STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675800	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Vida Serena Nursing and Rehabilitation	711 Kings Way Del Rio, TX 78840

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observation, interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #1 and #2) of 5 residents reviewed for accuracy of assessments. 1. The facility failed to ensure Resident #1 was coded on his Quarterly MDS, dated [DATE] for a fall with major injury that occurred on 01/18/2024. 2. The facility failed to ensure Resident #2 was coded on her Quarterly MDS, dated [DATE] for a fall with major injury that occurred on 05/21/2024. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1. Record review of Resident #1's Admission Record, dated 07/11/2024, reflected Resident #1 was admitted on [DATE] and was [AGE] years old. Resident #1 discharged on [DATE] to another nursing home. Resident #1 had diagnoses of cerebral infarction (a disruption in the brain's blood flow), dementia (a general term for impaired ability to remember, think, or make decisions), and heart failure (heart muscle is weakened and cannot pump enough blood to meet the body's needs). A diagnosis of fracture of right pubis (break in the right bone of the pelvis) was noted with onset date of 01/18/2024 and classified as during stay. Record review of Resident #1's Event Nurses' Note, dated 01/18/2024, reflected Resident #1 had an unwitnessed fall in his room on 01/18/2024 at 07:15 a.m. Under Resident statement, Resident #1 was noted as stating that he fell when walking back to bed after toileting himself. Resident #1 stated he got himself up and back into the bed. The event note reflected Resident #1 was assessed and found to have had a 1.0 cm by 05 cm abrasion on his right elbow and complained of pain to his right buttocks and right leg. Resident #1 was noted to have been sent to the local hospital for evaluation and treatment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675800	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's local hospital discharge paperwork, dated 01/18/2024, reflected a CT (an imaging procedure using x-rays to create detailed images of bones and soft tissues) Scan Report, noted date of service 01/18/2024, reflected a CT of the pelvis bone was performed on 01/18/2024 due to history of a fall. The impression revealed a nondisplaced fracture (bone cracked but did not move or change alignment) of the right inferior pubic ramus. Record review of Resident #1's Quarterly MDS, dated [DATE] reflected Resident #1 had a BIMS (Brief Interview of Mental Status) score of 7 indicating he was moderately impaired, he required partial/moderate assistance for transferring from lying to sitting on the side of the bed or sitting to standing; and he had no falls since admission/entry or reentry or the prior assessment. Record review of Resident #1's Quarterly MDS, dated [DATE] reflected Resident #1 had a BIMS (Brief Interview of Mental Status) score of 5 indicating he was moderately impaired, he required partial/moderate assistance for transferring from lying to sitting on the side of the bed or sitting to standing; and he had no falls since admission/entry or reentry or the prior assessment. Record review of Resident #1's comprehensive care plan, dated as closed 04/22/2024, reflected: - Resident #1 had an abrasion to his right elbow. The focus was initiated 01/18/2024. - Resident #1 had a right inferior pubic ramus (right lower section of the pelvis bone) fracture. The focus was initiated 01/18/2024. 2. Record review of Resident #2's Admission Record, dated 07/11/2024, reflected Resident #2 was initially admitted on [DATE], readmitted on [DATE], and was [AGE] years old. Resident #2 had diagnoses of systolic (congestive) heart failure (heart failure in which the left side of the heart cannot pump blood efficiently), muscle wasting and atrophy (shrinking of muscle or nerve tissue), lack of coordination, unsteadiness on feet, and mild cognitive impairment of uncertain or unknown etiology (mild difficulty with language, memory, and thinking with an unknown case). A diagnosis of fracture of unspecified part of right clavicle for closed fracture (a break in part of the right collarbone where the broken bone did not penetrate the skin) was noted with onset date of 05/21/2024, classification was blank. Record review of Resident #2's Event Nurses' Note- Bruise, dated 05/21/2024, reflected Resident #2 had a noted bruise on the right side of her neck/collar bone during a routine shower on 05/21/2024. Resident #2 was noted at the time of the event as cognitively impaired, required cueing, and combative. The event note reflected Resident #2 was assessed, the bruise was noted as purple discoloration with swelling and the resident verbalized pain with touch on site. Resident #2 was noted to have been sent to the local hospital for evaluation and treatment. Record review of Resident #2's local hospital discharge paperwork, dated 05/24/2024, reflected a CT Scan Report, noted date of service 05/21/2024, reflected a CT of the chest was performed on 05/21/2024 due to history of right clavicle trauma. The impression reflected a comminuted and mildly displaced right medial clavicular fracture with extension into the sternoclavicular joint (a break in at least two places on the right part of the collarbone, in the part of the bone close to the breastbone, and the breaks resulted in the bones only slightly not lining up straight). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER LA Vida Serena Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 711 Kings Way Del Rio, TX 78840	

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Quarterly MDS, dated [DATE] reflected Resident #2 had a BIMS score of 5 indicating she was moderately impaired, she required set-up or clean-up assistance with walking, substantial/maximal assistance for showers/baths, supervision or touching assistance for transferring from lying to sitting on the side of the bed, sitting to standing, chair/bed-to-chair transfers, and toilet transfers; and she had no falls since admission/entry or reentry or the prior assessment. Record review of Resident #2's Quarterly MDS, dated [DATE] reflected Resident #2 had a BIMS score of 3 indicating she was moderately impaired, she required substantial/maximal assistance for showers/baths, transferring from lying to sitting on the side of the bed, chair/bed-to-chair transfers, and toilet transfers; and she had two or more falls since admission/entry or reentry or the prior assessment but without injury. Resident #2's mobility for as sitting to standing and walking was coded as not attempted due to medical condition or safety concerns. Record review of Resident #2's comprehensive care plan, accessed 07/11/2024, reflected: - Resident #2 had a bruise to right side of neck/collar bone area with closed clavicle fracture. The focus was initiated 05/21/2024. An observation and attempted interview with Resident #2 on 07/11/2024 at 03:44 p.m., revealed Resident #2 was in her bed laying down, well dressed, and groomed. Resident #2's bed was in low position, against the wall on her left side, a fall mat was placed on the floor to the right side of the bed, and Resident #2's call light was pinched to mattress sheet and within reach, and side table was within reach. Resident #2 refused interview upon request. During an interview on 07/11/2024 at 04:36 p.m., the MDS Nurse stated that she was responsible for updating and reviewing the resident care plans and MDS Assessments. The MDS Nurse stated that after a resident fall, the resident would be screened by the therapy department and if the therapy department determined the resident's need for therapy services, she would complete an assessment and update the resident's care plan. The MDS Nurse stated that if a fall occurred within the lookback period or period of time designated to review between assessments, she would code the fall. The MDS Nurse stated that if Resident #1's fall occurred within that lookback period and if he was sent out to the local hospital for assessment and treatment, his fall should have been coded. The MDS Nurse stated Resident #1's fall should have been coded under the J section on the MDS Assessment for falls and that it would have been considered a major injury. She stated Resident #2's injury should have been coded on her last quarterly assessment. The MDS Nurse stated that because Resident #1 and Resident #2's injuries were care planned the impact of the MDS assessment having not been coded accurately would not have been a big deal, stated it would only have been a documentation issue. During an interview on 07/11/2024 at 05:59 p.m., the MDS Nurse stated she inaccurately coded Resident #2's fall. She stated she coded that Resident #2 had two (2) or more falls but not that Resident #2 had a major injury. She stated for Resident #1, she did not document the Resident #1's fall with fracture, which was a major injury. She stated that she would usually review resident orders and events, where the nurses document a resident fall but had missed Resident #1's fall with injury when completing his quarterly assessment in March 2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: LA Vida Serena Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 711 Kings Way Del Rio, TX 78840	

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/11/2024 at 06:38 p.m., the DON stated the nursing staff do not refer to the MDS assessments for interventions, only the care plan. She stated that she did not think the MDS having been coded inappropriately would have impacted the residents' (Resident #1 and Resident #2) care provided by the direct care nursing staff, as long as the care plan was updated with the appropriate interventions. She stated that she believed the inaccurate MDS coding would only impact the communication with the state on how much assistance both the residents (Resident #1 and Resident #2) would have required. During an interview on 07/11/2024 at 07:35 p.m., the ADMIN stated his understanding was that the MDS Assessment coding impacted financial reimbursement to the facility for resident care services, so as long as the care plan was updated appropriately, the care provided to the residents (Resident #1 and Resident #2) would not have been impacted. The ADMIN stated the impact would have been that the facility would have received less compensation for services. Record review of facility policy, 4. Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy 2. 2021 revealed The purpose of the MDS policy is to ensure each resident receives and accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being .Federal regulations at 42 CFR 483.20 (b) (1)(xviii), (g), and (h) require that: 1. The assessment accurately reflects the resident's status.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46447 Based on observation, interview, and record review the facility failed to post daily information that included the facility name, current date, total number and actual hours worked by registered nurses, licensed practical or licensed vocational nurses, certified nurse aides directly responsible for resident care per shift and the resident census. The facility did not post the required current nurse staffing information from 07/05/2024 to 07/11/2024. This failure could place all residents, their families, and facility visitors at risk of not having access to information regarding staffing data and the facility census. Findings included: Observation on 07/11/2024 at 10:30 a.m., revealed a document labeled [facility name] Direct Care Posting dated 07/04/2024, was posted on a wall across from the nurses' station. During an interview on 07/11/2024 at 10:31 a.m., the ADMIN confirmed the posted nurse staffing document was dated 07/04/2024. The ADMIN stated he believed the staffing document was supposed to be posted every morning around 10:00 a.m. The ADMIN stated the document had not been posted for several days. During an interview on 07/11/2024 at 10:56 a.m., the ADMIN stated he had misspoken earlier and that the night shift charge nurse was responsible for posting the daily census and staffing document. The ADMIN confirmed the night shift charge nurse had not posted the document for several days. During an interview on 07/11/2024 at 06:38 p.m., the DON stated that the night shift was responsible for posting the daily census and nurse staffing document. The DON stated the night shift charge nurse was new and had been putting the document in the ADON's box, who had been out for vacation and therefore did not know the document was there. The DON stated that the failure to post the census and nurse posting information daily would impact the facility's communication with residents, who are cognitively aware, and visiting resident families or guests who would look for that information when visiting the facility. During an interview on 07/11/2024 at 07:35 p.m., the ADMIN stated he was unsure on what the impact of not posting the facility's daily census and nurse staffing would be. The ADMIN stated he reached out to the facility's corporate office for a policy regarding the posting of daily census and nurse staffing and was told that the facility did not have a specific policy, just that the facility was to follow the federal and state regulations.