STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676250	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pecan Valley Rehabilitation and Healthcare	3838 E Southcross Blvd San Antonio, TX 78222

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 4 residents (Resident #1) reviewed for accidents and hazards: The facility failed to ensure Resident #1's environment was free of choking hazards when Resident #1 expired on 6/24/2025 as a result of asphyxiation by choking[PH1] [SA2] . An Immediate Jeopardy (IJ) was identified as past non-compliance on 7/07/2025. The Noncompliance began on 6/24/2025 and ended on 6/25/2025. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health and or death. The findings included: Record review of Resident #1's face sheet dated 6/24/2025 revealed a 72- year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and/or anxiety, unspecified pain and primary osteoarthritis left hand. Record review of Resident #1's significant change MDS dated [DATE] revealed a BIMs score could not be determined due to both long-term and short-term memory loss and severely impaired cognitive skills and inattention. The assessment indicated no behaviors exhibited with maximum to total dependance on staff for ADL care. Record review of Resident #1's care plan initialed on 10/21/2021 revealed the resident was full code status with interventions: in the event of cardiac or respiratory arrest, staff will perform cardiopulmonary resuscitation. ADL self-care performance deficit related to dementia, debility and muscle wasting with interventions which included maximal assistance to full dependance on ADL care of one staff person for all ADLs. A potential for pain related to dementia, impaired mobility and stiffness with an intervention of administer medications as ordered by physician. Record review of Resident #1's physician order summary for June 2025 revealed an order with a start date of 10/04/2021 for Lidoderm Patch 5% (Lidocaine) apply to left leg and right shoulder for pain, apply one patch to left leg and one patch to right shoulder, off at HS (bedtime). Record review of Resident #1's June 2025 MAR revealed Lidoderm Patch 5% (Lidocaine) was last documented as administered on the morning of 6/23/2025 by CMA A and last documented as removed by LVN C (time unknown). Record review of Resident #1's Lidoderm Patch 5% time/date CMA Administration Record audit report dated 7/03/2025 revealed: CMA A documented application of Lidoderm Patch 5% to right front shoulder on 6/23/2025 at 11:10 a.m. and LVN C documented handling (unknown handling) of the patch on 6/23/2025 at 7:46 p.m. Record review of Resident #1's nurse progress notes, LVN C documented she made rounds on Resident #1 at 12:57 a.m. and gave the resident acetaminophen. At 2:30 a.m., she documented she was summoned by a CNA, that the resident was not breathing. The residents code status was verified, CPR was initiated, checked the airway and AED was applied. EMS pronounced time of death at 2:49 a.m. and the ME office came to retrieve the body. Record review of form 3613-A Provider Incident Report dated 7/01/2025 revealed a facility self-reported incident that occurred on 6/24/2025 at 2:30 pm resulting in Resident #1's death, signed by the Executive Director. The supporting documents indicated an allegation was confirmed after investigation. The summary stated Resident #1 did not exhibit behaviors of putting foreign items or non-edible foods in her mouth. The report indicated the medical examiner's office verbally informed the facility that Resident #1 expired from accidental asphyxiation choking on 6/24/2025[PH3] . Record review of a witness statement by CMA A dated 6/24/2025, CMA A wrote on 6/23/2025 she administered Resident #1's routine medications and applied two patches to her left leg and to her right shoulder. She wrote Resident #1 appeared to be her normal state of condition. She also wrote she had never witnessed the resident put any object in her mouth. Record review of a written statement by CNA B dated 6/24/2025 revealed he last saw Resident #1 alive and breathing at 1:15 a.m[PH4] [SA5] .(6/24/25). At 2:15 a.m., he noticed the resident was unresponsive, called for a nurse and code and confirmed CPR was initiated and 911 was called. Record review of a written statement by LVN D dated 6/24/2025, LVN D wrote she saw LVN C running up the hallway asking for Resident #1's code status, which was full code. LVN C ran back to the resident room and CPR was initiated. She wrote when she got to the room, Resident #1 was already placed on the floor with a back board and AED in place. She (LVN D) got the ambu bag and connected to the oxygen tank and started breath resuscitation. Upon placing the mask to the resident's face, she noticed a white substance in the resident mouth. She wrote she did a finger sweep of the mouth but was unable to get the white substance out with glove. She wrote EMS arrived and took over. She wrote she assumed the white substance was thrush on her tongue. She wrote she was able to see the chest