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	02/27/2026

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 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** Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 4 of 6 residents (Resident #3, Resident #4, Resident #41, and Resident #42) who were reviewed for resident assessments. 1. The facility failed to document Resident #4's use of anticonvulsant medication on the quarterly MDS assessment. 2. The facility failed to document Resident #41's use of diuretic medication on the annual MDS assessment.3. The facility failed to document Resident #3's admission to hospice services on the Significant Change Assessment.4. The facility failed to document Resident #42's hospice services on her last quarterly MDS assessment. These failures 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 Resident #4's admission sheet dated 9/08/2024 with an original date of 3/14/2017 documented an [AGE] year-old female resident with diagnoses including dementia, diabetes mellitus, anxiety, insomnia, cerebral infarction (stroke), hyperlipidemia (high cholesterol), hypertension (high blood pressure) and heart disease. Record review of Resident #4's MDS assessment dated [DATE] documented in section reflected she was rarely/never understood. The assessment recorded the use of antidepressant, anticoagulant, diuretic, and hypoglycemic medications but did not record the use of anticonvulsant medications. Record review of Resident #4's order summary documented an order for the anticonvulsant medication Depakote with an order date of 10/23/2025. Depakote was ordered as Depakote 500 mg, Give 1 tablet by mouth two times a day. Record review of Resident #4's February 2026 MAR documented the resident had been receiving Depakote as prescribed during the 7 day look back period of 02/01/2026 through 02/07/2026. Record review of Resident #4's care plan with an initiation date of 10/24/2025 documented the resident uses an anticonvulsant medication for mood stabilization., with interventions including Administer medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. 2. Record review of Resident #41's admission sheet dated 01/20/2026 with an original date of 3/21/2024 documented an [AGE] year-old male resident with diagnoses including dementia, seizures, hyperlipidemia, hypertension, heart disease, diabetes mellitus, and cerebral infarction. Record review of Resident #41's MDS assessment dated [DATE] documented a BIMS score of 10 indicating moderate cognitive impairment and recorded the use of antibiotic, antiplatelet, and (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anticonvulsant medication. Further review of the MDS revealed the assessment did not record the use of diuretic medication. Record review of Resident #41's order summary documented an order for the diuretic medication Furosemide. Furosemide was ordered as Furosemide 40 mg, Give 1 tablet by mouth one time a day. Record review of Resident #41's January 2026 MAR documented the resident had been receiving Furosemide as prescribed during during the look back period of 01/18/2026 through 01/24/2026. Record review of Resident #41's care plan with an initiation date of 4/11/2024 documented The resident is on diuretic therapy., with interventions including Administer DIURETIC medications as ordered by physician., and Monitor/document/report PRN adverse reactions to DIURETIC therapy: dizziness, postural hypotension, fatigue, and an increased risk for falls. During an interview with the MDS Coordinator on 02/26/2026 at 1:26 PM, the MDS Coordinator stated it was important for the MDS to be as accurate as possible, because the assessment was a reflection of what nursing staff was doing for a resident and what nursing services and other services a resident was receiving during that time period. During an interview with the DON on 02/26/2026 at 2:08 PM, the DON stated it was important for the MDS to be accurate to have an accurate picture of what was going on with a resident and for reimbursement purposes. The DON further stated her expectation for staff was to go over the MAR and determine what was going on and to code appropriately. During an interview with the Administrator on 02/27/2026 at 3:12 PM, the Administrator stated it was important for the MDS to be accurate, because the assessment needed to reflect what is going on with a resident. The Administrator further stated her expectation for staff was they needed to gather all information accurately from a resident's chart before submission. 3. Record review of Resident #3's admission Record dated 02/26/26 documented an [AGE] year-old female originally admitted to the facility on [DATE] with the most recent admission on [DATE]. Resident #3's diagnoses included heart failure, unspecified; acute respiratory failure with hypoxia (inadequate oxygenation of the blood), pressure ulcer of unspecified site (injury to skin and underlying tissue caused by prolonged pressure), peripheral vascular disease (a slow, progressive circulation disorder caused by narrowed, blocked, or spasming blood vessels), and dysphagia (a language disorder caused by brain damage - most commonly from a stroke, tumor, or injury – that impairs the ability to produce, understand, read or write language). Record review of Resident #3's Significant Change MDS dated [DATE] indicated that Hospice care was not received. Resident #3's BIMS score was 8 which indicated severe cognitive impairment. Record review of Resident #3's Care Plan with a revision date of 01/30/26 revealed a focus of The resident has a terminal prognosis related to nonrheumatic aortic valve stenosis (narrowing of the aortic valve due to age related calcium buildup that restricts blood flow). One of the interventions included resident choosing hospice provider. Record review of a document titled Facility Notification of Hospice Admission informed the facility that as of 1/30/26, Resident #3 was being admitted to [Contract Name] Hospice. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/26 at 10:00 am, the MDS Coordinator stated that hospice should have been checked on Resident #3's MDS assessment dated [DATE] since that was the reason for the Significant Change Assessment. 4. Record review of the admission Record, dated 2/26/26, reflected Resident #42 was a [AGE] year-old female admitted on [DATE] with diagnoses that included atherosclerotic heart disease of native coronary artery without angina pectoris (a condition in which plaque builds up in the coronary arteries that supply blood to the heart muscle, causing narrowing of the arteries without current chest pain symptoms), neuromuscular dysfunction of bladder (a disorder in which nerve damage or neurological impairment affects the bladder's ability to store or empty urine normally), and anxiety disorder (a mental health condition characterized by excessive worry, nervousness, or fear that can interfere with daily functioning). Record review of Resident #42's quarterly MDS assessment, dated 11/6/25, showed Resident #42's memory was intact for daily decision making. It did not show the resident received hospice services while a resident. Record review of Resident #42's MDS assessment list, dated 2/26/26, revealed the last MDS was completed on 11/6/25 and stated the next quarterly ARD was due 2/6/26, complete by: 2/20/26, and was 6 days overdue. Record review of Resident #42's order summary, dated 2/26/26, revealed an order to admit to hospice on 4/24/25 for diagnosis of combined systolic heart failure. The order start date was 5/29/25 with no end date. During an interview on 2/27/26 at 11:53 a.m. the MDS Coordinator stated she could not say why Resident #42's quarterly MDS was done yet completed. She stated she tried to run a tracker to see whose MDS needs to be completed but it does not always find everyone who is due. The MDS Coordinator stated the MDS was overlooked. The MDS Coordinator stated the assessment assesses the resident's care over the last 90 days to make sure staff has access to information on residents' care needs. The MDS Coordinator stated Resident #42 was admitted on hospice, so it should have been on the admission assessment. The MDS Coordinator stated this was important to include on the MDS because it tells the state she receives hospice services and to ensure they are in the appropriate environment for the care they need. Record review of the facility policy titled Conducting an Accurate Resident Assessment with a copyright date of 2025 noted The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas., and Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 16 residents (Resident #21 and Resident #91) reviewed for infection control: 1. The facility failed to ensure CNA D and CNA E wore a PPE gown during incontinent care for Resident #21 who was on EBP. 2. The facility failed to ensure CNA D did not touch a clean brief with dirty gloves during incontinent care for Resident #21. 3. The facility failed to ensure LVN F cleaned the rubber hub of an insulin pen prior to placing a needle cap on the pen and administering it to Resident #91. 4. The facility failed to ensure LVN F sanitized her hands between glove changes while preparing and administering insulin to Resident #91. These failures could place residents at-risk for infection due to improper care practices.The findings included: 1 & 2. Record review of Resident #21's admission record, dated 2/27/26, revealed Resident #21 was admitted to the facility on [DATE] with diagnoses that included sepsis due to methicillin susceptible Staphylococcus aureus (a life-threatening systemic infection caused by bacteria entering the bloodstream, specifically a strain of Staphylococcus aureus that can be treated with methicillin-class antibiotics), neuromuscular dysfunction of bladder (a condition in which nerve damage or neurological impairment affects the bladder's ability to store or empty urine normally), and pressure ulcer of sacral region unspecified stage (a pressure injury located over the sacrum, the triangular bone at the base of the spine between the hips, caused by prolonged pressure that restricts blood flow to the skin and underlying tissue). Record review of Resident #21's admission MDS assessment dated [DATE] revealed the resident's cognition was severely impaired for daily decision making. Resident #21 was dependent on staff to roll from left to right and for personal hygiene. Record review of Resident #21's care plan, initiated 2/25/26, revised 2/25/26, revealed the resident was on enhanced barrier precautions related to wound and indwelling foley catheter. Interventions included Proper signage to be clearly indicated, PPE including gown and gloves available outside or near room, alcohol based handrub available, trash can inside room near exit for discarding PPE prior to exit of the room. Proper use of PPE to be observed, use of gown and gloves during high contact resident care activities that promote opportunities for transfer of MDROs. Staff to DON and DOFF PPE according to recommendations, which is before any high contact resident care activities like . dressing, bathing/showering, transferring, providing hygiene, changing linens, toileting or assisting with toileting and remove prior to leaving the room. During an observation on 2/27/26 at 10:35 a.m., CNA D and CNA E provided incontinent care to Resident #21. CNA E cleansed the residents peri area and buttocks area. Resident #21 had a stool and CNA E cleaned it off the resident. With the same gloves she had on to clean the residents stool CNA E grabbed a clean brief and placed it on the resident. CNA E stated she already messed up as she grabbed the clean brief and placed it on the resident. CNA E did not change her gloves between cleaning the resident's stool and touching the clean brief. During the incontinent care and catheter care CNA D and CNA E wore gloves only. CNA D and CNA E did not wear a PPE gown. During an interview on 2/27/26 at 10:45 a.m., CNA D and CNA E were asked if they forgot anything. This surveyor pointed to a sign hanging above the head of the bed on the resident's wall stating she was on EBP, gown and gloves were required for high contact care. CNA D and CNA E stated they were missing gowns and needed them because she had wounds and a catheter. CNA E stated she made a mistake, and used her dirty gloves to put the clean brief on Resident #21. CNA D and CNA E stated they needed gowns to prevent infection. CNA E stated she needed to change her gloves to prevent infection. 3&4. Record review of Resident #91's admission record, dated 2/27/26, revealed an [AGE] year-old female resident, admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus. Record review of Resident #91's admission MDS assessment, dated 12/23/25, revealed her BIMS score was a 12 (moderately impaired (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognition for daily decision making). She received insulin. Record review of Resident #91's care plan, initiated 12/19/25, revealed she had diabetes mellitus, and to administer medications as ordered. Record review of Resident #91's physician order summary, dated 2/27/26, revealed an order for insulin lispro, inject per sliding scale with a start date of 12/17/25, and no end date. During an observation on 2/26/26 at 11:23 a.m., LVN F checked Resident #91's blood glucose. LVN F returned to the nursing cart to draw up the insulin. LVN F removed the gloves she wore for the blood glucose check. LVN F then put on another pair of gloves and did not sanitize her hands between the glove change. LVN F then placed a needle cap on the end of the insulin pen and did not clean the rubber stopper before. LVN F then primed the insulin pen and administered it to Resident #91 in her lower abdomen area. During an interview on 2/26/26 at 11:30 a.m., LVN F stated she should have cleaned the insulin pens rubber stopper prior to placing the needle on it because she did not know if something touched it before. LVN F stated she should sanitize her hands between glove changes because you could get stuff on your hands. During an interview on 2/27/26 at 10:51 a.m., the DON stated staff were required to wear a PPE gown while providing incontinent or catheter care to Resident #21 because she had open wounds that needed to be protected. The DON stated staff were also expected to sanitize the rubber stopper of the insulin pen because it needed to be cleaned to prevent infection. The DON stated staff was expected to sanitize or wash their hands between gloves changes or clean hands. Record review of the facility's policy titled Enhanced Barrier Precautions, dated 2024 revealed the policy states, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The policy further states staff are to make gowns and gloves available for staff use and that PPE is required when performing high-contact resident care activities. The policy identifies high-contact resident care activities to include dressing, bathing, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use . urinary catheters, and wound care . requiring a dressing. The policy further states enhanced barrier precautions should be implemented for residents with a wound or indwelling medical device. Record review of the facility's policy titled Hand Hygiene, dated 2023, revealed the policy states, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy further states staff are to perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The use of gloves does not replace hand hygiene . perform hand hygiene prior to donning gloves, and immediately after removing gloves. The policy further indicates hand hygiene should occur between resident contacts,.after handling contaminated objects,.before preparing or handling medications,.before and after applying and removing personal protective equipment (PPE), including gloves. Record review of the facility's policy titled Perineal Care, dated 2022, revealed the policy states, It is the practice of this facility to provide perineal care to all incontinent residents . to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. The policy further states staff are to perform hand hygiene and put on gloves . apply other personal protective equipment as appropriate. The policy additionally states staff are to cleanse buttocks and anus, front to back . using a separate washcloth or wipes, and to change gloves if soiled and continue with perineal care. The policy further states staff are to remove gloves and discard. Perform hand hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident having pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown or pressure ulcers for 1 of 4 resident (Residents #21) reviewed for quality of care. The facility failed to ensure on 2/25/26 LVN A cleansed Resident #21's entire wound bed, did not use wound vac canister tubing that was touching the floor, and sanitized the entire surface area of scissors used to cut wound supplies. These failures could result in the residents with pressure ulcers worsening in size and staging.The findings included: Record review of Resident #21's admission record, dated 2/27/26, revealed Resident #21 was admitted to the facility on [DATE] with diagnoses that included sepsis due to methicillin susceptible Staphylococcus aureus (a life-threatening systemic infection caused by bacteria entering the bloodstream, specifically a strain of Staphylococcus aureus that can be treated with methicillin-class antibiotics), neuromuscular dysfunction of bladder (a condition in which nerve damage or neurological impairment affects the bladder's ability to store or empty urine normally), and pressure ulcer of sacral region unspecified stage (a pressure injury located over the sacrum, the triangular bone at the base of the spine between the hips, caused by prolonged pressure that restricts blood flow to the skin and underlying tissue). Record review of Resident #21's admission MDS assessment dated [DATE] revealed the resident's cognition was severely impaired for daily decision making. Resident #21 was dependent on staff to roll from left to right and for personal hygiene. The resident had pressure wounds including three stage 3 pressure ulcers (a full-thickness loss of skin in which adipose/fat tissue is visible in the wound bed and granulation tissue and epibole may be present; fascia, muscle, tendon, ligament, cartilage, and bone are not exposed) and one stage 4 pressure ulcer (a full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone). Record review of Resident #21's care plan, initiated 2/11/26, revised 2/25/26, revealed a care area for the resident has multiple pressure injuries, allow resident rest periods in between wound dressing changes, resident used wound vac for sacral wound.interventions were to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing weekly, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, and report improvements and declines to the MD. Record review of Resident #21's physician order summary dated 2/25/26 revealed orders for:-Wound Care Location: Sacrum Impairment: Pressure stage 4 every day shift every Mon, Wed, Fri for wound healing. Clean and dry affected area. Apply green foam NPWT dressing (Negative Pressure Wound Therapy, a wound treatment system that applies controlled suction through a sealed dressing connected to a vacuum device to remove drainage, reduce edema, promote blood flow, and support wound healing) to wound bed at -125 mmHg continuous suction (a controlled negative pressure measurement in millimeters of mercury created by a vacuum pump that continuously draws fluid and infectious material from the wound to promote tissue healing). Record review of Resident #21's skin assessment dated [DATE] revealed one wound was a sacrum stage 4 pressure ulcer (a severe pressure injury located over the sacrum, the lower portion of the spine above the buttocks, involving full-thickness skin and tissue loss with exposure of deeper structures such as muscle, tendon, or bone) and measured 10.5 cm x 20 cm x 1 cm. The wound had serosanguineous drainage (a mixture of serous fluid and blood, typically pale red and watery) and the primary dressing was negative pressure wound therapy. Observation on 2/25/26 at 2:56 p.m. revealed LVN A performing wound care to Resident #21's sacral pressure ulcer. At approximately 3:03 PM, LVN A sanitized the tray table, obtained supplies from the treatment cart, and placed wound care supplies on the tray table. LVN A removed the existing foam dressing and tubing from the wound vacuum and discarded the items in the trash. LVN A cleansed portions of the wound bed. However, areas of the wound bed were not (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleansed before the new dressing was applied. LVN A then removed tubing from a bag and replaced the canister on the wound vacuum unit. During the process, the tubing dropped and contacted the floor and remained on the floor while LVN A continued performing wound care. LVN A used scissors to cut wound care supplies and wiped the exterior surfaces of the scissors with a disinfectant wipe but, did not open the scissors to clean the inner blades or cutting surfaces. LVN A then placed foam dressing into the wound bed and covered the wound with adhesive dressing. After completion of the dressing application, LVN A picked up the tubing that had been resting on the floor and connected the tubing to the tubing attached to the resident's wound vacuum device. During an interview on 2/25/26 at 3:30 p.m., LVN A stated she typically cleaned the scissors at the beginning of the treatment, after cutting sponges, and before cutting additional supplies. LVN A stated the scissors should be opened because the blades also need to be cleaned and the scissors used were angled. LVN A stated the physician instructs staff to cleanse the wound from the top portion of the wound bed downward and stated she was cleaning the whole wound bed. LVN A stated she did not know the wound vacuum tubing had been on the floor and reported she was unaware it had touched the floor. LVN A stated that if the tubing had been on the floor, it would be contaminated and although that portion of the tubing does not directly connect to the wound it would still be considered dirty. During an interview on 2/26/26 at 4:09 p.m., the Director of Nursing (DON) stated staff were expected to cleanse the entire wound bed when performing wound care. The DON stated staff were expected to clean scissors used for wound care either before and after the procedure and should clean the entire pair of scissors, including the blades. The DON stated the wound vacuum system was a closed system, and she described it as dirty to dirty,. She reported that the tubing touching the floor would not present a risk to the resident because the tubing did not directly connect to the wound. Record review of the facility's policy titled Negative Pressure Wound Therapy,, dated 2025, revealed the policy states, To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The policy further defined negative pressure wound therapy stating, Negative pressure wound therapy is an active wound care treatment that uses controlled sub-atmospheric (negative) pressure to assist and accelerate wound healing. The therapy may be gauze based, foam based, or ?peel and stick,' and includes an evacuation tube and a computerized pump that applies the negative pressure .Negative pressure wound therapy will be provided in accordance with physician orders, including the desired pressure setting, continuous or intermittent therapy, and frequency of dressing change. Clean technique shall be utilized unless otherwise specified by the physician. The policy additionally stated staff are to Cleanse wound according to physician order .Select foam type or gauze appropriate to the size and characteristics of the wound, and place gently into the wound .Fill the entire wound base and sides, tunnels, and undermined areas. The policy further stated staff are to Apply the tubing to the dressing, Connect tubing assembly to the canister tubing. Make sure canister is fully engaged into the pump .Initiate NPWT at the prescribed settings in accordance with pump/product specifications.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week, for 1 of 1 facility reviewed for nurse services. The facility failed to have RN coverage for 2 days on 9/01/2025 and 12/26/2025. This failure could place residents at risk of not having staff with advanced care skills available to meet their needs.The findings included: Review of the facility's RN timecards from 8/1/2025 through 2/24/2026, revealed there were no RN hours for Monday 9/1/2025 and Friday 12/26/2025 Review of the facility's census dated 9/01/2025 documented a population of 90 residents. Review of the facility census dated 12/26/2025 documented a population of 90 residents. During an interview with the DON on 02/26/26 at 2:08 PM, the DON stated it was important to have sufficient RN staff at the facility to monitor the LVNs and to be present if there was an issue in the building. During an interview with the Administrator on 02/27/2026 at 3:12 PM, the Administrator stated it was important for there to be sufficient RN staff in the facility to give oversight and to provide direction in the event something should happen. The Administrator stated her expectation was that there be an RN in the facility for 8 consecutive hours a day, 7 days a week. Record review of the facility's policy titled Nursing Services and Sufficient Staff with a copyright date of 2025 noted It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. and Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 8 residents (Residents #71) reviewed for administration. The facility failed to document an incident Resident #71 had with Resident #83 in her electronic medical record. This deficient practice could place residents at risk of delayed or improper care due to inaccurate medical records.Record review of Resident #71's admission record, dated 2/25/26, revealed a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia, major depressive disorder, and generalized anxiety disorder. Record review of Resident #71's Quarterly MDS assessment, dated 12/31/25, revealed the resident's BIMS score was 13 (intact cognition). Record review of Resident #71's comprehensive care plan, initiated 10/06/25 and revised 12/16/25, revealed the resident was resistant to care, requesting all medications at once versus taking them throughout the day and then refusing to take them, refusing to take medications at times, refusing to allow a urine analysis to be attained at times, and refusing showers and nail care. Interventions included to allow the resident to make decisions about treatment regime, to provide sense of control, educate and encourage the resident to be compliant with scheduled medications, give clear explanation of all care activities prior to and as they occur during each contact, and provide consistency and care to promote comfort with ADL's, and maintain consistency and timing of ADL, caregivers and routines, as much as possible. Record review of Resident #71's nursing progress notes, revealed no notes about any incidents occurring between 2/21/26-2/22/26. Record review of Resident #71's behavioral health note, dated 2/23/26, revealed a note from the Nurse Practitioner that stated .The patient let me know that she had a blow up this weekend. The patient stated, I'm sure they called you about it. I stated that staff had reported nothing about the patient having a disgruntled episode. This seemed to surprise the patient. The patient described the situation and stated that she called a staff member a racial epithet for African Americans starting with the letter N. I advised the patient that it is very derogatory and harmful as well as toxic to demean her staff members. The patient expressed understanding. The patient stated that she couldn't help it because she was so angry. Record review of Resident #83's progress note labeled Late Entry, dated 02/23/2026 at 10:50 a. m., revealed the resident had a verbal outburst in a public area, and that staff had redirected the resident. The note further documented the nurse practitioner had been notified and medication orders were discussed with the resident's responsible party During an interview on 2/24/26 at 10:08 a.m., Resident #71 said sometime between 2/21/26-2/22/26 Resident #83 hit her with her walker while the two residents were arguing about another male resident. Resident #71 reported RN B intervened, separated the residents, and took her away from the area. Resident #71 stated she did not sustain any bruises or injuries, but she did not like that Resident #83 hit her with the walker. Resident #71 further stated she did not like RN B because RN B called her a liar after she reported that Resident #83 hit her with the walker. During an interview on 2/26/26 at 4:22 p.m., RN B stated he worked Saturday and Sunday at the facility, which were the days he normally works. RN B stated there was an incident involving Resident #71 and Resident #83 and that he was not present for the initial altercation. RN B stated when he arrived, both residents were arguing, and another staff member, LVN C, was attempting to intervene. RN B stated he separated the residents and took Resident #71 to the hallway where she resides. RN B stated Resident #71 was upset and reported she felt Resident #83 had provoked her. RN B stated Resident # 71 never reported to him that Resident #83 hit her. RN B stated while attempting to separate the residents, Resident #71 scratched his hands. RN B stated he notified the Director of Nursing (DON) of the incident. RN B stated because Resident #71 resides on a different hallway than his assigned hallway, he instructed the charge nurse for that hallway, LVN C, to document the (continued on next page)

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	02/27/2026

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident and notify the resident's family. RN B stated he also checked on Resident #83 after the incident, and she only reported Resident #71 yelled at her. RN B did not provide an exact date of the incident he stated it happened over the weekend between 2/21/26-2/22/26. During an interview on 2/27/26 at 12:21 p.m. LVN C stated she was in a resident room at the time the incident began between Resident #71 and Resident #83 and could hear a verbal back-and-forth between the two residents and heard loud yelling and screaming from Resident #71 directed toward Resident #83. LVN C stated she did not observe a physical altercation and only heard the residents yelling. LVN C stated RN B was the staff member who intervened and separated the residents. LVN C stated she assumed RN B documented the incident because he was the staff member present when the incident occurred. LVN C stated RN B did not ask her to document the incident or notify the resident's family or physician. LVN C stated if she had been the staff member who initially responded to the incident, she would have notified the family and physician and documented the incident. LVN C further stated Resident #71 did not report to her that she had been hit. During an attempted interview on 2/27/26 at 12:40 p.m. Resident #83 was not available for an interview. During an interview on 2/27/26 at 1:58 p.m., the Administrator stated if residents had any aggressive behaviors or altercations, staff were expected to complete skin assessments on the residents involved, notify the physician and the resident representative, and the staff involved should document the incident. The Administrator stated Resident #71 did not like Resident #83 because Resident #83 received attention from male residents. The Administrator stated Resident #71 had not previously reported to her that Resident #83 had hit her. However, since the allegation had been reported, the facility would complete skin assessments, notify the resident's psychiatrist and resident representative, and report the allegation to the state. The Administrator further stated staff should have documented incidents in the progress notes so that any allegations made later can be explained when reviewing the resident's medical record. Record review of the facility's policy titled Documentation in Medical Record, dated 2025, revealed the policy states, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The policy further states, Licensed staff and interdisciplinary team members shall document assessments, observations, and services provided in the resident's medical record . Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. The policy also states documentation shall be factual, objective, and resident centered . Documentation shall be accurate, relevant, and complete . containing sufficient details about the resident's care and/or responses to care.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations and interviews the facility failed to provide a safe, functional, sanitary, and comfortable environment for one of one laundry room reviewed for physical environment.The 2 dryers were found to have built up lint on top of the lint screen.This deficient practice could place residents at risk for burns due to a fire hazard. Findings included:During an observation of the laundry room and interview on 02/27/26 at 1:57 pm, the dryers were found to have about 2-3 inches of lint on top of the lint screens. The bottom part of the lint screens appeared to have been swept off with only a small amount of lint staying in the bottom of the dryer. The Housekeeping Supervisor stated that the Maintenance Director usually cleaned the upper part of the lint screen at least once a day since there were wires that might cause issues. The Housekeeping Supervisor stated that the Maintenance Director had been out ill for a few days and the Assistant Maintenance Director had other duties. She stated she did not know if other arrangements were going to be made for cleaning the dryers while the Maintenance Director was out.Record review of the facility's Physical Environment: Electrical Equipment policy dated 2025 stated:The facility will maintain all mechanical, electrical, and patient care equipment in safe operating condition.1. The Maintenance Director shall maintain schedules for routine inspection and maintenance of all mechanical, electrical, and patient care equipment.2. Frequency of inspection and maintenance shall be in accordance with the facility's Electrical Safety policy, current Life Safety code requirement, and manufacturer recommendations.4. Essential equipment shall be cleaned, repaired or replaced as soon as practicable. Examples of essential equipment include, but are not limited to:f. Laundry equipment

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess each resident using the quarterly review instrument specified by the State and approved by CMS in a timely manner for 1 (Resident #42) of 8 residents reviewed for timely assessment, in that: The facility failed to complete Resident #42's quarterly MDS assessment by 2/6/26 This failure could lead to residents not receiving necessary, complete, or correct care due to lack of current information. The findings were: Record review of the admission Record, dated 2/26/26, reflected Resident #42 was a [AGE] year-old female admitted on [DATE] with diagnoses that included atherosclerotic heart disease of native coronary artery without angina pectoris (a condition in which plaque builds up in the coronary arteries that supply blood to the heart muscle, causing narrowing of the arteries without current chest pain symptoms), neuromuscular dysfunction of bladder (a disorder in which nerve damage or neurological impairment affects the bladder's ability to store or empty urine normally), and anxiety disorder (a mental health condition characterized by excessive worry, nervousness, or fear that can interfere with daily functioning). Record review of Resident #42's quarterly MDS assessment, dated 11/6/25, showed Resident #42's memory was intact for daily decision making. Record review of Resident #42's MDS assessment list, dated 2/26/26, revealed the last MDS was completed on 11/6/25 and stated the next quarterly ARD was due 2/6/26, complete by: 2/20/26, and was 6 days overdue. During an interview on 2/27/26 at 11:53 a.m., the MDS Coordinator stated she could not say why Resident #42's quarterly MDS was done yet completed. She stated she tried to run a tracker to see whose MDS needs to be completed but it does not always find everyone who is due. The MDS coordinator stated the MDS was overlooked. The MDS coordinator stated the assessment assesses the resident's care over the last 90 days to make sure staff has access to information on residents' care needs. Record review of the facility's policy titled Conducting an Accurate Resident assessment with a copyright date of 2025 noted The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas., and Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment.