STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675974	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Valley Health & Rehabilitation Center	913 Hwy 90 W Castroville, TX 78009

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or serious bodily injury for 1 (Resident #1) of 4 residents reviewed for freedom from abuse, neglect, and exploitation. The facility failed to report an allegation of resident neglect regarding Resident #1's unwitnessed fall with major injury to the State Agency within the allotted time frame of 2 hours. This failure could place all residents at increased risk for potential neglect due to unreported allegations of neglect. The findings included: Record review of Resident #1's face sheet, dated 07/26/2024, revealed Resident #1 was admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), chronic idiopathic constipation (difficult time passing stool), traumatic hemorrhage of left cerebrum (blood within the brain tissue), dementia (loss of cognition function), and muscle weakness. Record review of Resident #1's annual MDS assessment dated [DATE] reflected a BIMS score of 1 (severely cognitively impaired). Resident #1 required dependent (helper does all the effort) for eating, oral hygiene, toileting hygiene, dressing, showering/bathing, personal hygiene, and chair/bed-to-chair transfer. Record review of Resident #1's incident report, dated 05/31/2024, revealed [Resident #1] was observed on the floor in dining area at end of 300 hall on 05/31/2024 at 1:20 p.m. Resident had been in Geri chair (a large, padded chair that is designed to help seniors with limited mobility) after being fed lunch. Resident had refused to go to the bed after lunch so was left in area to where he could be visually observed. Geri chair was in reclined position and brake locks on. Asked resident if he hit his head as he smiles and states Yes. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nursing progress note, dated 05/31/2024, revealed Call to 911 and [Resident #1] was transferred to the local acute hospital emergency room for further evaluation on 05/31/2024. Further record review of nursing progress note, dated 06/03/2024, revealed CT at hospital revealed parenchymal hemorrhagic contusion (bruises that occur when the brain has an impact on the surface of the skull) to the left frontal lobe. Returned to the facility on [DATE], no changes in mentation, activities of daily living function, and no new medications. Record review of Resident #1's post fall assessment, dated 05/31/2024, revealed for identified root cause was Resident slid from chair while in dining area after refusing to go to bed, and intervention system change was while up in chair, place near nurses' station for closer monitoring. Record review of Resident #1's Care Plan, dated 05/31/2024, reflected the resident has had an actual fall on 05/31/2024 (unwitnessed) found on floor next to chair - sent to hospital emergency room for evaluation - hit his head - follow up hospital and per CT scan indicated parenchymal hemorrhage contusions (bruises that occur when the brain has an impact on the surface of the skull) and intervention was apply soft helmet to resident as tolerated every shift, apply weighted blanket as needed for comfort to decrease anxiety, give resident sensory activity blanket while in room, increase comfort rounds, may have scoop mattress, may wedge pillow for positioning, and while up on chair, place near nurses station for closer monitoring. Observation on 07/26/2024 at 10:18 a.m. revealed Resident #1 was not in his room. Two fall mats were in place, a wedge pillow on the bed, had a scoop mattress, bed was in low position, and call light was within reach. Further observation on 07/26/2024 at 10:22 a.m. revealed the resident was at the main dining room with other residents and staff for activities. They listened to music. The resident was alert and very well responded. He smiled and was wearing a soft helmet, blanket, and sensory activity blanket. Interview on 07/26/2024 at 10:31 a.m. with LVN A revealed Resident #1 had no changes in mentation, activities of daily living function, and no new medications after he fell from the chair on 05/31/2024. Resident #1 liked attending activities with other residents and watching people at the nursing station. Interview on 07/26/2024 at 10:47 a.m. with ADON revealed Resident #1 fell from the Geri chair on 05/31/2024, and he said he hit his head with a smile, so a nurse called 911. They sent him to the hospital emergency room for further evaluation because he said he hit his head even though he did not have any pain. After this incident was occurred, the care team had a meeting and reviewed the incident. For Resident #1, staff should keep him near nursing station, so every staff could watch him. When the resident was on the bed during daytime, he was anxious because he did not like that, he was alone. The resident liked watching people at the nursing station and attending activities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/26/2024 at 10:53 a.m. with the Administrator she confirmed she reported the incident to the State Agency on 07/23/2024. However, Resident #1 fell on [DATE] and said he hit his head, so the facility nurses called 911 and sent the resident to the hospital emergency room . The Administrator called Resident #1's doctor because Resident #1's doctor was the same doctor in the hospital. The doctor said any falls where the resident hits his head should be kept in the ICU for further monitoring, so the hospital put Resident #1 in the ICU and watched the resident. Resident #1 had two CT scans at the hospital. One CT scan said Resident #1 had a contusion, and the other CT scan said no change and he was in stable condition comparing to the previous status, and the hospital sent the resident back to the facility. The reason why the Administrator did not report it to the State Agency was that Resident #1 was assessed by his doctor, and the resident had a contusion, but the doctor said it was not major injury because Resident #1 did not change anything regarding mental functions or physical functions by the contusion. However, Resident #1 belonged to VA care and they said it was major injury because Resident #1 had a contusion. That was why the Administrator reported it to the State Agency on 07/23/2024. Further interview on 07/26/2024 at 3:50 p. m. with the Administrator stated the Administrator should report any fall with major injury and injury with unknown origin to the State Agency, and the Administrator had the responsibility to report to prevent possible abuse or neglect. Record review of the facility policy, titled Compliance with reporting allegations of abuse/neglect/exploitation, undated, revealed It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes and . 8. Reporting/Response: The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation. The facility will analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.