record review of the Resident #1's admission Record dated 10/22/25 revealed Resident #1 was a 66year old female admitted to the facility on [DATE]. Resident #1 was admitted with multiple diagnoses which included: unspecified dementia with agitation (a cognitive disorder that causes a gradual decline in a person's ability to make decisions, remember things, solve problems, and communicate effectively), abnormalities of gait and mobility (altered ability of walking), Lack of coordination, muscle wasting and atrophy (multiple sites), schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder). Record review of an MDS dated [DATE] revealed Resident #1 had a BIMS score of 00 which indicated Resident #1 was severely cognitively impaired. The MDS also revealed Resident #1 required substantial assistance (helper doing more than half the effort) during meals and Resident #1 required mechanically altered diet (e.g. pureed food, thickened liquids). Record review of Resident #1's physician orders dated 10/22/2025 revealed an order for regular diet, pureed texture, and nectar consistency with start date of 7/17/2025. Record review of Resident #1's care plan revealed Resident #1 requires supervision/setup assistance by 1 staff to eat initiated 1/16/2025. Resident #1's care plan also revealed Resident #1 required a regular diet, pureed texture, and nectar consistency initiated on 7/18/2025. Record review of the Provider Investigation Report revealed on 10/16/2025 at about 6:45 p.m., CNA B provided a food tray to Resident #1 that was not checked by a nurse before it was sent to Resident #1's room to assist Resident #1 to eat. Record review of Methodist hospital Records dated 10/20/2025 revealed Resident #1's assessment and plan included Encephalopathy likely secondary to anoxic brain injury (not enough oxygen getting to the brain). Record review of statement dated 10/16/2025 written by CNA B, revealed CNA B went to assist Resident #1 to eat. CNA B's statement indicated she placed Resident #1's food tray on the bedside table and moved the tray closer to Resident #1 and that is when Resident #1 grabbed a whole hotdog from the plate and started eating the hotdog. CNA B's statement noted CNA B tried telling Resident #1 to hold on, but Resident #1's skin coloring started to change prompting CNA B to call for assistance and the ADON came in immediately to assist Resident #1. On 10/21/2025 attempts to contact CNA B were unsuccessful due to recording of disconnection of phone service. During an interview on 10/21/2025 at 3:32 p.m., the ADON stated on 10/16/2025 about 6:30p.m., she was called to the room of Resident #1 by CNA B and noticed Resident #1 was choking. The ADON stated she performed the Heimlich maneuver and performed a finger sweep which recovered what looked like regular texture bread and meat from the mouth of the resident. Resident #1 was still not breathing adequately and became unconscious. The ADON stated she started performing CPR, called a Code Blue, and EMS was called to the facility. During a phone interview on 10/21/2025 at 4:38 p.m., the dietary aide stated a CNA gave the wrong texture of food to Resident #1 on the evening of 10/16/2025 and this caused the resident to choke. The dietary aide stated his job is to cook the food and to serve the correct texture. The dietary aide stated he was the first one to see the meal tickets and the first one to plate the food and this included the protein, the starch and the vegetables for all residents. The dietary aide stated Resident #1's tray should have been pureed texture. The dietary aide stated the trays may have gotten mixed up and possibly an alternate meal was given to the Resident #1. During an interview on 10/27/25 at 9:30 a.m., the kitchen manager stated he found out there was choking incident from the dietary aide on 10/16/2025. The Kitchen Manager stated he asked the kitchen staff what happened, and they stated they sent out a puree diet for Resident #1. The Kitchen Manager stated the staff members informed him there was multiple requests for alternate food items from the menu and the food trays may have gotten mixed up. The kitchen manager stated it is wrong that Resident #1 did not get the correct diet type. The kitchen manager stated he performed an investigation on what happened in the kitchen by interviewing staff, assessing meal plans, making plans of correction, ensuring plans of correction are followed completed and

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 record review and interview, the facility failed to maintain clinical records in accordance with accepted professional standards of practice, that were complete and accurately documented, for one resident (Resident #5) of three residents reviewed for total body skin assessment documentation. 1. When Resident #5 was readmitted into the facility on [DATE], LVN E failed to document a bandage on Resident #5's forearm/elbow area. 2. When Resident #5's skin irregularity was assessed on 09/25/2025, LVN F failed to document and detail the right arm skin impairment. These failures could affect residents who require care and monitoring and place them at risk of not receiving the care and services to meet their needs. Record review of the Resident #5's admission Record dated 10/24/2025 revealed Resident # 5 was a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. Resident #5 was admitted with multiple diagnoses which included: cerebral infarction (stroke), muscle wasting and atrophy, intellectual disabilities, hemiplegia (paralysis of a limb) and hemiparesis (weakness of a limb).Record review of Resident #5's care plan date initiated 10/02/2025 revealed The resident has actual impairment to skin integrity of the Right antecubital fossa r/t Coban wrap. Goal: the resident's minor skin injury of the right antecubital fossa will be healed by next review date. Interventions: encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, identify/document potential causative factors and eliminate/resolve where possible, monitor the site for infection for 72hours.Record review of MDS Quarterly dated 10/13/2025 revealed Resident #5 had a BIMS score of 15 which indicated intact cognition. Additionally, Resident #5 needed setup/cleanup assistance with majority of his ADLs. Resident #5 was not coded for major skin irregularity or wound.Record review of Resident #5's Nursing Skin Observation Tool dated 09/25/2025 revealed LVN F documented Redness noted to right forearmDuring a phone interview on 10/24/2025 at 12:47PM the local area advocate ([NAME]) stated she was notified by a family member regarding a complaint that Resident #5 had a dressing on his arm for roughly 8 days without any clinical staff member assessing underneath the dressing. The [NAME] stated when she arrived in the facility on either 9/24/2025 or 9/25/2025, she entered Resident #5's room and saw Resident #5 with a neutral color dressing to elbow, with red discoloration to the very same area. The [NAME] stated while she spoke to Resident #5, he never exhibited any sign or symptom of distress and was very pleasant. The [NAME] stated she conversed with Resident #5 and found no immediate concerns for Resident #5 and left the facility.During an interview on 10/24/2025 at 1:43PM, LVN E stated, while the administrator was present, that she requested the administrator to be present during the interview. LVN E stated she did not document her observation of Resident #5's right arm bandage/dressing on 09/17/2025 because she did not think that it warranted documentation. LVN E stated in hindsight she should have documented her observation as an effort to ensure Resident #5's well-being. LVN E stated as part of her professional scope of practice documentation would aid in monitoring any irregularities but reiterated there were no negative outcomes due to her lack of documentation of Resident #5's bandage on 09/17/2025. LVN E stated there was no negative outcome due to her actions, however stated going forward she will document all her observations when she conducts her head-to-toe assessments. LVN E stated she attended a facility in-service on 09/25/2025 regarding documentation, refusals, measurement, and description of skin integrities. During an interview on 10/25/2025 at 11:07AM LVN F interviewed with ADON A present. LVN F stated she recalled Resident #5's right forearm discoloration on 09/25/2025. LVN F stated Resident #5 had some redness to his right arm, and within the general antecubital area, there appeared a straight line, roughly 2-3 inches in diameter. LVN F stated she did not observe any other discoloration to Resident #5 extremities. LVN F stated she did not place the details of what she saw in the note as she did not think to document it in a note. LVN F stated details like measurements, would help her assessment to ensure skin irregularities were not getting worse. LVN F stated by documenting her assessment findings, this documentation would aid in avoiding infections and ensure the safety and well-being of all her residents. LVN F stated she is more vigilant now, and thoroughly intentional with her observation documentation. LVN F stated there was no negative outcome to her lack of documentation for Resident #5.During an interview on 10/25/2025 at 4:00PM the DON stated, LVN E should have documented her observation of Resident #5's bandage on 09/17/2025, and furthermore LVN F should have documented her 09/25/2025 detailed assessment regarding Resident #5 skin impairment. THE DON stated the expectation of the facility was to document and detail all observational findings with as much detail