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	12/12/2025

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consider the views of the resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility or to demonstrate their response and rationale for such response for 1 of 1 Resident Council group reviewed. The facility failed to follow up on concerns and requests expressed in Resident Council meetings June 2025 through November 2025. The facility failed to provide the Resident Council group with a response, actions, and rationale taken regarding their concerns. This failure placed residents at risk of not having their grievances followed up and addressed. Findings included: Review of the Resident Advisory Council minutes from June 2025 to December 2025 reflected there was no documentation of the facility's responses to the following grievances: Review of document titled, Grievance Report Form dated 6/24/2025, reflected: Resident Council group communicated concerns with meals. The grievance report form was assigned to the Dietary Department. The grievance report form documents concerns were reported to AD. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of document titled, Grievance Report Form dated 6/24/2025, reflected: Resident Council group communicated concerns with water pass/hydration, rounding during the day (noon or so), night shift staff - make more rounds more often - 2x only during the night 11 pm and 5 am - need to answer call light and not just turn it off, and CNAs complaining and talking about being tired, pulling doubles, cussing in hallway. The grievance report form documents concerns were reported to AD. The grievance report form was assigned to the Nursing Department. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of document titled, Grievance Report Form dated 7/15/2025, reflected: Resident Council group communicated concerns with dining room requests of leaving out one napkin dispenser on countertop throughout the day, [NAME] letters/font on menus for easy reading, and posting of alternative menus. The grievance report form documents concerns were reported to Dietary/Admin/AD. The grievance report does not list it was assigned to a department or person. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of document titled, Grievance Report Form dated 8/18/2025, reflected: Resident Council group communicated concerns with call lights: need to be placed within reach, most times, it is wrapped on nightstand drawer or curtain, showers sometimes 1x(once) a week, and residents requesting specific shower times. The grievance report form documents concerns were reported to Nursing. The grievance report does not list it was assigned to a department or person. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of document titled, Resident Advisory Council Minutes 9/23/2025, reflected: Resident Council group communicated concerns with 500/600 hall showers,, no hot water, aids need to check water before shower; 100 hall - last rooms are getting colder in the evenings, check thermostat or provide extra blankets; 600 hall aids to check on residents more often during morning. Review of document titled, Grievance Report Form dated 11/18/2025, reflected Resident Council group communicated concerns with call lights down 100/600 hall, 2-10 shift lights get turned off, staff stating they are busy and will come back, and light has to be turned on again. The (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grievance report form documents concerns were reported to DON. There was no investigation conducted, no results or resolution reported to the Resident Council group. In an interview on 12/10/2025 at 2:00 PM, the Resident Council group stated the AD submits group grievances mentioned during monthly meetings to the management staff. The group stated they do not get information on the outcome of the grievances and would like this to change. In an interview on 12/10/2025 at 2:40 PM, the AD stated she was responsible for taking the minutes of the group meeting as the residents invite her monthly. She stated she will write down any group grievances, enter information on a grievance report, and give to department heads to address and return once resolved. She stated that if grievances are not investigated and communicated with the residents it would have a negative impact in that they may not feel as if they are being heard and feel discouraged. She stated the SW position has been vacant since the former SW transitioned to the ADM over 2 months back and the SW position was just filled today, 12/10/2025. She stated the SW was responsible for grievances and following up on them and stated the ADM has been present, but not in the SW capacity. She stated when residents have an immediate grievance, she tells them it was best to notify the DON or ADM if it needs to be addressed quickly and not to wait. She stated she does address resident rights during meetings and how to file grievances. She stated once grievance was resolved she would communicate resolution to the group. She stated she was unsure as to why this information was not documented in Resident Council group minutes or on the Grievance Report Form, but moving forward she will ensure if a grievance resolution was addressed during group meetings, she will ensure it was documented in the minutes. In an interview on 12/12/2025 at 12:32 PM, the DON stated an individual or the Resident Council group has a complaint staff will assist with completing a grievance form. She stated this grievance form will be submitted to self or ADM, if it pertains to a specific department, it will be assigned to the department head. She stated the department head is expected to address the concern, find a resolution, educate the nursing staff with an in-service, and return to the SW who tracks the grievance, notify the complainant and file. She stated the SW position has been vacant for some time, and the ADM is currently responsible for grievances as she transitioned from the SW to ADM position two months back. She stated if the grievance is not addressed and no resolution is provided to the individual or group filing the grievance it would cause the resident to become upset with the overall process. She stated she is unsure why the group grievances do not have findings, documented corrective actions taken by the facility, or if communicated to the resident as this is the responsibility of the ADM at this time. In an interview on 12/12/2025 at 12:40 PM, the ADM stated she was the former SW of the facility and transitioned over to the ADM position after becoming certified on 10/28/2025. She stated anyone can file a grievance or remain anonymous. She stated that any resident can file a grievance, the grievance was assigned to the department head relating to the grievance. She stated the grievance should be addressed within less than a week, it was returned to the SW to communicate the resolution to the person who filed the complaint, track it, and file. She stated this process was the same for both individual and group grievances. She stated for group grievances the AD will provide resolution details at the next Resident Council meeting. She stated if grievance was not investigated and a resolution was not provided to the individual or group it could affect them negatively as they are not being heard and they would feel ignored. She stated she was the former SW of the facility and transitioned over to ADM when she became certified on 10/28/2025. She stated the SW was responsible for tracking grievances, following up on the investigation and providing a resolution to the individual who filed the grievance. She stated the new SW was hired during recertification on 12/10/2025 and she was responsible for grievances until this recent hire. She stated she was sure the grievances the Resident Council group submitted were investigated by department heads, in-service training addressing the concern was provided to the nursing staff, and the group was notified of the outcome. She stated she was not sure why the grievance was not fully completed with the findings/conclusions regarding the residents' concern, whether the grievance was confirmed or not confirmed, any corrective action (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	taken by the facility. She stated this process will improve with the hiring of a new SW. Review of the facility policy dated 11/28/2016, titled Resident Rights reflected the following: Respect and dignity - The resident has a right to be treated with respect and dignity. Grievances. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Review of the facility policy dated 11/02/2016, titled Grievances reflected the following: The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Procedure3. The grievance official will: Oversee the grievance process Receive and track grievances to their conclusion Lead any necessary investigations by the facility Issue written grievance decisions to the resident 6. All written grievances decisions will include: The date the grievance was received A summary statement of the residents grievance The steps taken to investigate the grievance A summary of the pertinent findings or conclusions regarding the resident's concern(s) A statement as to whether the grievance was confirmed or not confirmed Any corrective action taken or to be taken by the facility as a result of the grievance The date the written decision was issued

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and maintain a comprehensive Quality Assurance & Performance Improvement Program (QAPI) Plan, disclose records upon request, and have governance and leadership for 1 of 1 QAPI Program Plan reviewed. The facility failed to maintain an effective, comprehensive QAPI program and plan that addresses the full range of services the facility provides. The facility failed to ensure the QAPI Program uses performance indicator data, resident and staff input, and other information to identify and prioritize problems and opportunities. The facility failed to identify and prioritize quality deficiencies and utilize Resident and Family Council minutes, Grievance Review process, and Daily QA meetings (Morning QA stand up meeting) for improving resident outcomes. This failure has the potential to impact residents' quality of life and resident rights. Findings included:Review of the Resident Advisory Council minutes reflected the following with no documentation of the facility's responses to the grievances: 6/24/2025 reflected: Resident Council notes included specific details of concerns about direct care and nutrition services. 7/15/2025 reflected: Resident Council notes included specific details of concerns about direct care and nutrition services. 8/18/2025 reflected: Resident Council notes included specific details of concerns about direct care, nutrition services, maintenance, and activities. 9/23/2025 reflected: Resident Council notes included specific details of concerns about direct care, nutrition services, maintenance, activities, and medication administration. 10/28/2025 reflected: Resident Council notes included specific details of concerns about direct care and nutrition services. 11/28/2025 reflected: Resident Council notes included specific details of concerns about direct care and nutrition services. In an interview on 12/10/2025 at 2:00 PM, the Resident Council group stated the AD submits group grievances mentioned during monthly meetings to the management staff. The group stated they do not get information on the outcome of the grievances and would like this to change. In an interview on 12/10/2025 at 2:40 PM, the AD stated she was responsible for taking the minutes of the group meeting as the residents invite her monthly. She stated she will write down any group grievances, enter information on a grievance report, and give to department heads to address and return once resolved. She stated that if grievances are not investigated and communicated with the residents it would have a negative impact in that they may not feel as if they are being heard and feel discouraged. She stated she was unsure as to why resolution information was not documented in Resident Council group minutes or on the Grievance Report Form, but moving forward she will ensure if a grievance resolution was addressed during group meetings, she will ensure it is documented in the minutes. In an interview on 12/12/2025 at 12:32 PM, the DON stated if an individual or the Resident Council group has a complaint staff will assist with completing a grievance form. She stated this grievance form will be submitted to self or ADM, if it pertains to a specific department, it will be assigned to the department head. She stated the department head was expected to address the concern, find a resolution, educate the nursing staff with an in-service, and return to the SW who tracks the grievance, notify the complainant and file. She stated if the grievance was not addressed and no resolution was provided to the individual or group filing the grievance it would cause the residents to become upset with the overall process. She stated she was unsure why the group grievances do not have findings, documented corrective actions taken by the facility, or if communicated to the residents as this was the responsibility of the ADM at this time. In an interview on 12/12/2025 at 12:40 PM, the ADM stated anyone can file a grievance or remain anonymous. She stated that any resident can file a grievance, the grievance was assigned to the department head the grievance was related to. She stated the grievance should be addressed within less than a week, it is returned to the SW to communicate the resolution to the person who filed the complaint, track it, and file. She stated this process was the same for both individual and group grievances. She stated grievances are discussed during the morning daily meetings. ADM stated for group grievances the AD (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will provide resolution details at the next Resident Council meeting. She stated if grievance was not investigated and a resolution was not provided to the individual or group it could affect them negatively as they are not being heard and they would feel ignored. She stated she was the former SW of the facility and transitioned over to ADM when she became certified on 10/28/2025. She stated the SW was responsible for tracking grievances, following up on the investigation and providing a resolution to the individual who filed the grievance. She stated the new SW was hired during recertification on 12/10/2025 and she was responsible for grievances until this recent hire. She stated she was sure the grievances the Resident Council group submitted were investigated by department heads, in-service training addressing the concern was provided to the nursing staff, and the group was notified of the outcome. She stated she was not sure why the grievance was not fully completed with the findings/conclusions regarding the residents' concern, whether the grievance was confirmed or not confirmed, any corrective action taken by the facility. She stated this process will improve with the hiring of a new SW. ADM stated during morning meetings the nursing staff address any deviations from expected performance or a negative trend. She stated the Champion Team Program also helps to implement a proactive approach to resolving resident and environmental issues before they escalate and the nursing staff report quality concerns directly to the ADM. ADM stated anything related to residents' life or safety was priority and would be worked on first. She stated HR, DON, and she act immediately upon facility concerns and implemented corrective actions of corporate in-services and staff writeups, which she follows up on. She stated the QAA Committee was not aware of the issues concerning the resident family group and response and resident records, which were identified during the survey this week and thus did not undergo good faith attempts to correct quality deficiencies. Review of document titled, Grievance Report Form dated 6/24/2025, reflected: Resident Council group communicated concerns with meals. The grievance report form was assigned to the Dietary Department. The grievance report form documents concerns were reported to AD. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of document titled, Grievance Report Form dated 6/24/2025, reflected: Resident Council group communicated concerns with water pass/hydration, rounding during the day (noon or so), night shift staff - make more rounds more often - 2x only during the night 11 pm and 5 am - need to answer call light and not just turn it off, and CNAs complaining and talking about being tired, pulling doubles, cussing in hallway. The grievance report form documents concerns were reported to AD. The grievance report form was assigned to the Nursing Department. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of document titled, Grievance Report Form dated 7/15/2025, reflected: Resident Council group communicated concerns with dining room requests of leaving out one napkin dispenser on countertop throughout the day, [NAME] letters/font on menus for easy reading, and posting of alternative menus. The grievance report form documents concerns were reported to Dietary/Admin/AD. The grievance report does not list it was assigned to a department or person. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of document titled, Grievance Report Form dated 8/18/2025, reflected: Resident Council group communicated concerns with call lights: need to be placed within reach, most times, it is wrapped on nightstand drawer or curtain, showers sometimes 1x(once) a week, and residents requesting specific shower times. The grievance report form documents concerns were reported to Nursing. The grievance report does not list it was assigned to a department or person. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of document titled, Resident Advisory Council Minutes 9/23/2025, reflected: Resident Council group communicated concerns with 500/600 hall showers,, no hot water, aids need to check water before shower; 100 hall - last rooms are getting colder in the evenings, check thermostat or provide extra blankets; 600 hall aids to check on residents more often during morning. Review of document titled, Grievance Report Form dated 11/18/2025, reflected Resident Council group communicated concerns with call lights down 100/600 hall, 2-10 shift lights (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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	get turned off, staff stating they are busy and will come back, and light has to be turned on again. The grievance report form documents concerns were reported to DON. There was no investigation conducted, no results or resolution reported to the Resident Council group. Review of the facility policy dated 11/28/2016, titled Resident Rights reflected the following: Respect and dignity - The resident has a right to be treated with respect and dignity. Grievances. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Review of the facility document undated, titled Quality Assurance Performance Improvement Program (QAPI) Plan reflected the following: The main purpose for the facility QAPI plan is to ensure all opportunities for improvement are identified and corrected using various methods to include action plans, root cause, PDSA methodology and various benchmarks as goals. This process will be done through a team approach involving all staff members and residents' representatives. The primary goal is to identify, correct and prevent reoccurrence of identified problems that arise within the facility. This plan will assist the facility to ensure that care and services delivered meet accepted standards of quality, identify problems and opportunities for improvement and ensure progress toward correction or improvement is achieved and sustained. 2. Governance and Leadership This involves leadership working with input from facility staff, as well as from residents and their families and/or representatives. 3. Feedback, Data Systems and Monitoring The facility will identify and prioritize quality deficiencies and will utilize all opportunities to identify areas with the potential for improving resident outcomes to include but not limited to: Resident interview, family interview and staff interview, observations and reviews Standards of Care Meeting Champion Round Program Resident and Family Council minutes Grievance Review process Daily QA meetings (Morning QA stand up meeting) Review of the facility policy dated 11/02/2016, titled Grievances reflected the following: The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. Procedure 3. The grievance official will: Oversee the grievance process Receive and track grievances to their conclusion Lead any necessary investigations by the facility Issue written grievance decisions to the resident 6. All written grievances decisions will include: The date the grievance was received A summary statement of the residents grievance The steps taken to investigate the grievance A summary of the pertinent findings or conclusions regarding the resident's concern(s) A statement as to whether the grievance was confirmed or not confirmed Any corrective action taken or to be taken by the facility as a result of the grievance The date the written decision was issued Review of the facility document undated, titled Champion Team Program reflected the following: STANDARD: The Champion Team Program is designed to foster open communication and collaboration among residents, staff, and families. By removing departmental barriers and promoting shared responsibility, the program aims to proactively address concerns and enhance the quality of care. Program Goals: Implement a proactive approach to resolving resident and environmental issues before they escalate.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 3 of 13 resident rooms (rooms 205, 206, 213) and 1of 1 hydration room and 1 of 1 laundry room reviewed for environmental concerns in that: 1-The facility failed to repair a bathroom ceiling vent that was dirty/rusty, replace a bathroom light bulb, repair a bedroom's broken window shade, repair a hydration room's ceiling, repair a laundry rooms ceiling vent and ceiling area, repair a laundry room's corner wall panel, clean a laundry room's corner wall area that had a film resembling mold, and replace laundry room floor tiles. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.The findings included: Observation on 12/11/25 from 1100am-1115am with the Administrator and Maintenance Director revealed the following:a-There was a bathroom ceiling vent that had dirt and rust on the vents in room # 205.b-There was an overhead light over the bathroom sink that did not turn on in room # 206.c-There was a broken window shade next to bed-B in room # 213.d-There was a ceiling area with peeling paint and water embarkation spots in the hydration room.e-There was a circular ceiling vent which measured approximately 2x3 ft in diameter that had dirt and rust on the vent in the laundry room.f-There was a ceiling area which measured approximately 1x1 ft in size that had peeling paint in the laundry room.g-There was a corner wall area that had a side panel which measured approximately 1.5 ft in length that was dislodged from the side- wall in the laundry room.h-There was a corner of the wall behind the washing machine which measured approximately 1.5x1.5 ft that contained a black-dotted film on the wall surface that resembled mold in the laundry room.i-There were 12 floor tiles which each measured 1x1 ft that were dirty and stained in the laundry room. During an interview on 12/11/25 at 11:20am with the Administrator and Maintenance Director the Maintenance Director stated that staff notify him of pending work order needs and he had been aware of the observed areas which needed repair. The Administrator stated the completed repairs would create a safer environment for the Residents and staff. Record review of the facility policy titled Preventative Maintenance in the Environment of Care Policy and Procedure Manual dated 2003 revealed Preventative maintenance will be completed routinely and according to protocol by the Maintenance Supervisor or qualified designee.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment [TT1] for 2 of 24 residents (Residents #28 and #44) reviewed for care plan. 1. The facility failed to develop and implement a care plan with a focus, goals, and interventions for Resident #28's needs for dialysis (a life-sustaining medical treatment that filters waste products and excess fluid from the blood when the kidneys fail.) 2. The facility failed to develop and implement a care plan with a focus, goals, and interventions for Resident #44's needs for an intravenous catheter (a thin, flexible tube inserted into a vein to deliver fluids, medications, blood, or nutrition, and to draw blood, commonly placed in the hand or arm.) These failures could place residents at risk for harm by not having their nursing interventions planned. The findings included: Resident #28A record review of Resident #28's admission record dated 12/12/2025 revealed an admission date of 10/29/2025 with a diagnosis of end stage renal disease (ESRD - when the kidneys permanently fail and can no longer function well enough to keep a person alive, requiring life-sustaining treatments like dialysis or a kidney transplant.) A record review of Resident #28's admission MDS dated [DATE] revealed Resident #28 was a [AGE] year-old male admitted for LTC Resident #28 was assessed with a BIMS score of 13 out of a possible 15, which indicated no cognitive impairment. review of section o Special Treatments, Procedures, and Programs revealed Resident #28 received dialysis treatments. A record review of Resident #28's physicians orders dated 12/10/2025 revealed the physician prescribed the following:- To receive dialysis therapy 3 times a week on Tuesdays, Thursdays, and Saturdays. - For nursing to assess Resident #28's dialysis device for a positive bruit and thrill every shift (a whooshing sound heard with a stethoscope over a dialysis port, while a thrill is the palpable vibration or buzzing sensation felt over that same dialysis port. - Nursing may withhold medications prior to Resident #28's dialysis appointments. A record review of Resident #28's care plan dated 12/10/2025 revealed the following:- To receive dialysis therapy 3 times a week on Tuesdays, Thursdays, and Saturdays. - For nursing to assess Resident #28's dialysis device for a positive bruit and thrill every shift (a whooshing sound heard with a stethoscope over a dialysis port, while a thrill is the palpable vibration or buzzing sensation felt over that same dialysis port. - Nursing may withhold medications prior to Resident #28's dialysis appointments. Further review revealed there were no focus care areas, goals, nor interventions. Resident #44A record review of Resident #44's admission record revealed an admission date of 10/17/2025 with diagnoses which included hemiparesis (weakness on one side of the body) and urinary tract infection. A record review of Resident #44's MDS assessment dated [DATE] revealed Resident #44 was an [AGE] year-old female admitted for LTC with a urinary tract infection. Resident #44 was assessed with a BIMS score of 15 which indicated no cognitive impairment. Resident #44 was assessed with adequate vision with glasses, and hearing without aides. Resident #44 was assessed with the ability to usually make herself understood and could usually understand others. Resident was assessed with the need for antibiotics via a peripherally inserted central catheter (PICC) intravenous access. A record review of Resident #44's nursing progress note dated 10/17/2025 revealed LVN F documented Resident #44 was admitted from the hospital with a PICC intravenous access (IV); . readmission Note readmitted / returned from the hospital. Has IV access via PICC Line,. Location of PICC line: RIGHT UPPER ARM. A record review of Resident #44's physician's orders dated 10/31/2025 revealed Resident #44 was prescribed antibiotics to treat a urinary tract infection (UTI) intravenously and orders to maintain her PICC IV line; Admit to Medicare Part A effective 10/17/2025 due to status post hospitalization requiring skilled nursing care for management of diagnosis of urinary tract infection. (continued on next page)

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	12/12/2025

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change dressing to double lumen PICC line to right upper extremity. Flush PICC line to right upper extremity with 10 milliliters of normal saline before and after medication . No blood pressure or vein puncture to right arm . levofloxacin in d5w intravenous solution 250mg / 50mg, use 50ml intravenously one time a day related to UTI. A record review of Resident #44's care plan dated 12/10/2025 revealed no focus, Goals, nor interventions for: UTI, PICC line, nor Antibiotic use. During an interview on 12/12/2025 at 8:30 AM the RN G stated she was the facility's MDS nurse. RN G stated Resident #44 was discharged to the hospital for evaluation and treatment for a diagnosed UTI. RN G stated Resident #44 was admitted to the facility with an intravenous line developed and maintained at the hospital. RN G stated Resident #44 returned with orders for antibiotic treatments through the intravenous line. RN G stated she assessed Resident #44 upon her admission and developed and implemented Resident #44's MDS and initiated Resident #44's care plan by introducing care plan templates. RN G stated she reviewed Resident #44 care plan and recognized she had failed to introduce nursing care plans with focuses, goals and interventions for Resident #44's UTI, antibiotic use, and PICC line. RN G stated she was responsible for bringing this information into the care plan and had not, I overlooked it due to human error. RN G stated the Administrator was her supervisor and was responsible for reviewing and ensuring the accuracy of the MDS and care plan. RN G stated residents who were admitted to the facility were reviewed in the IDT daily morning meetings and IV lines with antibiotic therapies would also be reviewed to ensure transcription to the care plan. RN G stated the potential negative outcome could be no care plan focuses, goals, and interventions for residents admitted with needs for PICC lines with antibiotic administration. During an interview on 12/12/2025 at 12:18 PM the DON and LVN H stated Resident #28 had a need for dialysis 3 times a week related to his kidney failure and diagnosis of ESRD. The DON and LVN H stated they had reviewed Resident #44's care plan and recognized Resident #44 did not have focuses, goals, and nursing interventions for Resident #28's dialysis, which could have included his chair days and times of service, how to handle Resident #28's shunt, e.g. no blood draws to shunt arm, no blood pressure to arm etc. The DON and LVN H stated this failure could have potential negative outcomes related to poor continuity of care. During an interview on 12/12/2025 at 11:40 AM the DON and the Administrator stated residents with care needs like dialysis and intravenous antibiotics should be assessed by nursing and care plans should be developed and implemented with focuses, goals, and interventions to promote a residents highest practical health status. The DON and the Administrator stated they were responsible to overview and ensure residents care plans were developed and implemented and in regard to the lack of care plan interventions for Residents #28 and #44 there was room for improvement, and the failure could have potential negative outcomes for care plans. A record review of the facility's undated Comprehensive Care Planning policy revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.The comprehensive care plan will describe the following - The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; . The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.

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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 - 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** Based on observations, interviews, and record reviews the facility failed to ensure that residents' environments remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents, for 1 of 8 residents reviewed for anti-slip mats. Resident #9 was assessed as a fall risk with a history of falls from her wheelchair. Resident #9 was prescribed an anti-slip mat on the seat of her wheelchair and had gone missing for days. This failure could place residents at risk of falls and injuries. The findings included: A record review of Resident #9's admission record dated 12/10/2025 revealed an admission date of 3/21/2025 with diagnoses which included a history of falling, syncope and collapse (fainting), and difficulty walking. A record review of Resident #9's annual MDS assessment dated [DATE] revealed Resident #9 was a [AGE] year-old female admitted for LTC and assistance with safety assistance and supervision related to her being assessed as a fall risk and history of falling. Resident #9 was assessed with a BIMS score of 12 out of a possible 15 which indicated moderate cognitive impairment. Resident #9 was assessed with adequate hearing and poor vision and used glasses. Resident #9 was assessed with the ability to usually understand others and could usually make herself understood. Resident #9 was assessed with the need to use a wheelchair. A record review of Resident #9's care plan dated 12/10/2025 revealed, Focus: Resident #9 has a potential for falls related to history of falls. Goal: Resident #9 will suffer no major injury related to falls through the review date. Interventions: . therapy referral; sic[brand name anti-slip mat] mat. A record review of Resident #9's nursing progress notes revealed LVN A documented on 3/4/2025 that Resident #9 had fallen out of her wheelchair; . Resident Statement: I was sitting in my wc sic[wheelchair] and I was undoing the blankets on my bed and since I was wearing my socks only I slipped and fell out of my wc . During an observation and interview on 12/9/2025 at 11:30 AM revealed Resident #9 in her bedroom seated in her wheelchair. Resident #9 stated she would like her red anti-slip mat back onto her wheelchair. Resident #9 stated she had her wheelchair washed last week and it was returned without her red mat. Resident #9 stated the mat helped her to not slip out of her wheelchair which, in the past, she had fallen out of her wheelchair. Resident #9 leaned over slightly to demonstrate there was no red mat on the wheelchair seat. During an observation and interview on 12/10/2025 at 8:00 AM revealed Resident #9 in her bed with her wheelchair at the bedside. Observation of the wheelchair seat revealed no anti-slip mat. Resident #9 stated she had been asking staff for her red mat and pointed out the mat was still missing from her wheelchair seat. During an interview on 12/11/2025 at 5:30 AM CNA B and CNA C stated they were CNAs during the daily 10:00 PM to 6:00 AM shift. CNAs B and C stated they would provide care for Resident #9 to include assistance in transferring Resident #9 from her bed to her wheelchair. CNA B and C stated they were aware Resident #9 was a fall risk but were unaware Resident #9 needed an anti-slip mat on her wheelchair. During an observation, interview, and record review on 12/11/2025 at 5:45 AM LVN D and LVN E stated they were nurses for Residents from 10:00 pm to 6:00 AM. LVN D stated she was the charge nurse for Resident #9 and was aware Resident #9 was a fall risk but was unaware Resident #9 needed an anti-lip mat for her wheelchair seat. LVN E stated she was aware Resident #9 was a fall risk and needed an anti-slip mat on her wheelchair seat but was unaware the mat was missing. LVN D reviewed Resident #9's care plan and revealed Resident needed an anti-slip mat for her wheelchair seat. LVN D was observed to go to Resident #9's room and assessed Resident #9 in bed with her wheelchair nearby. Resident #9 awoke and reported to LVN D that her anti-slip mat was missing since the wheelchair was washed last week. LVN D checked the wheelchair and stated the ant-slip mat was missing. LVN D stated she would replace the mat prior to Resident #9's use of the wheelchair. LVN D stated without the anti-slip mat Resident #9 was at risk for slipping out of her wheelchair. During an interview on 12/11/2025 at 2:04 PM the Administrator and the DON stated they (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had received a report from LVN D that Resident #9 did not have her anti-slip mat on her wheelchair seat; however, LVN D replaced the anti-slip mat immediately prior to Resident #9 using the wheelchair. The DON stated Resident #9 was at risk for falls and was prescribed to use an anti-slip mat to her wheelchair to mitigate any potential fall out of the wheelchair. The DON stated the lack of a wheelchair anti-slip mat could have potential to contribute to a slip out of the wheelchair. The DON and the administrator stated the nurses and CNAs had the responsibility to ensure residents received care according to their care plans and had the responsibility to report any discrepancies in the care provided. A policy for the failure to have an anti-slip mat on a wheelchair was requested on 12/12/2025 at 1:27 PM and as of 12/20/2025 was not received.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure medical records were maintained completely, accurately documented, readily accessible, and systematically organized per professional standards for 2 of 8 residents (Residents #9 and #76) reviewed for accurate medical records. Resident #76's hospital discharge documents were stored in Resident #9's medical record. This failure could place residents at risk of harm by keeping inaccurate records. The findings included:Resident #9A record review of Resident #9's admission record dated 12/10/2025 revealed an admission date of 3/21/2025 with diagnoses which included a history of falling, syncope and collapse (fainting), and difficulty walking. A record review of Resident #9's annual MDS assessment dated [DATE] revealed Resident #9 was a [AGE] year-old female admitted for LTC and assistance with safety assistance and supervision related to her being assessed as a fall risk and history of falling. Resident #9 was assessed with a BIMS score of 12 out of a possible 15 which indicated moderate cognitive impairment. Resident #9 was assessed with adequate hearing and poor vision and used glasses. Resident #9 was assessed with the ability to usually understand others and could usually make herself understood. Resident #9 was assessed with the need to use a wheelchair. Resident #76A record review of Resident #76's admission record revealed an admission date of 10/3/2025 with a discharge date of 10/20/2025 with diagnoses which included chronic obstructive pulmonary disease and anxiety disorder. A record review of Resident #76's discharge MDS assessment dated [DATE] revealed Resident #76 was a [AGE] year-old female admitted for rehabilitation care and after 17 days was discharged to her home with home healthcare. A record review of Resident #9's scanned medical records revealed a 13 page hospital discharge document for Resident #76, dated 10/3/2025. During an interview on 12/12/2025 at 7:30 AM Medical Records I (MR I) stated she was the was the staff member assigned to electronically scan Residents' documents into MR I stated she was given many boxes of documents to scan and felt overwhelmed and has been scanning records every day since and has currently caught up with the demand for scanning records as they are developed. MR I stated she had recognized she made mistakes in scanning the wrong records into the wrong residents' medical records. MR I stated her supervisors were DON and the Administrator and they were responsible for ensuring her training and supervision for accurate records. During an interview on 12/12/2025 at 11:40 AM the DON and the Administrator stated they were the supervisors for MR I and had recognized MR I had made some mistakes in scanning medical records. The administrator stated the facility would develop and implement an audit tool to ensure accurate medical records were scanned. The DON and the Administrator stated the failure to have accurate medical records could be potentially inaccurate records. A record review of the facility's undated Documentation policy revealed, Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software sic[name brand of medical record]. All documentation and clinical records are confidential and can be released only with signed permission of the resident or legal representative.Goal1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.