

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 12/05/2025
NAME OF PROVIDER OR SUPPLIER Harbor Valley Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility and demonstrate their response and rationale for such response, for 3 of 6 anonymous residents who attended resident council meetings. (Resident council meeting). The facility failed to provide residents with requested copies of the documentation of their grievances and their resolution. This failure could result in the residents feeling that their grievances are not being acted upon and could place all residents who attend the Resident Council meetings at risk for feelings of powerlessness and decreased self-worth. The Findings included: Record review of Resident Council minutes, dated 07/08/25, reflected food going to waste. Food no flavor, raw bacon being served. Record review of Resident Council minutes, dated 11/12/25, reflected talked about food not being good. No flavor. Record review of facility's grievances since 07/2025 reflected no grievances about food complaints from the resident council. Record review of facility's grievances since 07/2025 reflect out of 24 total grievances 11 of the grievances had written documentation regarding resolutions communicated to the resident or resident family. During the confidential Resident Council interview at an undisclosed date and time three residents in attendance stated they have not received copies of both their grievances filed and their resolution. The residents stated they must ask staff for a grievance form, and they know how to file grievances but once they have filed it nothing happens, and no one follows up with them regarding a resolution. The residents stated they had asked for copies of their grievance and documentation of the resolution and had not received either. The residents stated they usually give their grievance to the SW, or a staff member will take it to the SW or Administrator for the resident. The residents stated when they ask the SW for follow up on grievances, he states he is working on it and states he gave the grievance to the Administrator. During an interview with the Administrator on 12/03/25 at 2:00 pm, the Administrator was asked for the Grievance Log. He printed it off for the past 5 months since the track log (where they keep track of the number of grievances in the month) as well as the individual grievances are all placed in a computer program. The Administrator was asked if residents ever received a copy of the grievance resolution and he stated, If they ask for it, we can give them a copy. The Administrator then said that they usually just verbally tell the person filing the grievance about the outcome. During an interview with the SW on 12/04/2025 at 1:34 p.m., the SW stated if a resident comes with a grievance the SW gets with the Administrator depending on the concern. The SW stated if a resident comes to the SW wanting to change their meal the SW will connect the resident to dietary or if the resident is wanting more physical therapy the SW will connect the resident with the physical therapy department. The SW stated if it is an abuse grievance the SW refers to the Administrator as he is the abuse prevention coordinator. When asked about follow up to the concern/grievance the SW stated the follow up is usually in the moment of the concern and depending on the concern it is not documented. The SW stated if a resident wants to fill out documentation the SW shows the resident the grievance form. The SW stated the grievance forms are in his office and believes residents know where they can find the grievance forms. When asked what happens to the grievance when the SW receives a grievance form the SW stated he sends it to the Administrator who then inputs it into the computer. When asked (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676478	If continuation sheet Page 1 of 23

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 3 of 5 residents (Resident #68, #10 and #74) reviewed for resident assessments: 1.The facility failed to ensure Resident #68's most recent quarterly MDS assessment was updated to include the resident did not receive insulin injections. 2. The facility failed to ensure Resident #10's most recent quarterly MDS assessment, dated 11/20/25, was updated to include the resident having a significant weight gain in the last 6 months. 3. The facility failed to ensure Resident #74's admission MDS assessments dated 04/09/25 and most recent quarterly MDS assessments dated 09/01/25 04/09/25 and most recent quarterly MDS assessment dated [DATE] were updated to include the resident had difficulty with chewing. This failure could place residents at risk for inadequate care due to inaccurate assessments.The findings included:1.Record review of Resident #68's face sheet dated 12/3/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included heart disease, multiple sclerosis (chronic autoimmune disease in which the immune system attacks myelin, the protective covering around nerves in the brain, spinal cord, and optic nerves), diabetes (chronic medical condition in which the body either does not produce enough insulin or cannot use insulin effectively), hyperlipidemia (abnormally high levels of fats in the blood, high cholesterol), and hypotension (low blood pressure).Record review of Resident #68's quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills, was diagnosed with diabetes, and received insulin injections. Record review of Resident #68's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills, was diagnosed with diabetes, and received insulin injections. Record review of Resident #68's Order Summary Report for December 2025 revealed the resident received Metformin 500 mg tablets two times a day for diabetes with start date 9/25/25 and no end date.Record review of Resident #68's comprehensive care plan with revision date 6/14/23 reflected that the resident had diabetes and interventions included to provide diabetes medication as ordered by the doctor.During an interview on 12/3/25 at 1:57 p.m., Resident #68 stated she did not receive insulin injections and had never been treated with insulin injections while residing at the facility. Resident #68 stated the nursing staff checked her sugars daily.During an interview on 12/4/25 at 10:23 a.m., LVN C stated he had worked for the facility for almost a year and a half and did not recall Resident #68 ever having been treated with insulin. LVN C stated Resident #68 had her sugars checked daily but was not treated with insulin.During an interview on 12/4/25 at 3:19 p.m., the DON stated Resident #68 used to be treated with insulin back in March of 2025. The DON stated she did not know why Resident #68's MDS reflected the resident received insulin injections. The DON stated the purpose of the MDS was to populate or was used to flag patients with certain medical needs.2. Record review of Resident #10's admission Record, dated 12/02/2025, reflected a [AGE] year-old male with an initial admission date of 02/03/2025 and re-admission date of 03/21/2025. It reflected Resident #10 had diagnoses that included Type 2 Diabetes, Muscle Wasting and Atrophy (body tissue wasting away), and Dysphagia (difficulty swallowing). Record review of Resident #10's quarterly MDS Assessment, dated 11/20/2025, reflected Resident #10 had a BIMS score of 9 out of 15, indicating the resident was moderately cognitively impaired. Resident #10's MDS assessment reflected Resident #10 had no weight gain (gain of 5% or more in the last month or gain of 10% or more in the last 6 months).Record review of Resident #10's Weight Summary, undated, reflected Resident #10 gained 15.6% in the last 6 months.Record review of Resident #10's care plan, undated, reflected, [Resident #10] is at risk for nutritional and/or hydration deficits., initiated 02/05/25.During an interview on 12/05/25 at 11:42 a.m., the MDS nurse revealed she was out of town and could not access residents' MDS assessments. She revealed residents' significant weight changes needed to be documented in their (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respective MDS assessments. (The MDS nurse was unable to confirm weight gain for Resident #10.)3. Record review of Resident #74's admission Record, dated 12/02/2025, reflected a [AGE] year-old female with an admission date of 03/31/2025. It reflected Resident #74 had diagnoses that included Altered Mental Status. Record review of Resident #74's admission MDS Assessment, dated 04/09/2025, reflected Resident #74 had None of the above in Section L-Oral/Dental Status to include Mouth or facial pain, discomfort or difficulty with chewing and Resident #74 had a mechanically altered diet (require change in texture of food or liquids). Record review of Resident #74's Quarterly MDS Assessment, dated 09/01/2025, reflected Resident #74 had a BIMS score of 2 out of 15, indicating the resident was severely cognitively impaired. It further reflected no selection (to include mouth or facial pain, discomfort or difficulty with chewing) in Section L-Oral/Dental Status. Record review of Resident #74's care plan, undated, reflected, [Resident #74] is at risk for nutritional and/or hydration deficits r/t .dysphagia [difficulty swallowing] advanced texture., initiated 04/03/25. Record review of Resident #74's Order Summary Report, dated 12/02/25, reflected resident's diet was Dysphagia Puree [smooth, creamy substance] texture, dated 09/25/25. During an interview on 12/02/25 at 11 a.m., Resident #74 revealed the only teeth she had were a couple in the back of her mouth on each side. She revealed it caused her to have issues with chewing her food so she received meals with food that she could swallow and not need to chew. During an interview on 12/05/25 at 11:42 a.m., the MDS nurse revealed Resident #74's lack of teeth should be noted in her MDS assessment. It was important because it can influence someone's nutrition and oral hygiene. During a telephone interview on 12/5/25 at 11:53 a.m., the MDS Coordinator stated she was pretty much the only person compiling the MDS assessments. The MDS Coordinator stated she relied on information provided by the medication administration record and the physician's orders when completing an MDS assessment. The MDS Coordinator stated she could not explain why Resident #68's most recent quarterly MDS assessment reflected the resident received insulin injections and could not refer to the resident's record because she was out of town. During an interview on 12/4/25 at 5:35 p.m., the Administrator revealed it was important for the MDS nurse to note significant weight changes in residents' MDS assessments. He stated it was important that the MDS was accurate because it captured all of the care areas and services provided for the residents and it makes sure the services provided were appropriate. The Administrator stated it was his expectation that the MDS Coordinator would be auditing the accuracy of the MDS assessments. The facility did not provide a policy for the accuracy of MDS assessments requested on 12/4/25 at 3:19 p.m.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 6 of 18 residents (Resident #3, 68, #71, #45, #7 and #4) reviewed for care plans: 1. The facility failed to ensure a focus area for activities was reflected in Resident #3's comprehensive care plan. 2. The facility failed to ensure a focus area for activities was reflected in Resident #68's comprehensive care plan. 3. The facility failed to ensure a focus area for activities was reflected in Resident #71's comprehensive care plan. 4. The facility failed to ensure a focus area for activities was reflected in Resident #45's comprehensive care plan. 5. The facility failed to ensure a focus area for activities was reflected in Resident #7's comprehensive care plan. 6. The facility failed to ensure a focus area for hospice was reflected in Resident #4's comprehensive care plan. These deficient practices could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. The findings included: 1. Record review of Resident #3's face sheet dated 12/3/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included schizophrenia (a chronic, severe mental health disorder that affects how a person thinks, feels, and behaves), delusional disorders (a mental health condition characterized by the presence of one or more delusions that last at least one month; fixed false belief that is not based in reality and cannot be changed even with clear evidence), hallucinations (sensory experiences that appear real but are created by the mind, occurring without any external stimulus), and acquired absence of limb. Record review of Resident #3's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #3's comprehensive care plan with initiated date 9/16/25 did not reflect a focus area dedicated to activities. Record review of Resident #3's document titled Multidisciplinary Care Conference, unsigned and dated 10/2/25 under the Activities Summary section for Evaluation/Goals reflected, engage resident in daily activity of choice as tolerated. 2. Record review of Resident #68's dated 12/3/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included heart disease, multiple sclerosis (chronic autoimmune disease in which the immune system attacks myelin, the protective covering around nerves in the brain, spinal cord, and optic nerves), diabetes (chronic medical condition in which the body either does not produce enough insulin or cannot use insulin effectively), hyperlipidemia (abnormally high levels of fats in the blood, high cholesterol), and hypotension (low blood pressure). Record review of Resident #68's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills. Record review of Resident #68's comprehensive care plan with revision date 2/22/23 did not reflect a focus area dedicated to activities. Record review of Resident #68's document titled Multidisciplinary Care Conference, unsigned and dated 7/17/25 under the Activities Summary section for Evaluation/Goals reflected, engage resident in daily activity of choice as tolerated. 3. Record review of Resident #71 face sheet dated 12/3/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] and 8/19/23 with diagnoses that included reduced mobility, major depressive disorder (a mental health condition characterized by persistent, intense feelings of sadness or loss of interest that last at least two weeks and interfere with daily functioning), and age-related osteoporosis (a medical condition in which the bones become weak, brittle, and more likely to break) with current pathological fracture. Record review of Resident #71's most recent quarterly MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Multidisciplinary Care Conference document). The Activities Director stated care plans were important because they were used to follow-up on the residents, to determine if there was a decline, communication with the family, and how involved the residents were in activities. The Activity Director stated she did not enter the information into the care plan since the MDS Coordinator was responsible to enter information in that document. During an interview on 12/5/25 at 8:48 a.m., the Regional RN stated activities needed to be incorporated into the comprehensive care plan and it needs to be detailed in the care plan. The Regional RN stated there needs to be a better process in place. The Regional RN stated the comprehensive care plan was important because staff used the comprehensive care plan to give instruction on how to provide quality of care to the residents. During an interview on 12/5/25 at 3:19 p.m., the DON stated it was important to include activities in the comprehensive care plan because it contributed to the resident's quality of life because it was individualized and specific to the resident. The DON stated the MDS Coordinator retrieved information from different disciplines and incorporated it into the comprehensive care plan. The DON stated, she believed the Activities Director provided resident activities information in the progress notes, and the MDS Coordinator took that information and incorporated it into the comprehensive care plan. The DON stated it was the MDS Coordinator who was responsible for developing the care plan based on the information received from the other disciplines. The DON stated she would sign-off on the comprehensive care plans and reviewed them. Record review of the facility document titled Care Plans - Comprehensive with revision date 3/1/22 revealed in part, .An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident's Comprehensive Care Plan has been designed to. Incorporate identified problem areas. Incorporate risk factors associated with identified problems. Build on the resident's strengths. Reflect treatment goals and objectives in measurable outcomes. Identify the professional services that are responsible for each element of care. Aid in preventing or reducing declines in the resident's functional status and/or functional levels. Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly and any significant change in status.		

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 12/05/2025
NAME OF PROVIDER OR SUPPLIER Harbor Valley Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman, send the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged , and record the reason for the transfer or discharge in the resident's medical record in for 1 (Resident #99) of 2 residents reviewed for safe transfer or discharge.1.The facility failed to record the reasons for the transfer in Resident #99's medical record.2. The facility failed to send notice of transfers or discharges to the ombudsman.3. The facility failed to provide Resident #99 and/or the resident's representative with a thirty-day written notice of an impending transfer or discharge.This failure could result in residents experiencing psychosocial harm (feelings of anger and sadness) due to inappropriate discharges and placed residents at risk of being discharged without alternate placement and not having access to available advocacy services, discharge/transfer options, and denying them their rights in the appeal process.The findings include:Record review of Resident #99's admission Record, dated 12/05/2025, reflected a [AGE] year-old male with an admission date of 04/06/2025 and a discharge date of 09/23/2025. It reflected Resident #99 had diagnoses that included dependence on wheelchair, mild protein-calorie malnutrition (lack of proper nutrition), cognitive communication deficit, need for assistance with personal care, and major depressive disorder.Record review of Resident #99's Quarterly MDS Assessment, dated 09/01/2025, reflected Resident #99 had a BIMS score of 5 out of 15, indicating the resident was severely cognitively impaired. Record review of Resident #99's care plan, undated, reflected, [Resident #99] discharge planning will honor his personal wishes. The expectation, based on care plan meetings and talking with the patient, is to stay in facility for LTC., initiated 04/26/2025 and revised on 10/09/2025.Record review of Resident #99's progress note, dated 09/23/25 at 01:47PM, authored by LVN M, reflected [Resident #99] being discharged to [facility name], being picked up at this time via stretcher. discharged med list and medications sent with [Resident #99]. Transportation unable to take residents belongings. Notified RP [name]. No concerns expressed at this time. Attempted to call report to [facility name] x 3 attempts, unable to get ahold of a nurse at this time. No distress noted upon departure.Interview on 12/05/25 at 02:08PM, the SW revealed nurses oversaw discharge documentation in the residents' electronic medical record.Interview on 12/05/25 at 02:57PM, LVN M revealed he could be more specific in documentation for residents for transfers and discharges. He revealed he sometimes forgot to fill out the Final Discharge Summary assessment, which typically needed to be done, but he did put required information in his progress note. He revealed it was important for adequate documentation.Email communication on 12/05/25 at 03:25 PM, the ombudsman revealed she never received notice of Resident #99's discharge.Email communication on 12/05/25 at 03:39 PM, the ombudsman revealed the facility was not sending her their monthly discharge summary.Email communication on 12/05/25 at 04:29 PM, the ombudsman revealed the ADM or SW typically sent her the facility's discharge summary, but each facility was different.Interview on 12/05/25 at 04:43PM, the ADM revealed he was not aware that they had to notify the ombudsman of discharges or transfers. He revealed it was the SW that contacted the ombudsman for the monthly discharges.Interview on 12/05/25 at 05:34 PM, the DON revealed the basis for a transfer was not documented in the resident's medical record if it did not have to do with nursing. Interview on 12/05/25 at 05:40PM, the BOM revealed Resident #99 was discharged because of payment. She revealed she worked with his family to get him transferred somewhere else so they did not have to give him a 30-day discharge notice so Resident #99 could come back to this facility if they chose to.Record review of facility's policy Documentation of Transfers/Discharges, revised 09/13/17, reflected Our facility shall provide a resident and/or the resident's representative (sponsor) and a (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative of the Office of the State Long-Term Care Ombudsman, with a thirty (30)-day written notice of an impending transfer or discharge.1. All documentation concerning the transfer or discharge of a resident must be recorded in the resident's medical record. The documentation must include: a. The basis for the transfer.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Significant Change MDS assessment with 14 days after the facility determined, or should have determined, there had been a significant change in a resident's physical or mental condition for 1 of 24 residents (Resident #45) reviewed for assessments. The facility failed to complete a Significant Change MDS for Resident #45 within 14 days of the resident's discharge from hospice services. This failure placed residents who had a significant change in condition requiring an MDS assessment at risk of not receiving needed services. The findings were: Record review of Resident #45's admission Record dated 12/04/25 revealed a [AGE] year old woman admitted to facility on 07/16/25 with diagnoses that included cerebral infarction due to unspecified occlusion or stenosis of bilateral anterior cerebral arteries (a stroke caused by blocked blood flow in major arteries to the brain), vascular dementia (a decline in thinking skills due to reduced blood flow to the brain often caused by stroke), aphasia (a communication disorder caused by brain damage that impairs a person's ability to speak), dysphagia, oral phase (a swallowing disorder), and encounter for attention to gastrostomy (a medical visit for care of a feeding tube). A record review of Resident #45's medical record revealed the resident had been placed on hospice and a Significant Change Assessment had been completed on 11/08/25. Upon further review of Nursing Progress Notes dated 11/14/25 it was noted that the family had decided to take Resident #45 off of hospice services as of 11/14/25. There was no additional Significant Change MDS completed to reflect the resident was no longer on hospice. Interview on 12/04/25 at 2:30 pm, ADON B was asked for the hospice binder for Resident #45. ADON B stated that since the resident had been taken off of hospice, her chart had been given to Medical Records. ADON B was able to retrieve the binder about an hour later. The hospice binder was reviewed, and it contained both an election form dated 10/31/25 and a cancellation form dated 11/14/25. During an interview with the DON on 12/04/25 at 3:20 PM, the DON stated Resident #45 was taken off hospice on 11/14/25 since family could not agree about the need for hospice. No additional MDS had been done to reflect this change. The DON stated the MDS Coordinator was responsible for updating MDS Assessments. The DON also stated the nurse managers had clinical meetings every morning to discuss changes in residents' conditions. Record review of the Medical Record indicated that the ADON B had made a note in the Progress Notes on 11/14/25 that Resident #45 had been taken off of hospice services. During a phone interview on 12/05/25 at 11:39 AM with MDS Coordinator, she stated she had seen the orders to take the resident off of hospice but did not get the information in time to make the change before she had to leave town for a family emergency. The MDS Coordinator stated, We had orders and I had written it down to do a sig change to take her off hospice. The BOM didn't notify us that she came off. Hospice usually notifies the BOM and she notifies us. The MDS Coordinator stated she knew a significant change MDS should have been done within 14 days but she failed to complete one on time. Review of the policy for Change in a Resident's Condition or Status revised 6/10/2025 stated:Change in the resident status or condition can be addressed by any staff member. The staff member noticing a change in the resident condition shall report to the Nursing supervisor/charge Nurse and at that point the assessment process will begin. The Nurse Supervisor/Charge Nurse is responsible for enacting the following protocol.2. A significant change of condition is a decline or improvement in the resident's status that:c. Requires interdisciplinary review and/or revision to the care plan8. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outline in the MDS RAI Instruction Manual.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan and quarterly review assessments were reviewed and revised by an interdisciplinary team that included, but was not limited to the attending physician, a registered nurse, a nurse aide, and a member of food and nutrition services staff responsible for the resident for 2 of 8 residents (Resident #68, and #10) reviewed for care plan timing and revision. 1. The facility failed to have a complete interdisciplinary team attend Resident #68's care plan meeting to include the attending physician, a registered nurse, a nurse aide, and a member of food and nutrition services staff. 2. The facility failed to have a complete interdisciplinary team (to include the attending physician, a registered nurse, a nurse aide, and a member of food and nutrition services staff) attend Resident #10's care plan meeting. These deficient practices could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1. Record review of Resident #68's face sheet dated 12/3/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included heart disease, multiple sclerosis (chronic autoimmune disease in which the immune system attacks myelin, the protective covering around nerves in the brain, spinal cord, and optic nerves), diabetes (chronic medical condition in which the body either does not produce enough insulin or cannot use insulin effectively), hyperlipidemia (abnormally high levels of fats in the blood, high cholesterol), and hypotension (low blood pressure). Record review of Resident #68's quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills, was diagnosed with diabetes, and received insulin injections. Record review of Resident #68's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills, was diagnosed with diabetes, and received insulin injections. Record review of Resident #68's document titled Multidisciplinary Care Conference, unsigned and dated 7/17/25 under the Activities Summary section for Evaluation/Goals reflected, engage resident in daily activity of choice as tolerated. The Multidisciplinary Care Conference document reflected the following sections titled Attendance at Meeting, Nursing Summary, Name of Contributing Charge Nurse, Name of Contributing CNA, Other contributing nursing staff, Dietary Summary, Social Work Summary, Pharmacy Summary, Restorative Care/PT/OT Summary, Physician Summary, and Resident/Family sections were blank. Record review of Resident #68's Order Summary Report for December 2025 revealed the resident received Metformin 500 mg tablets two times a day for diabetes with start date 9/25/25 and no end date. Record review of Resident #68's comprehensive care plan with revision date 6/14/23 reflected that the resident had diabetes and interventions included to provide diabetes medication as ordered by the doctor. 2. Record review of Resident #10's face sheet, dated 12/02/2025, reflected a [AGE] year-old male (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with an initial admission date of 02/03/2025 and re-admission date of 03/21/2025. It reflected Resident #10 had diagnoses that included major depressive disorder, schizophrenia (serious mental health condition that affects how people think, feel, and behave), type 2 diabetes, hypothyroidism (thyroid gland does not make enough thyroid hormone), hyperlipidemia. Record review of Resident #10's quarterly MDS Assessment, dated 11/20/2025, reflected Resident #10 had a BIMS score of 9 out of 15, indicating the resident was moderately cognitively impaired. Record review of Resident #10's Multidisciplinary Care Conference, dated 10/23/25, reflected the staff who were present at the 10/23/25 care plan meeting was the SW, AD, and 2 LVNs (full names unknown). During an interview on 12/4/25 at 3:19 p.m., the DON stated it was the MDS Coordinator, the SW, and the Activities Director who attended the care plan meetings. The DON stated, other disciplines were invited to care plan meetings at the request of the Resident or the RP, such as nursing, dietary, housekeeping, etc. The DON stated the SW coordinated the care plan meetings. The DON stated, I can't tell you, can't remember the last time she was at a care plan meeting. The DON stated it was usually one of the two LVN ADONs who attended care plan meetings, but normally I don't attend a care plan meeting. During a follow up interview on 12/4/25 at 4:37 p.m. the DON stated, care plan meetings were attended by the SW, the MDS Coordinator, the Activities Director, and the resident and/or RP. The DON stated, no RN goes to those meetings. The DON stated that the MDS Coordinator was an LVN. During an interview on 12/4/25 at 5:00 p.m. ADON LVN M stated she could not recall the last time she was invited to a care plan meeting. ADON LVN M stated the MDS Coordinator was always present at the care plan meetings and usually the Activities Director, SW, and the Director of Rehab participated in care plan meetings. ADON LVN M stated, I have not seen a doctor at a care plan meeting, but one time when a family member requested it. ADON LVN M stated the SW schedules the care plan meetings and he runs them. During an interview on 12/4/25 at 5:10 p.m., ADON LVN N stated it had been a while since he had participated in a care plan meeting. ADON LVN N stated the MDS Coordinator, the SW, and the Activities Director participated in care plan meetings. ADON LVN N stated the MDS Coordinator and the SW run the meeting. ADON LVN N stated the MDS Coordinator represented the nursing department, but when he was invited, he would usually review medications. ADON LVN N stated the SW will give us a piece of paper regarding an invite to a care plan meeting. ADON LVN N stated if requested, it's rare, but unless invited, a doctor won't show up. ADON LVN N stated, disciplines were invited based on a specific problem, such as if there was a dietary issue, then dietary would be invited. During an interview on 12/5/25 at 8:16 a.m., CNA L stated she had been employed by the facility for almost 6 years and had never been invited or had attended a care plan meeting. CNA L stated she had not heard of other CNA staff being invited to a care plan meeting. CNA L stated the care plan meeting was when the team talked to the family regarding the resident's care. CNA L stated, I know that the SW, the MDS Nurse, Activities Director, Dietary Manager and the Therapy usually go. I have not heard of CNA's going to a care plan meeting. During an interview on 12/5/25 at 8:27 a.m., Resident #68 stated she could not recall participating in (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a care plan meeting or sitting down with a team of facility staff to discuss her medical needs. Resident #68 stated she believed a care plan meeting was for her benefit but could not elaborate. During an interview on 12/05/2025 at 8:33 a.m. the Director of Rehab stated she participated in care plan meetings for residents who were included in her case load. The Director of Rehab stated, care plan meetings were held on Thursdays usually, and run by the SW. She stated the SW, MDS Coordinator, herself, the Dietary Manager, and the Activities Director participated in those meetings. The Director of Rehab stated she had never seen the doctor at the meetings but sometimes they participated by phone. The Director of Rehab stated she had never signed anything indicating she had participated in a care plan meeting. During an interview on 12/5/25 at 11:42 a.m., the MDS nurse revealed it was important to have a multidisciplinary team to attend residents' care plan meetings to receive proper feedback to provide appropriate care for the residents. She further revealed the attendants for residents' care plan meetings would be noted in the resident's Multidisciplinary Care Conference assessments and to refer to this assessment to see who was in attendance. (The MDS nurse could not review any specific resident's assessments as she was out of town and did not have access to resident records.) During a telephone interview on 12/5/25 at 11:53 a.m., the MDS Coordinator stated she was pretty much the only person compiling the MDS assessments. The MDS Coordinator stated she relied on information provided by the medication administration record and the physician's orders when completing an MDS assessment. The MDS Coordinator stated she could not explain why Resident #68's most recent quarterly MDS assessment reflected the resident received insulin injections and could not refer to the resident's record because she was out of town. During an interview on 12/5/25 at 4:11 p.m., the SW stated, care plan meetings were coordinated by him and were scheduled every Thursday. The SW stated, he, the Activities Director, and the Rehab therapist participated in the care plan meetings. The SW stated that the MDS Coordinator also attended the care plan meetings, and she represented nursing, unless a charge nurse was invited. The SW stated he followed guidelines and basically it was the SW, the Activities Director, the MDS Coordinator, and maybe possibly a charge nurse or manager for the unit participated in care plan meetings. The SW stated, as far as he knew, there was no requirement for a doctor to be involved in the care plan meeting, and since I've been here, I have never had the doctor invited. The SW stated he did not keep a record or any paperwork related to who attended or participated in a care plan meeting. The SW stated the care plan meetings were important because it helped to update a resident's plan of care and used as a standard of practice for where we are with the resident and their feedback on how we are doing with their care. During an interview on 12/5/25 at 4:43 p.m., the Administrator stated he had been invited to care plan meetings and had even randomly shown up to ensure the meetings were occurring. The Administrator stated it was the SW who communicated when a care plan meeting would occur and was aware it required involvement by the IDT which included dietary, activities, nursing, therapy, SW, and housekeeping/laundry. The Administrator stated the doctor sometimes would participate in person or by phone, and because the care plan meetings were a requirement, the meetings were still held even if the doctor did not participate. Record review of the facility policy titled Care Plans & Comprehensive with revision date 3/1/22 revealed in part, .An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	developed for reach resident.Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Record review of the facility policy titled Care Plans &ndash; Interdisciplinary Team revision date 3/1/22 revealed in part, .2. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel: a. The resident's Attending Physician; b. The Registered Nurse who has responsibility for the resident; c. The Dietary Manager/Dietician; d. The Social Services Worker responsible for the resident; e. The Activity Director/Coordinator.i. The Charge Nurse responsible for resident care; j. Nursing Assistants responsible for the resident's care.		

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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** Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 8 residents (Resident #10) reviewed for personal hygiene. The facility failed to keep Resident #10's toenails and fingernails trimmed. This failure could place residents who require assistance from staff for personal hygiene at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections. Record review of Resident #10's admission Record, dated 12/02/2025, reflected a [AGE] year-old resident with an initial admission date of 02/03/2025 and re-admission date of 03/21/2025. It reflected Resident #10 had diagnoses that included Type 2 Diabetes, Major Depressive Disorder, and Polyneuropathy (nerve disease caused by damage to nerves). Record review of Resident #10's Quarterly MDS Assessment, dated 11/20/2025, reflected Resident #10 had a BIMS score of 9 out of 15, indicating the resident was moderately cognitively impaired. Resident #10's MDS assessment indicated that Resident #10 was Dependent (helper does ALL of the effort) for personal hygiene. Record review of Resident #10's care plan, undated, reflected, [Resident #10] is at risk for skin impairment and/or [pressure ulcer] development r/t fragile skin. with intervention Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short., initiated 02/11/2025. Record review of Incidents for the last 6 months reflected Resident #10 had no incidents of skin tears or injury of unknown origin. Interview and observation on 12/02/2025 at 10:30 AM, Resident #10 revealed he had long nails and had told the facility he needed a podiatrist about a month or two ago. (He could not recall the name of the person he told.) He revealed it was important for his nails to be trimmed because he could scratch himself. He revealed he could feel his toenails were long because they brushed up against each other. Observation revealed his fingernails were past his fingertips (length unknown). Interview and observation on 12/05/25 at 02:15 PM, CNA H observed and revealed Resident #10 needed his fingernails trimmed. She revealed she had the ability to trim his fingernails, but the nurse would help with trimming his toenails. She revealed it was important to have his nails trimmed to prevent injury. Interview and observation on 12/05/25 at 02:20 PM, LVN G revealed nurses typically made sure to cut residents' nails once a week. LVN G observed and revealed Resident #10's fingernails and toenails needed to be trimmed. She revealed Resident #10 should be on the list to be seen by podiatry. She revealed any nursing staff member had the ability to report the Resident #10's nails needed to be trimmed. She revealed it was important for Resident #10's nails to prevent injury and because he was diabetic. Interview on 12/04/25 at 01:44 PM, the SW revealed he kept up with residents' ancillary services (supplementary services like podiatry (treatment of the feet) and vision). He revealed he would keep a list of residents who needed ancillary services, and he would speak with nursing staff to see if any other resident needed to be added to the list. The SW revealed he could not find records that showed Resident #10 had been on the list to see the podiatrist for the last 3 months so Resident #10 was probably not seen by the podiatrist. Interview and observation on 12/04/25 at 04:07 PM, the DON revealed it was important to cut residents' nails, especially their feet because having long nails could cause injury to themselves, especially for diabetics because they were more prone to amputations. She revealed the nurses were able to cut fingernails and not toenails. The DON observed Resident #10's toenails and said he needed to be on the list to see the podiatrists. She revealed she could not say how long Resident #10 had not had his toenails or fingernails trimmed but it was possible that Resident #10 had not been seen by the podiatrist in November at least. Record review of facility's policy, Resident Rights, dated April 2019, reflected You have the right to: Receive all care necessary to have the highest possible level of health. Record review of facility's policy, Coordination of Medical Care, revised April 2008, reflected 2. Coordination of medical care includes, but is not limited to: a. Ensuring that residents have (continued on next page)		

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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 12/05/2025
NAME OF PROVIDER OR SUPPLIER Harbor Valley Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate physician coverage and services, including emergency care. (This was the policy given after requesting a policy about podiatry.)		

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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** Based on observation, interview and record review the facility failed to ensure the resident's environment remains as free of accident hazards as is possible, for 2 of 2 resident (Resident #41, Resident #90), in the facility reviewed for accidents, in that: 1.The facility failed to ensure Resident #41 did not have a razor in his room. 2.The facility failed to ensure Resident #90 did not have scissors in her room. This failure could place residents at risk of injury and contribute to avoidable accidents and a decline in health.The findings include:1.Record review of Resident #41's face sheet dated 12/03/2025 revealed a [AGE] year-old male originally admitted to the facility on [DATE], with a current admission date of 06/09/2025. Record review of Resident #41's admission Record, dated 12/03/2025, reflected a primary admission diagnosis of encephalopathy, unspecified (a group of conditions that cause brain dysfunction) with other diagnoses that included depression, Parkinson's disease without dyskinesia (movement disorder of the nervous system), muscle weakness, unsteadiness of feet, other abnormalities of gait and mobility (manner of walking), other lack of coordination, cognitive communication deficit (difficulties in communication affecting how individuals think, process information and express themselves) and other diagnoses. Record review of Resident #41's MDS dated [DATE] revealed a BIMS of 13 out of 15 indicating independent decision making and recorded the needed use of supervision or touching assistance with personal hygiene. Record review of Resident #41's care plan provided on 12/03/2025 revealed a focus area for the following: . an ADL self-care performance deficit r/t weakness and debility, initiated on 04/18/2025, with interventions including PERSONAL HYGIENE: requires (X)1 staff participation with personal hygiene and oral care initiated on 04/18/2025. During an observation on 12/03/2025 at 9:20 a.m., revealed Resident #41 was in his wheelchair, halfway out of his doorway with a razor in hand as CNA E proceeded to walk out of Resident #41's room and down the hallway. During an interview on 12/03/2025 at 9:20 a.m., Resident #41 stated the nurse gave him the razor to shave. Resident #41 stated he normally got to keep his razor in his room so he could shave and when he needed to shave, he asked a CNA for help. During an interview on 12/04/2025 at 8:35 a.m., CNA E stated Resident #41 mostly did everything on his own with little assistance. CNA E stated Resident #41 needed assistance with toileting and shaving. When asked if Resident #41 could have a razor in their room CNA E stated residents were not allowed to keep razors in their room. When asked if Resident #41 could be left alone with a razor, CNA E stated the resident was not allowed to be alone with a razor. When asked if any training had been given regarding residents having razors in their room or being left alone with a razor CNA E stated they were not sure. When asked where razors came from, CNA E stated they get them from the closet. When asked what the danger would be for a resident to have a razor in their room or be left alone with a razor, CNA E stated the risk depends on the resident and their abilities, if the resident had Parkinsons disease (movement disorder of the nervous system) they could shake and that staff need to be with them. CNA E stated they could be a risk of harm. During an interview on 12/04/2025 at 3:11 p.m., LVN F stated they weren't sure the assistance required for Resident #41. When asked about the process for shaving Resident #41, LVN F stated the resident alerted staff when they would like to be shaved, and a CNA would get the razor from the closet and assist the resident. When asked if Resident #41 could have a razor in their room or be left alone with a razor LVN F stated they were not aware if residents could. When asked if Resident #90 could have scissors in their room, LVN F stated they were not aware of any residents that could have scissors in their room. When asked what the danger would be for a resident to have a razor in their room or be left alone with a razor, LVN F stated there could be a risk for potential harm to themselves or others. When asked what the danger would be for a resident to have scissors in their room, LVN F stated it would be the same as a razor which could be a risk for potential harm to themselves or others. During an interview on 12/04/2025 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:18p.m., the ADON A stated Resident #41 needed minimal to maximal assistance and sometimes supervision depending on the day he's having and task. ADON A stated Resident#41 would ask a CNA if he needed to shave and usually waited for someone to help. ADON A stated he knew Resident #41 had his own personal shavers that his partner brought. When asked where Resident #41 kept his personal shavers ADON A stated they may be in a cubby by the dresser or different places at different times. When asked if a resident could have a razor in their room should it be documented, ADON A stated he was not sure and the thing would be to look at if the resident was a threat to themselves or others but most likely the documentation would be in the care plan but was unsure if it needed to be documented at all. When asked how residents were assessed for possible threat to themselves or others ADON A stated they could use the PHQ 9 (patient health questionnaire), BIMS level, or if they were able to independently use a razor. When asked if the MDS notes that reflected Resident #41 may need assistance with shaving if Resident #41 should be left alone with a razor ADON A stated he was not sure. When asked if Resident #90 was allowed to have scissors in their room ADON A stated he was not sure if she was allowed to have scissors or items like that in their room. ADON A stated Resident #90 could have scissors if she could use them safely which could be determined by the PHQ 9 or BIMS level to gauge independence level and cognition. ADON A stated they were unsure if a resident could have scissors in their room if it needed to be documented. When asked what the danger would be for a resident to have a razor in their room or be left alone with a razor, ADON A stated they didn't believe there was any risk to Resident #41 or others. When asked what the danger would be for a resident to have scissors in their room, ADON A stated there could possibly be a risk but believed Resident #90 was capable of having them in her room. During an interview on 12/04/2025 at 3:44 p.m., the DON stated regarding residents who requested to shave a CNA gets a basin and a razor and then CNA shaves them. When asked where razors are kept, the DON stated they are kept in the clean utility room either in the hallways if it has a keypad or central supply which has a keypad as well. The DON stated some residents can shave independently and if they could it would probably be documented under the care plan under ADL self-performance, it would depend on the assistance required and the care plan would not be specific if a razor can be used independently or not. When asked about Resident #41's ADL assistance needed, the DON stated he liked to be independent, for the most part was a one person assist with most ADLs. When asked what assistance Resident #41 required the DON stated someone would have to help him. When asked if Resident #41 could be left alone with a razor the DON stated he was allowed to be and he was safe. The DON stated they were not sure if it would need to be documented if Resident #41 could be left alone with a razor and that Resident #41 usually kept his razor in his drawer. When asked if Resident #90 was allowed to have scissors in their room the DON stated they try to get them not to have that stuff and that they educate family, but that the residents kept items like scissors in their room. The DON stated they would make sure the residents don't have dementia, so they don't keep sharp items in their room. When asked if a resident could keep scissors in their room if it would need to be documented and the DON stated they weren't sure if it would need to be documented. When asked what the danger would be for a resident to have a razor in their room or be left alone with a razor, the DON stated if Resident #41 had depression or suicidal thoughts they would be concerned he could harm himself and that it could be a risk to other residents who go in and out of other residents rooms. When asked what the danger would be for a resident to have scissors in their room the DON stated the residents keep them in their personal drawers that are not locked and that they can't take their items out of their rooms. 2. Record review of Resident #90's face sheet dated 12/03/2025 revealed a [AGE] year-old female with and admission date of 04/06/2024. Record review of Resident #90's admission Record, dated 12/03/2025, reflected a primary admission diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (a stroke characterized by paralysis or weakness on one side of the body) with other diagnoses that included rheumatoid arthritis, unspecified (autoimmune disorder that primarily affects the joints which can result in joint deformity over time) (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other abnormalities of gait and mobility (manner of walking), need for assistance with personal care, cognitive communication deficit (difficulties in communication affecting how individuals think, process information and express themselves) and other diagnoses. Record review of Resident #90's MDS dated [DATE] revealed a BIMS of 12 out of 15 indicating independent decision making and recorded the needed use of supervision or touching assistance with personal hygiene and supervision or touching assistance to partial/moderate assistance with dressing. Record review of Resident #90's care plan provided on 12/03/2025 revealed a focus area for the following: . an ADL self-care performance deficit r/t impaired balance, initiated on 07/09/2024, with interventions including PERSONAL HYGIENE: requires (X)1 staff participation with personal hygiene and oral care, DRESSING: requires (X)1 staff participation in dress initiated on 07/23/2024, and . is at risk for falls r/t deconditioning, gait/balance problems, unaware of safety needs, initiated on 04/08/2024, with interventions including be sure [Resident #90's] call light is within reach and encourage her to use it for assistance as needed, initiated on 04/08/2024. During an observation on 12/02/2025 at 10:54 a.m., revealed Resident #90 had scissors in her top bedside drawer. During an interview on 12/02/2025 at 1:14 p.m., Resident #90 stated the staff at the facility knew Resident #90 had scissors in their room and that no one had told her she couldn't have scissors. Resident #90 stated she kept the scissors at her bedside in case she needed to use them for anything such as opening soda cans or if she needed to cut something but often must ask for assistance because of her hands. During an observation on 12/03/2025 at 8:55 a.m., revealed Resident #90 had scissors in her top bedside drawer. During an interview on 12/04/2025 at 2:54 p.m., CNA D stated they assumed safety scissors were allowed for Resident #90 to keep in her room. CNA D stated they weren't sure if it was documented anywhere but that it was not something that they had been spoken to about. When asked what the danger would be for a resident to have scissors in their room, CNA D stated for Resident #90 there was no risk and if she left them lying around CNA D would just pick them up. During an interview on 12/04/2025 at 5:40 p.m., when asked if residents could have items such as razors or scissors in their rooms the Administrator stated residents have rights that the facility cannot take away. When asked what the danger would be for a resident to have a razor or scissors in their room the Administrator stated that it would be more about if a resident had been judged incompetent or not. Record review of the facility's policy titled Residents Rights, undated, revealed the following:Dignity and RespectYou have the right to: - Live in safe, decent, and clean conditions		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a drug regimen of each resident was reviewed at least once a month by a licensed pharmacist for 1 of 3 residents (Resident #2) reviewed for (DRR) Drug Regimen Review. The facility failed to have a record of Resident #2's DRR for November 2025. This failure could place residents at risk of not having their medications reviewed by a pharmacy consultant for appropriate doses or pharmacy recommendations. The findings included: Record review of Resident #2's face sheet dated 12/5/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included senile degeneration of brain (age-related deterioration of the brain tissue), heart disease, encounter for palliative care (a specialized medical focus on improving quality of life for people with serious, chronic, or life-limiting illnesses), abnormal weight loss, reduced mobility, and dementia with anxiety (a progressive decline in cognitive function that affects memory, thinking, problem-solving, and daily functioning). Record review of Resident #2's most recent comprehensive MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills and was treated with an antipsychotic and antidepressant. Record review of Resident #2's Order Summary Report dated 12/5/25 revealed the following: - Lorazepam 0.5 mg tablet every 4 hours as needed for anxiety/agitation with order date 11/7/25 and no end date. - Seroquel 25 mg tablet one time a day for hallucinations; give with 50 mg tablet to equal 75 mg with order date 12/1/25 and no end date. - Trazadone 100 mg tablet one time a day for insomnia with order date 10/29/25 and no end date. Record review of Resident #2's comprehensive care plan with revision date 12/2/25 revealed a focus area related to the use of psychotropic medications related to anxiety, depression, and history of hallucinations with interventions that included medication management to provide psychiatric services, administer medications as ordered, and consult with pharmacy, and MD to consider dosage reduction when clinically appropriate. Record review of the DRR for the residents by the Pharmacy Consultant dated 11/28/25 did not include Resident #2. During an interview on 12/5/25 at 10:42 a.m., the DON stated she would have to refer to the Pharmacy Consultant to determine why Resident #2 did not get a DRR for November 2025. During a follow up interview on 12/5/25 at 10:55 a.m., the DON stated she spoke with the Pharmacist Consultant and stated Resident #2 was not a part of the DRR because the resident was receiving respite care. During a telephone interview on 12/5/25 at 11:33 a.m., the Pharmacist Consultant stated she had been misinformed during a meeting in which she assumed a resident who was receiving respite care did not require a DRR. The Pharmacist Consultant stated she referred to her supervisor and was told that every resident who resided in the facility, regardless of status, including respite residents, were supposed to be included in the DRR. The Pharmacist Consultant stated the DRR was important because it ensured they followed regulations, and to ensure the medication therapy was appropriate. Record review of the facility document titled, Medication Regimen Reviews dated 7/1/18 revealed in part, . The Consultant Pharmacist shall review the medication regimen of each resident at least monthly. The Consultant Pharmacist will perform a medication regimen review (MRR) for every resident in the facility. Routine reviews will be done monthly.		

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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. Based on interview and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. 1. The facility failed to maintain the temperature of walk-in refrigerator at or below 41 degrees F in November 2025.2. The facility failed to maintain the temperature of the milk refrigerator at or below 41 degrees F in December 2025.3. The facility failed to take temperatures for the cold foods (to include tossed salad on 12/03/25, milk and orange juice on 12/01/25, 12/02/25 and 12/04/25). These failures could place residents at risk for food borne illness.The findings included: Record review of Refrigerator Temperature-walk in, dated November 2025, reflected the following days had temperatures that were above 41 degrees Fahrenheit:(day: degrees Fahrenheit for morning and/or evening)6: evening 42 (signature unknown)7: evening 43 (signature unknown)15: evening 43 (signed by [NAME] I)19: morning 42 (signature unknown), evening 43 (signature unknown) Record review of Refrigerator Temperature-milk, dated December 2025, reflected the refrigerator was 42 degrees Fahrenheit (signed by Dietary Aide J) for the night shift on 12/02/25. Record review of Week at a Glance, dated 12/02/25, reflected Tossed Salad was served on Wednesday (12/03) with no temperature taken for tossed salad on Service Line Checklist, dated 12/03/25 and unauthored. Record review of Week at a Glance further reflected milk and orange juice were served for breakfast on 12/01/25, 12/02/25 and 12/04/25 with no temperature documented on the Service Line Checklist for milk and orange juice on 12/01/25, 12/02/25, and 12/04/25. Interview on 12/04/2025 at 6:11 PM, [NAME] I revealed he took temperatures of cold foods and knew if the temperature was above 41 degrees Fahrenheit he had to close the door, tell someone, and take the temperature again. He revealed it was important for food to be at the right temperature because people could get sick and food could spoil. He revealed he did not take temperatures of cold foods/drinks before meal service, and the dietary aide would do this. Interview on 12/04/25 at 06:14 PM, Dietary Aide J revealed she had not had any temperatures for cold foods that were above 41. She revealed if cold foods were above 41, then she would tell the dietary manager. She revealed it was important for food to be at the appropriate temperature, so the food did not spoil. She further revealed she assumed that residents could get sick if food wasn't at the appropriate temperature. She revealed she did not take temperatures of cold items right before meal service and the line cook took these temperatures. Interview on 12/05/25 at 02:18 PM, the CDM and Corporate Dietary Manager revealed it was important to ensure temperatures were within appropriate range to prevent food borne illnesses. They revealed they would communicate with the team on having foods within appropriate temperature and who needed to take temperatures at meal service. Interview on 12/05/25 at 05:34 PM, the DON revealed there had not been any foodborne illness outbreaks in the facility this year. Record review of the FDA Food Code 2022, U.S. Department of H&HS, revealed 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (2) At 5 C (41 F) or less. Record review of the facility's policy Food: Preparation, revised 02/2025, reflected 14. All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit for hot holding, and less than 41 degrees Fahrenheit for cold food holding. Record review of the facility's policy Food Storage: Cold Foods, revised 02/2023, reflected 2. All perishable foods will be maintained at a temperature of 41 degrees of Fahrenheit or below, except during necessary periods of preparation and service.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 and to help prevent the development and transmission of communicable disease and infection for 1 of 5 residents (Resident #10) reviewed for infection control: The facility failed to ensure LVN K cleaned an insulin pen's rubber seal with an alcohol swab prior to insulin administration for Resident #10. This failure could place residents at risk for cross contamination and infection due to improper care practices. The findings included: Record review of Resident #10's face sheet dated 12/4/25 revealed a [AGE] year old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included type 2 diabetes (a chronic medical condition in which the body does not use insulin effectively and over time may also not produce enough insulin causing blood glucose levels to become too high), metabolic encephalopathy (a temporary or permanent disturbance of brain function caused by an imbalance in the body's chemistry), and gout (a form of inflammatory arthritis caused by a buildup of uric acid crystals in the joints leading to sudden, severe pain and swelling). Record review of Resident #10's Order Summary Report dated 12/4/25 revealed the following:- Insulin Lispro injection 100 unit/ml, inject as per sliding scale subcutaneously three times a day for diabetes, with order date 2/3/25 and no end date. During the observation of the medication pass on 12/4/25 at 11:48 a.m., LVN K prepared Resident #10's insulin Lispro and placed an insulin needle through the insulin pen's rubber seal without cleaning the rubber seal with an alcohol wipe prior to administering the insulin. During an interview on 12/4/25 at 12:04 p.m., LVN K stated he was unsure if the rubber seal on Resident #10 insulin pen was supposed to be cleaned with an alcohol wipe. LVN K stated, I probably should have cleaned the rubber seal first before piercing it with a needle because it was a break in infection control and could result in cross contamination. LVN K stated the risk of cross contamination could result in the resident getting an infection. During an interview on 12/4/25 at 3:19 p.m., the DON stated it was her expectation for nursing to clean the rubber seal from an insulin pen with an alcohol wipe because it needs to be clean. The DON stated it was important to make sure it's (rubber seal on the insulin pen) not dirty before the needle is inserted because the resident could get an infection and it was considered an infection control issue. Record review of the document titled INSTRUCTIONS FOR USE Insulin Lispro KwikPen injection for subcutaneous use with revision date July 2023 revealed in part, .Always use a new needle for each injection to help prevent infections. Pull the Pen Cap straight off. Wipe the Rubber Seal with an alcohol swab.		