STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676478	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Valley Health and Rehabilitation	6211 Old Pearsall Road San Antonio, TX 78242

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on interviews and record reviews the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admissions, at least once every 60 days thereafter for 1 of 5 residents (Resident #1) whose care was reviewed in that: The facility failed to ensure Resident #1 was seen by her physician within 60 days. This deficient practice could affect residents and could lead to a decline in health status or untreated conditions. The findings were: Record review of Resident #1's face sheet, dated 3/29/24, revealed Resident #1 was admitted to the facility on [DATE] with diagnoses of unspecified dementia [a general term for impaired ability to remember, think, or make decisions], unspecified severity, without behavioral disturbance, psychotic disturbance [a disconnection from reality], mood disturbance, and anxiety, dysphagia [difficulty swallowing], unspecified, unsteadiness on feet, generalized anxiety disorder, and muscle weakness (generalized). Further record review of this document revealed Resident #1's physician was Physician C. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 7, signifying severe cognitive impairment. Record review of Resident #1's physician's notes from 9/1/2023 to present, obtained on 4/4/24, revealed Resident #1 was seen by Physician C on 4/2/24. Prior to 4/2/24, Resident #1 was seen by Physician C on 9/29/23, which was 188 days ago. During an interview on 4/4/24 at 10:23 a.m., Resident #1's family member stated at one point Resident #1 had not seen a physician for six months. During an interview on 4/4/24 at 10:48 a.m., Physician C stated Resident #1 was one of his residents. Physician C stated he did not have a nurse practitioner or a mid-level provider who saw his residents on his behalf. Physician C stated he saw Resident #1 recently but he could not recall the exact date of the visit before. Physician C stated when he saw a resident, he would write a note in the resident's electronic health record. (continued on next page)

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

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24 at 11:49 a.m., the DON stated she could not recall the facility's policy on the frequency of physician visits. The DON stated a process to ensure residents are seen by their physicians regularly was currently in progress. When asked what negative effects could occur to the residents if they were not seen by their physician regularly, the DON stated, I guess adverse effects, I don't know. Record review of a facility policy titled, Physician Visits, dated April 2008, revealed the following: The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43889 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles in locked compartments for 1 of 1 medication cart (100 Hall medication cart) reviewed for storage of drugs. Agency LVN A left the 100 Hall medication cart unlocked. This deficient practice could place residents at risk of medication misuse and drug diversion. The findings were: Observation on 4/3/24 at 5:46 a.m. revealed Agency LVN A was at the nurses station. Agency LVN A left the nurses station to answer a call light in 200 Hall. The 100 Hall medication cart was unlocked and unattended. During an interview on 4/3/24 at 5:48 a.m., Agency LVN A stated she was working on the medication cart, then she went to her computer, then she went to check on a resident. Agency LVN A stated the medication cart should have been locked. Agency LVN A stated she was educated on medication security when she first oriented at the facility. During an interview on 4/3/24 at 10:51 a.m., the DON stated she, the ADON, medical records, and the treatment nurse will round every hour to check of medication carts were locked. When asked what negative effects could occur to the residents if medications were not secured correctly, the DON stated, the residents could get into the medications. Record review of a facility policy titled, Storage of Medications, dated April 2007, revealed the following: Compartments (including . carts) containing drugs and biological shall be locked when not in use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: The facility failed to ensure the bottle of eyewash solution was within its expiration date. These deficient practices could place staff at risk for injury. The findings were: Observation and interview on [DATE] at 8:01 a.m. revealed a bottle of eyewash solution above the handwashing sink had an expiration date of ,d+[DATE]. Cook B confirmed the eyewash solution was expired and did not know how frequently the eyewash solution was checked. Record review of a facility policy titled, Storage of Medications, dated [DATE], revealed the following: the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.