

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 05/08/2025
NAME OF PROVIDER OR SUPPLIER LA Vida Serena Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources were reported immediately to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 1 of 3 Residents (Resident #1) reviewed for Neglect,</p> <p>The facility did not report an allegation of neglect per facility policy to the State Survey Agency (HHSC) when Resident # 1 received an injury to the left lateral calf occurred.</p> <p>This deficient practice could affect any resident and could contribute to further neglect.</p> <p>The findings were:</p> <p>Record review of Texas Unified Licensure Information Portal (TULIP) on 5/6/25 at 1:50 P.M. revealed no self-reported incidents regarding allegations of Neglect were reported for Resident # 1 .</p> <p>Record review of Resident # 1's face sheet dated 5/6/25 revealed an [AGE] year-old female admitted to the facility on [DATE], readmitted [DATE] with the diagnosis that included: anxiety disorder (mental illness characterized by feelings of uneasiness, worry, and fear) , Communication deficit (impairment in the ability to receive, send, process, and comprehend concepts of verbal, nonverbal communication), and dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities).</p> <p>Record review of the quarterly MDS assessment, 1/29/25, revealed a BIMS score of 3, which indicated severe cognitive impairment. Section G revealed Resident #1 required extensive assistance with 2 persons for transfers.</p> <p>Record review of Resident #1's progress note, dated 3/7/25, revealed injury to left lower calf 10 cm X 1 cm X 0.5 cm, sent to [local hospital] for evaluation and treatment.</p> <p>Record review of Resident #1's care plan dated 3/7/25, revealed [Resident's name has a laceration to left lateral calf] interventions: perform wound care as ordered.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of resident #1's hospital discharge instructions, reviewed 5/5/25 at 10:30 AM, dated 3/7/25, revealed that resident #1 received 13 stitches on the left lower calf.</p> <p>Interview with CNA (A) on 5/6/25 at 10:20 AM revealed she transferred Resident # 1 from the wheelchair to the bed with X 1 assist when the resident's left leg caught on the bed rail. She did not notice the injury to Resident #1's left leg until Resident #1 was in bed, and this was when she notified LVN (B) .</p> <p>Interview with LVN (R) on 5/6/25 at 10:52 AM revealed she was the nurse on duty on 3/7/25 when CNA (A) notified her of the injury to Resident #1's left lower leg. She notified MD, who ordered Resident # 1 to be sent to the local ER.</p> <p>Interview with the MD on 5/6/25 at 1:34 PM revealed he was notified by LVN(R) on 3/7/24 regarding the injury to the left lower leg of Resident # 1, and he ordered for Resident # 1 to be sent to the local ER for an evaluation.</p> <p>During an interview with the DON on May 6, 2025, at 11:15 AM, she shared LVN (R) had reached out to her on March 14, 2025, about an injury to Resident #1's left lower leg. The DON also noted she promptly informed the Administrator about this incident. In a follow-up interview with the DON on the same day at 11:30 AM, she emphasized it was the Administrator's role to report any neglect allegations to HHSC, which was why she did not take the step to report the leg injury for Resident #1. Nonetheless, she conveyed she felt strongly that any allegations of neglect should indeed be reported , to help those responsible accountable for their actions if required.</p> <p>Interview with the Administrator on 5/06/25 at 12:45 P.M. revealed he did not report the injury involving Resident #1, as the incident was witnessed. However, upon reviewing the neglect guidelines from HHSC, he acknowledged he should have reported the incident.</p> <p>Record review of facility policy titled, Abuse, Neglect: , dated 9/9/24, , reflected, The Facility will report and cooperate with any investigations concerning reports of abuse, neglect, exploitation, mistreatment of residents, misappropriation of residents property and injuries of unknown source by the company's employees as outlined in state law (including to the state survey and certification agency) .</p>		

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<p>F 0657</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on the interviews and record review, the facility failed to review and revise Resident Care Plans after each assessment for 1 of 3 Residents (Resident # 1) whose records were reviewed for care plan revision/timing,</p> <p>The kardex of Resident # 1 was not updated to reflect the required extensive assistance with 2 persons for transfers via mechanical lift .</p> <p>These deficient practices could affect any resident and contribute to the Residents not receiving the care and services they need.</p> <p>The findings included:</p> <p>Record review of Resident # 1's face sheet dated 5/6/25 revealed an [AGE] year-old female admitted to the facility on [DATE], readmitted [DATE] with the diagnosis that included: anxiety disorder (mental illness characterized by feelings of uneasiness, worry, and fear), Communication deficit (impairment in the ability to receive, send, process, and comprehend concepts of verbal, nonverbal communication), and dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities).</p> <p>Record review of the quarterly MDS assessment, 1/29/25, revealed a BIMS score of 3, which indicated severe cognitive impairment. Section G revealed Resident #1 required extensive assistance with 2 persons for transfers.</p> <p>Record review of the Kardex for resident # 1, dated 3/08/25, revealed a care plan with focus area [resident's name is at risk for falls] interventions: staff X 2 to assist with transfers via mechanical lift.</p> <p>Interview with CNA (A) on 5/5/25 at 11:15 AM revealed that on 3/7/25, when she transferred Resident # 1 from the wheelchair to bed, Resident #1's transfer status was X1 on the Kardex.</p> <p>Interview on 5/07/2025 at 2:30 PM, the MDS nurse stated she had not updated the Kardex for Resident #1 regarding transfer status, staff X 2 to assist with transfers via mechanical lift lift until 3/8/25, as it was missed during audits. She emphasized failing to update these care plans/kardex might prevent staff from being aware of Resident #1's transfer status, potentially injuring Resident #1. The MDS nurse stated it was her responsibility to update the Kardex to reflect the transfer status.</p> <p>Interview on 5/7/2025 at 11:00 a.m., the DON stated the MDS nurse should have updated Resident #1's Kardex to reflect extensive assistance with 2 persons for transfers via mechanical lift as soon as the Quarterly MDS assessment was completed 1/29/25. She added her ADON was responsible for overseeing care plans, and she audited them at random as failure to update Kardex timely could negatively affect Residents.</p> <p>(continued on next page)</p>		

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility policy, titled Comprehensive Care Planning, undated, revealed . The resident care plan will be reviewed after each admission, quarterly, annually, and/or a significant change in MDS assessment, and revised based on the changing goals, preferences, and needs of the resident and in response to current interventions.		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident #1) reviewed for accident hazards and supervision,</p> <p>On 03/07/2025, Resident #1 was transferred by CNA (A) using a standing pivot transfer x 1 staff instead of a mechanical lift. During transfer, Resident #1 was injured, resulting in a laceration to the left lower calf requiring 13 stitches.</p> <p>The non-compliance was identified as past non-compliance. The PNC began on 3/7/25 and ended on 3/09/25. The facility had corrected the non-compliance before the survey began.</p> <p>This failure could lead to injury or death to residents.</p> <p>Findings included:</p> <p>Record review of Resident # 1's face sheet dated 5/6/25 revealed an [AGE] year-old female admitted to the facility on [DATE], readmitted [DATE] with the diagnoses that included: anxiety disorder (mental illness characterized by feelings of uneasiness, worry, and fear. Communication deficit (impairment in the ability to receive, send, process, and comprehend concepts of verbal, nonverbal communication), and dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities).</p> <p>Record review of the quarterly MDS assessment, 1/29/25, revealed a BIMS score of 3, which indicated severe cognitive impairment. Section G revealed Resident #1 required extensive assistance with 2 persons for transfers.</p> <p>Record review of the Care plan for resident # 1, dated 3/08/25, revealed a care plan with focus area [resident's name is at risk for falls] interventions: staff X 2 to assist with transfers via mechanical lift .</p> <p>Record review of the progress note for Resident # 1, dated 03/07/2025, revealed on 03/07/2025 at 12:45 PM, [CNA A] transferred [Resident #1] from the chair to the bed and left leg rubbed against bed frame. [Resident #1] voiced that her leg hurt. Further review revealed Resident #1 was noted to have an abnormality in the left lower leg, and the resident was transferred to the local hospital for treatment.</p> <p>Record review confirmed that [Resident #1's] MDS assessment , dated 3/7/2025 was a staff X 2 to assist with transfers via mechanical lift.</p> <p>Record review of a progress note, dated 03/07/2025 at 12:45 PM, revealed, This nurse was called into the residents' room by CNA (A), left lower extremity assessed, and [Resident #1] was able to state where the pain was, and 911 was called.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's hospital discharge records dated 3/7/25 revealed that Resident # 1 received 13 stitches to the left lower leg.</p> <p>During an Interview with the DON on 05/07/2025 at 1:25 PM, the DON stated CNA (A) should have transferred Resident #1 using two staff members with a mechanical lift as per Resident #1's MDS assessment. The DON also stated residents may be injured if CNAs do not follow the MDS assessment.</p> <p>Interview with CNA (A) on 5/7/2025 at 9:58 AM revealed she transferred Resident #1 without using a mechanical lift, opting for a single-person pivot transfer. She had previously used the lift but was unaware it was indicated in the MDS assessment. As a result of the incident, she was suspended for one day and retrained on locating the Kardex /Care plan.</p> <p>During a follow-up interview on 5/8/2025 at 8:02 AM , CNA (A) reported that Resident #1 complained of pain in her left lower leg after the transfer, and blood was observed on the left lower calf.</p> <p>Record review of the facility's policy titled, Hydraulic Lift, undated, revealed, The Resident will achieve safe transfer to bed or chair via mechanical lift device.</p> <p>The Administrator was notified on 05/08/2025 at 1:00 PM that a past non-compliance was identified due to the above failure.</p> <p>The facility implemented the following interventions before the survey entrance on 05/05/2025.</p> <p>During an interview with the DON on 5/06/25 at 2:18 PM, the DON stated the facility implemented a system for PRN (as needed) staff to review forms before their shift to identify each resident's care needs.</p> <p>Record review of in-service training titled, How to use Kardex in EMAR /Report change of condition to charge nurse, dated 03/7/2025 to 03/09/2025, showed that 36 of 36 staff members, and 2 of 2 PRN staff (as needed) completed the in-service training. Further, review revealed the in-service training addressed: CNAs look at Kardex, mechanical lift's to be used if indicated for two-person assist, where to find POC (Plan of Care), competencies, and demonstration of mechanical lift transfers.</p> <p>Interviews with 12 staff members on 05/6/25 from 11:00 a.m. to 1:00 p.m. the following staff [CNA (B), CNA (C), CNA (D), CNA (E), CNA (F), CNA (G), CNA (H), MA (I), CNA (J), CNA (K), CNA (L), CNA (M)] confirmed completion of in services/training: Always Follow the POC (Plan of Care), the CNA's look at the Kardex, mechanical lifts to be used if it is indicated 2 people assist, and where to find the POC (Plan of Care). The Staff were able to verbalize understanding and information provided in the in-service/training.</p> <p>Observation on 05/6/25 at 10:30 AM confirmed MA (N) and LVN (O) transferred Resident #2 using a two-staff mechanical lift transfer.</p> <p>Observation on 5/6/25 at 7:10 AM confirmed CNA (P) and LVN (Q) transferred Resident #3 using a two-staff mechanical lift transfer.</p> <p>The non-compliance was identified as past non-compliance. The PNC began on 3/7/25 and ended on 3/09/25. The facility had corrected the non-compliance before the survey began.</p>		