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	09/12/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 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 had the right to be free from abuse, neglect, misappropriation of resident property and exploitation for 1 of 11 residents (Resident #1) reviewed for resident abuse. The facility failed to ensure Resident #1 was free from physical abuse as evidence by on 08/05/2025, in the resident's room CNA A pushed Resident #1 onto the bed forcefully and held Resident #1 by pressing on the resident's chest when Resident #1 tried to get up. The noncompliance was identified as a PNC. The IJ began on 08/05/2025 and ended on 08/08/2025. The facility had corrected the noncompliance before the investigation began. This failure could place residents at risk of serious injury, physical harm, serious impairment or death.The findings included: Record review of Resident #1's face sheet, dated 09/11/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included hepatic encephalopathy (the loss of brain function when a damaged liver does not remove toxins from the blood), dementia (loss of memory and thinking ability), anxiety disorder (a mental health disorder characterized by feelings of worry), and delusional disorder (A delusion is an unshakable belief in something that's untrue. The belief isn't a part of the person's culture or subculture, and almost everyone else knows this belief to be false). Resident #1 was discharged to another nursing home on [DATE] because of the resident's wandering behaviors. Record review of Resident #1's admission MDS assessment, dated 07/05/2025, revealed the resident's BIMS was 8 out of 15, which indicated the resident had moderate cognitive impairment, had verbal behavioral symptoms directed toward others, such as threatening others, screaming at others, and/or cursing at others, and required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand, chair to bed, and toilet transfer. Record review of Resident #1's comprehensive care plan, dated 07/19/2025, revealed [Resident #1] resistive to care related to refuses medication, refuses care, refuses showers, becomes easily agitated and refused to be redirected. For intervention - 1:1 supervision, educate resident/family/caregivers of the possible outcomes of not complying with treatment or care, encourages as much participation/interaction by the resident as possible during are activities, give clear explanation of all care activities prior to an as they occur during each contact, and if resident resists with activities of daily livings, re-assure resident, leave and return 5 to 10 minutes later and try again. Record review of the facility's Provider Investigation Report, dated 08/08/2025, revealed On 08/05/2025, [Resident #1] was being transferred to bed by [CNA-A] used abrupt force to place resident in bed. Further record review of the Provider Investigation Report revealed the facility suspended CNA-A immediately, and the facility nurse assessed Resident #1 on 08/05/2025 at 6:15 p.m., and no injury was noted, and the facility immediately reported to Texas Health and Human Services the incident, contacted the local police and received a case number, physician and family were notified, staff educated on reporting abuse and neglect and resident rights and providing compassionate care to residents. Staff members and residents were interviewed. Record review of Resident #1's nurses notes, dated 08/05/2025, revealed At approximately 3:25 p.m., resident was observed by nurse ambulating in the hallway without wearing pants, and their brief was nearly falling down. Resident then entered another resident's room and stated, 'I want to use the bathroom.' Resident was redirected appropriately. Staff attempted to explain and encourage the resident to return to their own room. During redirection, resident displayed aggressive behavior and attempted to physically strike the CNAs. Resident was safely guided back to their room by staff. Nurse attempted to administer Ativan as needed order for agitation; however, resident refused multiple times. CNAs assisted resident with hygiene, changing clothing, and ensuring resident's dignity and comfort were maintained. Will continue to monitor behavior closely and ensure safety of resident and others. Resident's family member was aware. Further record review of the resident's nurse note dated 08/05/2025 at 6:30 p.m. revealed The administrator along with the nurse manager notified this resident's family reported resident was being mishandled by a CNA. This nurse completed head to toe assessment. This nurse assessed pain level and asking the resident 'Do you have any pain?' Resident denies any pain. Nurse observed that resident has no verbal/nonverbal indicated of pain. Resident family stay at the bed side while the nurse did head to toe assessment for resident. [CNA-A] removed from patient care. Medical doctor was notified. The resident denies pain at times and continues one on one due to wandering. Record review of Resident #1's incident report, dated 08/05/2025, revealed on 08/05/2025, [Resident #1] was being transferred to bed by [CNA-A]