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	08/30/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review, the facility failed to ensure the residents' right to formulate an advance directive for 1 of 8 residents (Resident #192) reviewed for advanced directives, in that: The facility failed to ensure Resident #192's desire to formulate an advanced directive was properly documented in his electronic medical record. This failure could place residents at-risk of having their end of life wishes dishonored, and of having CPR performed against their wishes. The findings included: Record review of Resident of #192's face sheet, dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included lack of coordination, type 2 diabetes mellitus (chronic health condition that affects how body turns food into energy), hypertension (high blood pressure), atrial fibrillation (Atrial fibrillation (AFib) is an irregular and often very rapid heart rhythm.), and chronic kidney disease stage 4 severe (the last stage before kidney failure). Record review of Resident #192's admission BIMS assessment, dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #192's baseline care plan, dated [DATE] revealed the resident was a full code and his cognition was intact. Record review of Resident #192's comprehensive care plan, initiated on [DATE] did not contain any advanced directive information. Record review of Resident #192's Order Summary Report, dated [DATE] revealed a full code order, with a start date of [DATE], and no end date. (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: 676478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #192's admission packet, dated [DATE], contained a section titled Advanced Directive Acknowledgement the form had the section selected for I choose to formulate and issue the following advanced directives. Do Not Resuscitate . was selected and Feeding restrictions ., was selected. The document contained a signature on the legal representative line and the facility representative line. The document was signed on [DATE]. During an interview on [DATE] at 11:50 a.m. the SW stated if a resident requested a DNR they facility would provide the information and ensure the necessary paperwork was filled out within a 48 hour period because of the importance of the paperwork. The SW stated no residents were pending paperwork for advance directives and Resident #192 was a full code as far as he knew. This surveyor inquired about the advance directive form in Resident #192's admission packet. The SW stated he was not made aware the resident wished to put advance directives in place. The SW stated the director of marketing filled out the paperwork with the resident and his family and must have forgotten to notify him. The SW stated if advanced directives were not put in place the resident would have a full code resuscitation. The SW stated he would meet with the resident and his family to see if he wanted to be a DNR. The Marketing Director was not avaliable for interview. During an interview on [DATE] at 12:02 p.m. Resident #192's RP stated they did fill out the paper work and selected the advance directives for the resident. The RP stated they wished to honor whatever Resident #192 wanted. During an interview on [DATE] at 12:08 p.m. Resident #192 stated he had certain circumstances that he did and did not want life saving measures but did not want a feeding tube or to be intubated. On [DATE] at 12:40 p.m. the SW provided an updated document titled Advanced Directive Acknowledgement, dated [DATE], signed by Resident #192, the provider, and the RP. It stated the resident did not want to be hospitalized , did not want artificial means of feeding, and did not want other treatment such as respiratory intubation (uses a laryngoscope to guide an endotracheal tube (ETT) into the mouth or nose, voicebox, then trachea. The tube keeps the airway open so air can get to the lungs.). Record review of the facility document titled Frequently Asked Questions about Advanced Care Planning, no date stated What is Advance Care Planning? Advance care planning means planning ahead for how you want to be treated if you are very ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die they are not able to talk or to let others know how they feel. Texas law allows you to tell you doctor how you want to be treated by using an advance directive. Chapter 166 of the Texas Health and Safety code is the state law on advance care planning through advance directives. Chapter 166 explains advance directives, includes forms to use for advance directives and states how medical decisions can be made when a person does not have an advance directive. Advance Care planning is a 5-step process. o Thinking about what you would want to happen if you could not talk or communicate with anyone o Finding out about what kind of choices you will need to make if you become very ill at home, in a nursing home, or hospital o Talking with your family and doctor about how you want to be treated o Filling out papers that spell out what you want if you are in an accident or become sick (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Telling people what you have decided.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 8 Residents (Resident #42) whose MDS records were reviewed for accuracy. 1. The facility failed to ensure Resident #42's Annual MDS assessment dated [DATE] was updated when the resident's insulin was discontinued on 12/15/2023. This failure could place residents at risk of improper or incorrect care or services necessary for their physical, mental, and psychosocial well-being due to inaccurate assessments. The findings included: 1. Record review of Resident #42's face sheet dated 08/28/24, revealed Resident #42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (change in how your brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness), Type 2 diabetes mellitus with diabetic neuropathy (chronic health condition that affects how body turns food into energy) and gastrostomy status (surgical opening into the stomach for nutritional support). Record review of Resident #42's Annual MDS assessment dated [DATE], Section N showed the resident received insulin injects the past 7 days and the resident was taking hypoglycemic including insulin. Record review of Resident #42's physician orders, dated 8/28/24, revealed no active orders for insulin. The last insulin order was discontinued on 12/15/2023. During an interview on 08/30/24 at 1:48 pm with MDS Coordinator LVN D, stated she would verify what active orders resident had and update the MDSs. LVN D stated Resident #42 did not have any current orders for insulin, and it should not be on the MDS. LVN D stated the MDS should give an accurate depiction of the medications and care the resident receives. Record review of the facility's policy titled Resident Assessment Instrument (MDS 3.0), dated 03/01/2022, stated .A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission . 2. The Interdisciplinary Assessment Team must use the MDS 3.0 form currently mandated by Federal and State regulations to conduct the resident assessment. Other assessment forms may be used in addition to the MDS 3.0 form . 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning and to meet their unique care needs .

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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. 45857 Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible for 1 of 8 Residents (Resident #86) and 2 of 4 storage closets (Hall 100 and Hall 200) reviewed for accident hazards in that: 1. The facility failed to remove a potential hazard for Resident # 86's room. 2. The facility failed to ensure the storage clostes on Halls 100 and 200, which contained potential hazard items, were locked. This deficient practice could place residents at risk of remaining in an environment that was not free of accident hazards. The finding included: 1. During an observation and interview on 8/28/24 at 10:17 a.m. in Resident #86's room by his bedside was a basin with a disposable razor in it. Resident #86 was laying in bed. He stated staff would bring supplies for a bed bath and assist him with shaving. Resident #86 stated he did not noticed the razor next to his bed and was unsure how long it had been there. 2. During an observation on 8/28/24 at 4:08 p.m. a closet on hallway 200 and a closet on hallway 100 named clean linen closet were not locked and had no locking mechanism. The closets contained linen and a storage rack with perineal skin cleanser, lotion, zinc oxide skin protectant, shave gel, mouthwash, fluoride toothpaste, hand sanitizer, germicidal wipes, and disposable razors. All the items stated keep out of reach of children. During an interview on 8/28/24 at 4:10 p.m. the supply coordinator CNA F stated the clean linen storage closets did not have locks on the doors so the CNA could get supplies but if a resident got into the closet they could ingest products that would be harmful to them. During an Interview on 8/30/24 at 12:54 p.m. the DON stated they had requested for locks to be put on the clean linen storage closets but the had placed them on the soiled linen closets instead. The DON stated residents were at risk if they ingested the products. The DON stated they try to promote residents' independence if they are able to shave on their own and staff should dispose of any razors when they are done shaving. The DON stated it is a risk to residents who wandered in the facility. The DON stated Resident #41 and Resident #55 resided on hallway 200 and did wander in the facility. No policy for potentially hazard items storage was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews, and record reviews, the facility failed to store all drugs and biologicals under proper temperature controls, for 1 of 4 medication carts (100 hall cart) reviewed for storage. 1. The facility failed to ensure medications that required refrigeration were not stored on the 100 hall medication cart. This failure could place residents at risk for not receiving therapeutic effects of their medications. The findings included: 1. Observation on [DATE] at 4:13 p.m. revealed the 100-hallway nursing cart contained 9 separate glucometers stored in individual boxes. The boxes contained a log, to check if the meter was functioning properly with test control solutions, and serial numbers written on them to identify the meter that was tested . The logs had dates for testing of [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Four of the glucometers did not match the serial number documented on the log they were stored with. An insulin lispro pen with an open date of [DATE] was being used for a resident, a bottle of spray deodorant with an expiration date of ,d+[DATE] was on the cart, and 3 bottles of lorazepam with refrigerate stickers. Interview on [DATE] at 3:44 p.m. LVN E stated night shift would check the glucometers and did not notice that some of the meters were mixed up and did not match the logs they were stored with. LVN E stated there was confusion on if the meters needed to be check daily or weekly, but she was used to checking them daily. LVN E stated she was unsure if the medications that had labels to refrigerate needed to be refrigerated. LVN E stated insulin is good for 30 days and did not think any of the insulin was past the 30-day open date. 2. During an observation on [DATE] between 3:08 p.m. and 3:50 p.m. hallway ,d+[DATE] medication storage room, hallway ,d+[DATE] medication storage room, and central supply room contained gauze with an expiration date of ,d+[DATE], peristoma cleanser and adhesive remover with an expiration date of [DATE], small bore y type extension set with an expiration date of [DATE], gauze bandage with zinc oxide with an expiration date of ,d+[DATE], 20 gauge IV catheter with an expiration date of [DATE], 22 gauge IV catheter with an expiration date of [DATE], 22 gauge IV catheter with an expiration date of [DATE], bottles of peroxide with an expiration date of ,d+[DATE], and oral care kit with an expiration date of ,d+[DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:54 p.m. the DON stated most of the expired supplies they did not use and just needed to be discarded. The DON stated the meters get check weekly so there is no risk to the resident because they are only mixed up in the boxes. The DON stated they followed the manufactures guidelines for glucometer checks which is weekly or when they open a new bottle of strips. The DON stated the purpose of staff testing the meters with the control solutions weekly was to make sure the patient blood glucose readings were correct. The DON stated they had a book which showed how long insulins were good for after opening because all insulin expirations dates were different. The DON stated if the insulin had been opened for longer than the use by date then it was probably not good any longer but she could not say if there would be an adverse effect for the resident. The DON stated the bottles of lorazepam should be stored in the fridge and could not be therapeutically effective if stored on the medication cart. The DON stated no staff had ever notified her they were confused on how to store refrigerated medications. Record review of the facility's policy, dated ,d+[DATE], stated Policy Statement The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received . 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications . 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 6.45% based on 2 out of 31 opportunities, which involved 1 of 5 Residents (Residents #36) reviewed for medication administration, in that: The facility failed to ensure LVN H administered Resident #36's insulin lispro (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) and insulin glargine (a long-acting insulin pen that lowers blood sugar levels in adults with diabetes) correctly. These failures could place residents at risk for not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions. The findings included: 1. Record review of Resident #36's face sheet, dated 8/30/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included senile degeneration of the brain (mental deterioration associated with old age) and type 2 diabetes mellitus (a chronic condition that affects the way your body processes blood sugar). Record review of Resident #36's order summary report, dated 8/30/24 revealed the following: -insulin lispro inject solution 100 unit/ml, inject as per sliding scale, subcutaneously before meals and at bedtime, with an order date of 4/5/24 and no end date. - insulin glargine inject solution 20 units subcutaneously one time a Day, with an order date of 8/21/24 and no end date. During an observation on 8/29/24 at 8:27 a.m. LVN H planned to inject 20 units of insulin glargine and 3 units of insulin lispro per the sliding scale to Resident #36. LVN H cleaned the rubber stopper of both pens with an alcohol swab. LVN H then placed the needles onto the pens. LVN H then turned the insulin glargine to 20 units and the insulin lispro to 3 units. LVN H did not prime the insulin pens. LVN H then administered the two insulins to Resident #36. During an interview on 8/29/24 at 8:40 a.m. LVN H said you should clean the insulin pens with alcohol, put the needle caps on, then turn the dial to 1 unit to prime the insulin pen to make sure the accurate amount of insulin is given. During an interview on 8/30/24 at 1:28 p.m. the DON stated staff should prime the insulin pen prior to each insulin administration to ensure accurate administration of insulin. The facility provided a policy for insulin administration via syringe only and not for insulin pen administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of manufacturer instructions for (insulin lispro) Instructions for Use, dated 8/2023, stated . Priming your Pen Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle and repeat priming steps 6 to 8. Small air bubbles are normal and will not affect your dose.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview, and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 4 residents (Resident #30) reviewed for hospice services, in that: The facility failed to ensure Resident #30's most recent Physician Certification of Terminal Illness and Hospice election form were completed and part of the hospice documents. The most recent plan of care, list of hospice personnel involved in the care, and hospice physician orders were not available at the facility. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. The findings were: Record review of Resident #30's face sheet, dated 8/30/24, revealed the resident was admitted to the facility on [DATE] with diagnoses including: cerebral atherosclerosis (a disease that causes plaque buildup in the brain arteries and can lead to stroke or aneurysm) and chronic kidney disease stage 2 (In Stage 2 CKD, the damage to your kidneys is still mild, and you have an eGFR between 60 and 89. Your kidneys are still working well, but at this stage, you will have signs of kidney damage. A common sign of kidney damage is protein in your urine (i.e., your pee).) Record review of Resident #30's quarterly MDS assessment, dated 08/15/2023, revealed a BIMS score of 10 which indicated moderate cognitive impairment. Section O of the MDS indicated the resident received hospice care. Record review of Resident #30's care plan, revised 6/19/24, revealed Resident #30 had a terminal prognosis related to cerebral atherosclerosis and was on hospice with interventions to consult with physician and social services to have hospice care for resident in the facility. Record review of Resident #30's order summary, dated 8/30/24, revealed: - [hospice provider] with diagnosis: cerebral atherosclerosis, with a start date of 8/06/21, and no end date. -an order for Admit to [facility] for respite care/skilled services/hospice services under [hospice provider], with an order date of 7/5/23. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #30's facility clinical record as of 8/30/24, revealed a binder with Resident #30's DNR form and a staff sign in sheet. No Certification of Terminal Illness, Hospice election form, list of hospice personnel, the most recent hospice plan of care, list of staff involved in the care, or hospice physician orders were in the binder. During an interview on 8/29/24 at 3:21 p.m. medical records stated they were recently given the responsibility for ensuring residents had all their hospice documents. Medical record stated the resident had been on hospice since 2021 and the only records they had for Resident #30 were in the binder. Medical records stated they had previously contacted the hospice company to get all of the documents but did not follow up to see if they ever sent them. During an interview on 8/30/24 at 12:43 p.m. the DON stated she had made nursing staff aware that they needed to update resident's hospice binders. The DON said she had medical records assist with obtaining missing records and was not aware they were still pending records from hospice. The DON stated the records were to ensure continuity of care between the hospice provider and the facility for Resident #30. Record review of the facility policy titled Hospice Program, dated 3/1/22, stated, Our facility has designated (Name)[blank], (Title) [blank] to coordinate care provided to the resident by our facility staff and the hospice staff. (Note: this individual is a member of the IDT with clinical and assessment skills who is operating within the State scope of practice act). He or she is responsible for the following: a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services; b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the resident and family; C. Ensuring that the LTC facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physicians; d. Obtaining the following information from the hospice: (1) The most recent hospice plan of care specific to each resident; (2) Hospice election form; (3) Physician certification and recertification of the terminal illness specific to each resident;(4) Names and contact information for hospice personnel involved in hospice care of each resident;(5) Instructions on how to access the hospice's 24-hour on-call system; (6) Hospice medication information specific to each resident; and (7) Hospice physician and attending physician (if any) orders specific to each resident. E. Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45857 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 to help prevent the development and transmission of infections involving 2 of 6 staff (LVN) reviewed for infection control, in that: The facility failed to ensure MA G cleaned the blood pressure cuff between resident #9 and Resident #80. These deficient practices could place residents at-risk for infections. The findings included: During an observation on 8/29/24 at 7:59 a.m. MA G was observed taking resident #9's blood pressure prior to administering medications to the resident. MA G return to her cart and place the blood pressure cuff on the cart. MA G did not sanitize the blood pressure cuff. MA G then went to resident number 80s room and took their blood pressure with the same cuff. MA G again return to her cart and place the blood pressure cuff on top of her cart. MA G again did not sanitize the blood pressure cuff. During an interview on 8/29/24 at 8:30 a.m. MA G stated she thought she only needed to clean the blood pressure cuff after every two residents. MA G stated she cleans the blood pressure cuff to disinfect it and prevent contamination from other residents. During an interview on 8/30/24 at 12:45 p.m. the DON staff should sanitize the blood pressure cuff between each resident to prevent infections. Record review of the facility's policy, titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 3/1/22, revealed, resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard .4. Reusable resident care equipment will be decontaminated and/ or sterilized between residents according to manufacturer's instructions .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, record reviews, and interviews the facility failed to ensure resident rooms were equipped to assure full visual privacy for each resident for 1 (Resident #193's room) of 16 rooms reviewed for full visual privacy. The facility failed to provide Resident #193 with a privacy curtain. Resident #193's buttocks was visible from the hallway during incontinent care. This failure could cause a decrease in feelings of self-worth by being exposed during cares. Findings included: 1. Record review of Resident #193's face sheet, dated 8/30/24, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: hypertensive heart (high blood pressure) and chronic kidney disease with heart failure and stage 1 through state 4 chronic kidney disease, reduced mobility, and Dysphagia (difficulty swallowing). Record review of Resident #193's comprehensive care plan, initiated on 3/27/24 revealed he had a peg tube and wounds. The care plan stated he had an ADL self-care performance deficit related to weakness and debility with interventions for x2 staff assistance for toilet use, bathing, and transfers. Record review of Resident #193's quarterly MDS assessment, dated 7/19/24, revealed the resident's cognitive skills for daily decision making was severely impaired- he never/rarely made decisions. During an observation on 8/28/24 at 9:30 a.m. Resident #193 was observed laying on his side in bed. A staff member was holding the resident on his side and his back side was facing the door. The resident's back and buttocks were exposed and visible from the hallway. A second staff member was standing in the doorway inside the room and the treatment nurse was standing in the hallway outside the door. During an interview on 8/28/24 at 9:36 a.m. LVN A stated the aides had the door open because they were waiting for her to provide wound care to the resident's pressure wound. During an interview on 8/28/24 at 9:49 a.m. CNA B and CNA C stated there was no privacy curtain in Resident #193's room and one had never been installed. The aide stated nursing staff and maintenance were aware there had never been a curtain, but they could normally provide privacy by closing the door. CNA B and CNA C stated it was an invasion of privacy for the resident. During an interview on 8/30/24 at 12:40 pm, the DON stated they had ordered the resident a curtain track. The DON stated if you were able to see the resident from the hallway that is not providing privacy and she would not like it so she would assume the resident did not like it either. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a document titled Resident Rights, dated 4/19, stated Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States .Dignity and respect You have the right to .Be treated with dignity, courtesy, consideration and respect .