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	01/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 5 Residents (Resident #1) reviewed for dignity. Nursing staff failed to greet Resident #1 upon entering her room; failed to engage with Resident #1 while she was attempting to talk with them in Spanish and failed to request the assistance from other staff who could understand Resident #1 so they could determine if she needed assistance. Resident #1 was Spanish speaking only. This deficient practice could affect any Resident who did not speak English and could result in the Residents needs not being met and contribute to feelings of unworthiness. The findings were: Review of Resident #1's face sheet, dated 1/12/25, revealed she was admitted to the facility on [DATE] with diagnosis of unspecified Dementia (according to Mayo Clinic Dementia is a term used to describe a group of symptoms affecting memory, thinking and social abilities.), Dysphagia (according to Mayo Clinic: Dysphagia is a medical term for difficulty swallowing.), unsteadiness on feet, Generalized Anxiety Disorder, Muscle Weakness, unspecified protein-calorie malnutrition and history of falling. Review of Resident #1's quarterly MDS assessment, dated 12/24/24, revealed Resident #1's BIMS score was 7 of 15 reflective of severe cognitive impairment; her preferred language of English/Spanish; she had impairment of one side (lower extremity) and she used a manual wheelchair. Review of Resident #1's Care Plan revised on 8/8/23 read: Resident #1 [Resident name] has a communication problem r/t: Language barrier. Resident #1 [Resident name] is primarily Spanish speaking and family requests to have a Spanish speaking CNA each shift every day. DON informed family that Spanish speaking staff is available if not in respective hall that other staff is available in facility to assist with translating. Some interventions included: Anticipate and meet needs. Discuss with resident/family concerns or feelings regarding communication difficulty. Monitor/document/report to MD PRN changes in: Ability to communicate, Potential contributing factors for communication problems, Potential for improvement. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/10/25 at 5:16 PM with Resident #1's family member D revealed she had videos that showed staff walking into Resident #1's room, unable to communicate with Resident #1 due to the language barrier and some staff ignoring Resident #1 while she was trying to talk with them. She stated this was very upsetting because the ADM and DON assured her that if a Spanish speaking staff was not assigned to the hall then there would be another staff who spoke Spanish to assist with translation. Family member D stated that according to the videos some of the staff did not engage a Spanish speaking staff to assist. Family member D stated it was also upsetting that staff ignored Resident #1 like she was not even a person without trying to determine if she needed help. Review of video #1 dated 12/9/24 (no time) revealed CNA C entering Resident #1's room with a meal tray and she placed it on the bedside table. She did not introduce herself or explain the purpose of her visit. Resident #1 was talking to CNA C in Spanish and CNA C shrugged her shoulders while walking to the other side of the room behind the privacy curtain. CNA C commented I need to learn Spanish, I don't know Spanish from the other side of the privacy curtain and then she re-appeared on Resident #1's side of the room. Resident #1 commented, no. CNA C shook her head and walked out of the room. CNA C did not state she was going to get another staff member to help with translation. Review of video #2 dated 12/13/24 (no time) revealed CNA C coming into Resident #1's room with a meal tray on top of a bedside table. She did not greet Resident #1; did not introduce herself or explain the purpose of her visit. Resident #1 was talking to CNA C in Spanish (most of the conversation could not be made out). Resident #1 stated in Spanish this was the food that was brought to me earlier. I can't eat this; the rest of it was not understandable. At the end of the conversation Resident #1 asked CNA C in Spanish if CNA C could bring her something else. CNA C did not re-appear in front of the camera and was heard talking in the background but could not understand what she said. Further review revealed CNA A did not tell Resident #1 that she would get another staff to help translate while she was in Resident #1's vicinity. Review of video #3 dated 12/13/24 (no time) revealed CNA B entering Resident #1's room. She did not introduce herself or explain the purpose of her visit. Resident #1 was talking to CNA B in Spanish and asked about her cell phone. CNA B commented, huh, no hablo [NAME], (I don't speak Spanish) twice. Resident #1 asked CNA B in Spanish to send someone who spoke Spanish and commented, I want them to understand me. CNA B said something like (maybe I'll try to see if I can get [name of another staff] while looking and walking to the other side of the room behind the privacy curtain. CNA B did not direct her attention at Resident #1 and Resident #1 asked her twice, what, what. CNA B came around the privacy curtain and then Resident #1 asked CNA B in Spanish to send the lady or girl who spoke Spanish. Review of video dated #4, dated 12/25/24, no time, revealed CNA B standing at the foot of the bed while Resident #1 was talking to her in Spanish. CNA B did not responding or engage with Resident #1. Another staff member approached the doorway and CNA B met the other staff at the doorway and then exited the room all the while Resident #1 was trying to talk in Spanish with CNA B. Observation and interview on 1/11/25 at 4:15 PM with Resident #1 and family member E revealed family member E and Resident #1 engaged in conversation in Spanish. Resident #1 presented as being anxious and confused. Family member E reiterated concerns that family member D expressed on 1/10/25. She stated some staff did not speak Spanish and not able to understand Resident #1. Staff would not get another staff to help with translation and would ignore Resident #1. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 1/11/25 at 5:05 PM with Resident #1 revealed she was sitting in the common area with CNA A. She engaged in conversation, spoke plainly and in Spanish and stated she was good, making the best of living in this place with no concerns reported. Surveyor was Spanish speaking and able to converse with Resident #1. Surveyor asked how staff communicated with her. She stated not all staff spoke Spanish and she could not talk to them. Surveyor asked other questions about her care and Resident #1 did not respond. She presented as alert with confusion. Interview on 1/11/25 at 5:10 PM with CNA A revealed he spoke some Spanish and did the best he could to communicate with Resident #1. He stated he had a good rapport with Resident #1 and took the time to listen and understand what she was telling him. Interview on 11/11/25 at 5:20 PM with Family Member D revealed she provided verbal permission to share Videos with the ADM and the DON and not any other staff. Interview on 1/11/25 at 5:30 PM with the ADM and the DON revealed upon reviewing Videos #1 through #4, the DON identified CNA B and CNA C in the videos. The DON stated that protocol required any staff who walked into Resident #1's room to greet Resident #1, while introducing themselves and explaining the purpose of their visit even if they did not speak Spanish. The DON stated staff should acknowledge any resident while the resident was talking to them which was common courtesy. She stated the non-Spanish speaking staff should find another Spanish speaking staff to help with translation. Although, she stated there was not always Spanish speaking staff on the night shift. The DON stated that CNA B and CNA C did not follow protocol when entering Resident #1's room and did not engage with her failing to treat Resident #1 with dignity. The ADM agreed with the DON and stated it looked like staff needed sensitivity training. Review of facility policy, Residents' Rights Nursing Facilities, undated, read in relevant part You have the right to be treated with dignity, courtesy, consideration and respect.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition for 1 of 5 Residents (Resident #1) who needed assistance with meals. Nursing staff failed to set up Resident #1's meal tray to include raising the head of the bed, opening up condiments, ensuring the meat was cut when served and ensuring the bedside table was close to Resident #1 and in a position where she could reach the food on the meal tray. This deficient practice could affect any Resident who required set-up assistance during meals and could result in the resident having difficulties reaching the food and it could discourage the resident to eat their meal. The findings were: Review of Resident #1's face sheet, dated 1/12/25, revealed she was admitted to the facility on [DATE] with diagnosis of unspecified Dementia (according to Mayo Clinic Dementia is a term used to describe a group of symptoms affecting memory, thinking and social abilities.), Dysphagia (according to Mayo Clinic: Dysphagia is a medical term for difficulty swallowing.), unsteadiness on feet, Generalized Anxiety Disorder, Muscle Weakness, unspecified protein-calorie malnutrition and history of falling. Review of Resident #1's quarterly MDS assessment, dated 12/24/24, revealed Resident #1 revealed her BIMS score was 7 of 15 reflective of severe cognitive impairment and was independent when eating her meals. Review of Resident #1's Care Plan revised on 3/22/22 read: Resident #1 [Resident name] has an ADL Self Care Performance Deficit r/t cognition impairment, weakness & debility. Intervention included requires staff assist X1 to eat per family request. Observation on 1/10/25 at 12 PM revealed Resident #1 was lying in bed with the head of bed up at about 30 degrees. There was a call light wrapped around the left 1/4 siderail. There were two siderails up on each side of Resident #1's bed. Resident #1 did not wake to her name. Further observation revealed a bedside table positioned at an angle by the bed and in front of the nightstand on the right side while looking at Resident #1. The bedside table was at about the level of Resident 1's knees. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/10/25 at 5:16 PM with Resident #1's family member D revealed she had videos that showed staff walking into Resident #1's room delivering meal trays but not helping Resident #1 with her meals. Family member D stated Resident #1 was able to feed herself but she needed staff to cut her meat. She also mentioned staff would leave the trays on the bedside table away from Resident #1. Resident #1 was not able to easily reach the food making it awkward when she ate. In addition, staff did not raise the head of the bed which resulted in Resident #1 sitting up in bed suspended without back support, reaching across the bed to her left side to reach the food on the meal tray. Family member D stated that sometimes Resident #1 would put the plate of food on her laps and often times she would get food on the front of her shirt. Staff would not change her shirt. Family member D stated she did not expect staff to provide Resident #1 with one to one supervision. However, she expected staff to raise the head of the bed, to sit Resident #1 up in bed, and place the bedside table close to her where she could reach the food easily so she would be comfortable during meals. Review of video #1 dated 12/9/24 (no time) revealed CNA C entering Resident #1's room with a meal tray. She placed it on the bedside table in front of the nightstand and at an angle on the edge of the right side of the bed when looking at Resident #1. CNA C did not remove the cover of the plate, did not ask Resident #1 if she needed help opening condiments, or set up the utensils. Further observation revealed CNA C did not ask Resident #1 if everything was ok or if she needed help with anything. Resident #1 was talking to CNA C in Spanish and CNA C shrugged her shoulders while walking to the other side of the room behind the privacy curtain. CNA C commented I need to learn Spanish, I don't know Spanish from the other side of the privacy curtain and then she re-appeared on Resident #1's side of the room. Resident #1 commented, no. CNA C shook her head and walked out of the room. Review of video #2 dated 12/13/24 (no time) revealed CNA C coming into Resident #1's room with a meal tray on top of a bedside table. She did not greet Resident #1; did not introduce herself or explain the purpose of her visit. CNA C placed the bedside table with the meal tray in front of the nightstand, at an angle on the edge of the right side of the bed when looking at Resident #1. CNA C did not remove the cover of the plate, did not ask Resident #1 if she needed help opening condiments, or set up the utensils. Further observation revealed CNA C did not ask Resident #1 if everything was ok or if she needed help with anything. Resident #1 was talking to CNA C in Spanish (most of the conversation could not be made out). Resident #1 stated during her conversation, this was the food that was brought to me earlier. I can't eat this; the following comments were not understandable. At the end of the conversation Resident #1 asked CNA C if CNA C could bring her something else as CNA C was walking away. CNA C did not re-appear in front of the camera and was heard talking in the background and the door closing. Her comments were not understandable. Review of video #5 dated 12/20/24 (no time) revealed the AD was in Resident #1's room by the bedside table. There was a meal tray on top of the bedside table which was located in front of the nightstand at the edge of the side of the rights side of the bed when looking at Resident #1. The AD had poured sugar into Resident #1's coffee. She was speaking with Resident #1 in Spanish, was very respectful during the conversation. However, she did not lift the head of the bed. Resident #1 was observed propping herself up on her left arm as she stirred the cup of coffee. Further observation revealed the plate of food was still covered and the orange juice was covered with a plastic lid. There was also a unopened carton but could not make out the content. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 1/11/25 at 4:15 PM with Resident #1 and family member E revealed family member E and Resident #1 engaged in conversation in Spanish. Resident #1 presented as being anxious and confused. Family member E reiterated concerns that family member D expressed on 1/10/25. She stated some staff did not speak Spanish and not able to understand Resident #1. Staff would not get another staff to help with translation and would ignore Resident #1. Observation and interview on 1/11/25 at 5:05 PM with Resident #1 revealed she was sitting in the common area with CNA A. She engaged in conversation, spoke plainly and in Spanish and stated she was good, making the best of living in this place with no concerns reported. Surveyor was Spanish speaking and able to converse with Resident #1. Surveyor asked how staff communicated with her. She stated not all staff spoke Spanish and she could not talk to them. Surveyor asked other questions about her care and Resident #1 did not respond. She presented as alert with confusion. Interview on 1/11/25 at 5:10 PM with CNA A revealed he spoke some Spanish and did the best he could to communicate with Resident #1. He stated he had a good rapport with Resident #1 and took the time to listen and understand what she was telling him. CNA A stated Resident #1 usually ate her meals in her room. He stated she could feed herself but needed help with cutting the meat, opening up milk cartons, opening up condiments, setting up her tray. Interview on 1/11/25 at 5:30 PM with the ADM and the DON revealed, upon reviewing videos #1 #2 and video #5, the DON identified CNA C and the AD in the videos. The DON and ADM stated Resident #1's family members had not expressed any recent concerns. They stated in the past they had expressed concerns about there not always being Spanish speaking staff and that it was difficult for Resident #1 to communicate with staff. The DON and ADM stated if there was not a Spanish speaking staff assigned to Resident #1's hall there was always someone in the facility who was Spanish speaking who could help with translation. The DON stated that Resident #1 was able to eat on her own. However, staff should be setting up her tray which included removing the lid from the plate, opening condiments as needed, setting up utensils, removing lids from the drinks and opening up other food items provided in a carton. The DON stated staff should raise the head of the bed and position the bedside table over the bed and close to Resident #1 where she could access the food easily. The DON stated CNA C and the AD did not follow protocol which resulted in Resident #1 propping herself up in bed and not having easy access to the meal tray and food. The ADM stated he agreed with the DON. Review of a facility policy, Assistance with Meals, revised on 3/27/2013, read in relevant part Residents shall receive assistance with meals in a manner that meets the individuals needs of each resident.

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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** 27520 Based on observations, interviews and record reviews the facility failed to each resident received assistance devices to prevent accidents for 2 of 2 Residents (Resident #2 and Resident #3) who were observed during mechanical lift transfers. 1. CNA F failed to lock the mechanical lift while raising and lowering Resident #2 during a transfer. He failed to widened the base of the mechanical lift which resulted in the wheelchair getting stuck between the legs while lifting Resident #2. CNA F failed to widened the base when transferring Resident #2 from the wheelchair to the bed while suspended in the air and when lowering Resident #2 onto the bed. 2. CNA I failed to lock the base of the mechanical lift while raising and lowering Resident #3 during a transfer. CNA H reached behind CNA I and locked the base of the mechanical lift with her left foot while CNA I was lowering Resident #3 into the bed. These deficient practices could affect any resident who was transferred via mechanical lift and could result in avoidable accidents and possible injuries. The findings were: 1. Review of Resident #2's face sheet, dated 1/12/25, revealed she was admitted to the facility on [DATE] with a diagnosis of unspecified Dementia (according to Mayo Clinic Dementia is a term used to describe a group of symptoms affecting memory, thinking and social abilities.), difficulty walking and muscle weakness. Review of Resident #2's MDS assessment, dated 10/28/24, revealed her BIMS score was 13 indicative of mild cognitive impairment and she required substantial/maximal assistance for transfers. Review of Resident #2's Care Plan, revised 2/15/24, revealed Resident #2 has an ADL Self Care Performance Deficit r/t dementia, weakness and debility. The intervention for transfers read: TRANSFER: requires (X)2 staff participation with hoyer lift for transfers. Observation on 1/8/25 at 3:45 PM revealed CNA F and CNA G transferring Resident #2 from the wheelchair to the bed using a mechanical lift. CNA F did not lock the mechanical lift or widen the base when raising Resident #2 up from the wheelchair. The wheelchair was stuck in the base. Resident #2 and the wheelchair started to go up in the air together until CNA G pushed down on the wheelchair preventing the wheelchair to be lifted off the floor. CNA F transferred Resident #2 over to the bed and then lowered her into the bed. CNA F never locked the base or widened the base of the mechanical lift during the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/8/25 at 4 PM with CNA F and CNA G revealed CNA F stated he thought he widened the base on the mechanical lift but did not remember locking the lift. CNA F stated the wheelchair got stuck on the base of the mechanical lift and then commented, I guess I didn't widen the base. CNA G stated she did not see CNA F lock or widen the base on the mechanical lift; however, stated she was not looking. CNA F and CNA G stated they should always lock and widen the base of the mechanical lift so that it did not tilt over and so the resident did not fall during the transfer. CNA F and CNA G both stated Resident #2 could get injured had she fallen. 2. Review of Resident #3's face sheet, dated 1/12/25, revealed she was admitted to the facility on [DATE] with a diagnosis of difficulty walking, need for assistance with personal care and muscle weakness. Review of Resident #3's MDS assessment, dated 12/21/24, revealed her BIMS score was 0 indicative of severe cognitive impairment and she required partial to moderate assistance for transfers. Review of Resident #3's Care Plan, revised 2/5/24, revealed Resident #2 has an ADL Self Care Performance deficit r/t weakness and debility. An intervention for transfers read: TRANSFER: requires (X)1 staff participation with transfers. Observation and interview on 1/10/25 at 1:45 PM revealed CNA H, CNA I and CNA J transferring Resident #3 from the wheelchair to the bed using a mechanical lift. CNA J applied the brakes on the wheelchair. CNA H guided Resident #3 while on the sling and suspended in the air. CNA I operated the mechanical lift. She did not apply the brakes on the mechanical lift while lifting or lowering Resident #3 during the transfer. While CNA I was lowering Resident #3 onto the bed CNA H noted the brakes on the lift had not been applied. CNA H reached around CNA I with her foot and applied the right brake. Interview with CNA I revealed she did not apply the brakes on the mechanical lift while transferring Resident #3. She stated she should always apply the brakes before raising the Resident into the air and lowering the Resident onto the bed. She stated this would ensure stability preventing the mechanical lift from moving during the transfer and to prevent the Resident from falling. CNA H, CNA I and CNA J all stated Resident #3 could have been injured if she fell . Interview on 1/12/25 at 1:06 PM with the DON revealed nursing staff should lock the base of the mechanical lift before lifting, lowering a resident and while transferring a resident to prevent the mechanical lift from moving. Furthermore, nursing staff should widen the base during the transfer for stability so the mechanical lift did not tilt and the resident did not fall. The DON stated it was important to use the safety technique to prevent falls and possible injuries. The DON stated that Resident #2 and Resident #3 were both transferred by two staff using a mechanical lift. She also stated staff should never lock the base of the mechanical lift while in use by another staff because it could cause it to tilt; it could result in a fall and the resident could get injured. Review of a the manufacturer operating instructions provided by the DON on 1/12/25 read in relevant part Lift Preparation and Procedure: Warning: During lifting and lowering, whenever possible, always keep the base legs of the lift in the widest position. Warning: Before transfer, ensure wheelchair wheel locks are in locked position. Warning: Do not lock or block the patient lift casters when lifting. The casters must be free to roll so that the patient lift can stabilize as the patient is lifted or lowered.