

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  08/09/2024
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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47611</b></p> <p>Based on interview and record review, the facility failed to ensure each resident was free of any significant medication errors for 1 of 6 residents (Resident #4) reviewed for medications.</p> <p>The facility failed to prevent Resident #4 from being administered incorrect medications of Seroquel 50 mg PO and Ativan 0.5 mg PO.</p> <p>This deficient practice could result in a risk to the residents' health and complications which can lead to an infection, injury or death.</p> <p>The findings included:</p> <p>Record review of resident #4's Face Sheet, dated 8/06/2024, showed resident was admitted on [DATE] with diagnosis of chronic respiratory failure, type 2 diabetes and hypertension (high blood pressure).</p> <p>Record review of the Facility Incident Report, dated 3/15/2024, reflected MA failed to correctly identify Resident #4 prior to medication administration and Resident #4 was administered Seroquel 50 mg PO and Ativan 0.5 mg PO.</p> <p>Record review of Resident #4's doctors' orders, dated 3/12/2024 showed no medication orders for Seroquel or Ativan.</p> <p>In an interview on 8/06/2024 at 11:11 am via phone call MA stated that there was no name on Resident #4's door and when she entered the room, she had asked Resident #4's name. She stated that Resident #4's RP was present in the room and neither corrected nor verified MA's question. She then administered the medications to the resident.</p> <p>In an interview on 8/6/24 at 11:19 am RN A stated she was made aware of the medication error by the RP and returned to the facility to assess the resident. She stated the resident was administered Seroquel 50 mg PO and Ativan 0.5 mg PO. She verified that the resident had no such medication orders.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy titled, Administering Medications, dated 11-25-2017, reflected The individual administering the medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident may include: a. Checking identification band; b. Checking photograph attached to medical record; c. Calling resident by name, and; d. If necessary, verifying identification with other facility personnel.</p> <p>The facility course of action prior to surveyor entrance included:</p> <p>MA resigned before she was terminated.</p> <p>Review of in-services administering medications, resident rights, ANE, and Professionalism/Customer Service were completed between 3/11/2024 and 3/13/2024.</p> <p>Review if an in-service, dated 3/11/2024 related to medication administration revealed eleven signatures.</p> <p>Review if an in-service, dated 3/13/2024 related to resident rights revealed fifteen signatures.</p> <p>Review if an in-service, dated 3/13/2024 related to abuse and neglect revealed twenty-nine signatures.</p> <p>Review if an in-service, dated 3/13/2024 related to professionalism/customer service revealed fifteen signatures.</p> <p>Interviews with eleven employees who consisted of employees on the day shift, mid-shift and night-shift and consisted of RN's, LVN's and MA's began from 8/07/2024 at 10:34 am to 8/08/2024 at 2:38 pm and revealed they had received in-services on administering medications, resident rights, ANE, and professionalism/customer service.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47611</p> <p>Based on observations, interviews, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relayed the call directly to a centralized staff work area for 1 of 12 residents (Resident #77) reviewed for call lights.</p> <p>The facility failed to ensure Resident #77's emergency call button in the bedroom was operating properly.</p> <p>This failure could place residents at risk of injury, pain, and hospitalization .</p> <p>The findings included:</p> <p>Record review of a face sheet dated 8/09/2024 for Resident #77 indicated he was a 94-year male admitted [DATE] with re-admitted [DATE] with diagnosis of dementia (the loss of cognitive functioning), atherosclerosis (thickening of the arteries caused by plaque), and cerebral ischemic attack (mini stroke that happens in the brain).</p> <p>Record review of a quarterly MDS dated [DATE] for Resident #77 indicated he had a BIMS score of 09 indicating moderate cognitive impairment and that he was dependent on staff with ad'l's.</p> <p>Record review of a care plan dated 7/23/2024 for Resident #77 indicated he was incontinent of bowel and bladder and was dependent on staff for assistance.</p> <p>During an observation on 8/08/2024 at 2:20 pm the bedroom call button in Resident #77's room was not functioning and had exposed wires.</p> <p>During an interview on 8/8/24 at 2:24 pm with LVN A she observed and verified the call light was not working. She verified that the potential for harm towards the resident could be an injury, pain or hospitalization .</p> <p>During an interview on 8/8/24 at 2:55 pm the maintenance director stated the call light wires were not connected. He stated he fixed the issue and that the call light was functioning properly.</p> <p>Record review for policy titled, Answering the Call Light, dated June 2012, indicated, Be sure the call light is plugged in at all times. Report all defective lights to the Nurse Supervisor promptly.</p>		