STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676495	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Starr County Nursing and Transitional Care	5260 Brand St Rio Grande City, TX 78582

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828 Based on observations, interview and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preference for one (Resident #2) of four residents reviewed for call light. The facility failed to ensure Resident #2's call light was within reach. This failure could place residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings were: Record review of Resident #2's face sheet dated 07/18/2024 reflected an [AGE] year-old male with an admitted [DATE]. Resident #2's relevant diagnoses included cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it), unsteadiness on feet, need for assistance with personal care, and lack of coordination. Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 04, which indicated Resident #2's cognition was severely impaired. Record review of Resident #2's quarterly comprehensive care plan dated 04/29/24 reflected: Problem: the resident was at risk for falls related to weakness and debility. Interventions: be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance. Date initiated: 08/12/2022. An observation on 07/17/24 at 2:45 p.m., Resident #2 was lying awake in bed, his bed was set to the lowest position. Resident #2's call light was not within reach or sight. An interview on 07/17/24 at 2:48 p.m., Resident #2 said he did not know where his call light was. He said whenever he needed assistance, he would call out for help or would wheel himself to the front of his door to get the staff's attention. Resident #2 said would rarely use the call light. (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: 676495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation on 07/17/24 at 2:56 p.m., CNA A said Resident #2 was able to use the call light, but he preferred calling out for help. Surveyor observed CNA A looking for Resident #2's call light and she found it inside his dresser drawer next to his bed. She said she was not sure why it was there but that it should have been within Resident #2's reach. CNA A said she would round resident's rooms every two hours or as needed. She said one of the things she checked when doing her rounds was to make sure resident's bed was set to the lowest position and their call light was within reach. CNA A said a negative outcome for Resident #2 not having his call light within reach could be not receiving the assistance he needed in case he fell . She said she had been in-serviced on making sure the resident's call light were always within reach when she was first hired and monthly after that. An interview on 07/17/24 at 3:10 p.m., CNA B said she had been assigned to Resident #2's room on 07/17/2024. She said her shift on 07/17/2024 was 6 a.m. to 6 p.m. CNA B said she had already rounded Resident #2's room between 3 to 4 times since her shift began. CNA B said Resident #2 had been showered in the morning and while he was being showered, she changed his linen. CNA B said she remembered placing Resident #2's call light inside his dresser drawer next to his bed and must have forgotten to take it out and place on his bed when she was done. CNA B said she had not noticed Resident #2's call light was not within reach the 3 other times she had gone into his room. She said Resident #2 rarely used his call light, she said he preferred calling out for help. CNA B said she had not told her charge nurse that Resident #2 did not like to use his call light. She said a negative outcome for Resident #2 not having his call light within reach could an injury. She said she had been in-serviced on making sure the resident's call light were always within reach when she was first hired and monthly after that. An interview on 07/17/24 at 3:19 p.m., LVN C said she was Resident #2's charge nurse on 07/17/24. LVN C said she and CNA's rounded each resident every 2 hours or as needed. LVN C said she had already made several rounds to resident #2's room that day and had not noticed his call light was not within reach. LVN C said Resident #2 rarely used his call light. She said when he needed something, he would yell out or wheeled himself to the door to motion a staff member. She said she had not told the DON that Resident #2 did not like to use the call light. LVN C said a negative outcome for Resident #2 not having his call light within reach could be him not receiving the care he needed. An interview and observation on 07/17/24 at 3:25 p.m., ADON/LVN D said Resident #2 was able to use the call light but preferred yelling out when he needed something. Surveyor observed ADON-LVN D ask Resident #2 to press his call light to verify that he was able to use it. Resident #2 was observed pressing the call light and saying he knew to press it when he needed assistance. ADON-LVN D said a negative outcome to Resident #2 not having his call light within reach would be staff would not know resident needed help at that moment. She said all staff are in-serviced on making sure resident's call lights are within reach when they are first hired and monthly after that. An interview on 07/18/2024 at 4:00 p.m. the Administrator said the ADON's had audited all residents on 07/17/2024 to make sure their call lights was within reach. She was not able to say what negative outcome could be if a resident did not have their call light within reach. Record review of the facility's Call Lights: Accessibility and Timely Response policy dated 10/13/2022 reflected: Policy: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The purpose of this policy is ot assure the facility is adequately equipped with a call light at teach resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Policy Explanation and Compliance Guidelines: 1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light 5. Staff will ensure the call light is within reach of resident and secured, as needed.

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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 49301

Based on interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #1) of 3 residents reviewed for accuracy of assessments.

The facility failed to ensure Resident #1 was coded in the MDS for a fall on 2/16/24.

This failure could place residents at risk of receiving care and services to meet their needs.

The findings included:

Record review of Resident #1's face sheet dated 07/18/24 reflected Resident #1 was admitted on [DATE] and was [AGE] years old. Resident #1 had diagnoses of subsequent encounter of fracture of shaft of humerus to right arm, muscle weakness, age-related osteoporosis, dementia, and mood disorder.

Record review of Resident #1's comprehensive care plan reflected: Resident #1 had an actual fall r/t muscle wasting/atrophy, lack of coordination, and difficulty walking.

2/15/2024 1:30 pm witnessed fall, no injury.

Date Initiated: 01/27/2024.

Revision on: 03/10/2024

Interventions included: o 2/16/2024: Orthopedic Consult

Record review of Resident #1's Discharge MDS dated [DATE] revealed:

Short-term memory problem modified independence with some difficulty in new situations only.

Required substantial/maximal assistance for self-care except eating and oral hygiene supervision/touching assistance, and upper body dressing partial/moderate assistance.

Required substantial/maximal assistance for mobility.

No falls since Admission/Entry or Reentry or Prior MDS Assessment.

Record review of Resident #1's progress notes dated 2/15/2024 at 10:47 a.m., written by LVN D indicated SN was made aware by therapist that resident was on floor in dining room. SN went to assess resident and was laying supine on floor. Resident able to move all extremities with no pain or distress voiced. SN assessed head and noted no redness. As per staff, they didn't hear the fall but when they look resident was already on the floor. SN notified NP no new orders given. Neuro checks initiated. SN notified RP, but no answer. Resident unable to give description.

(continued on next page)

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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	Record review of a progress note for Resident #1 dated 2/15/2024 at 12:28 p.m., written by LVN E indicated Resident noted abnormal movements. Resident trying to get off wheelchair. Noted with uncoordinated movement. NP made aware. Neuro checks in place. New orders for Hydroxyzine 25mg q12hrs x 14day. SN will pass on report. Orders carried out. Record review of the facility's incident log not dated revealed that on 2/15/24, Resident #1 had a witnessed fall on. No other information is noted on the facility log. During an interview on 7/17/24 at 4:34 p.m., MDS-RN - Care Management Specialist said she had worked at the facility for four months. She said that a fall with a fracture should be captured on the following MDS, in this Resident's case, the Discharge MDS. She said that it had not been captured by MDS. During an interview on 7/17/24 at 5:00 p.m., ADON-LVN D said the fall should have been captured on the MDS by the MDS department. She said that the care plan and MDS are an interdisciplinary team effort. She said that if the MDS and care plan are not updated, staff would not know that the care plan is current with the resident needs. Record review of CMS's RAI Version 3.0 Manual dated 10/2023, , reflected section: J1800: Any falls since admission/entry or reentry or Prior to Assessment. Coding instructions: Code 1, yes if the resident has fallen since the last assessment. Continue to number of falls since admission/entry or reentry or prior to assessment. J1900: Any falls since admission/entry or reentry or Prior to Assessment. Coding instructions: Code 1, yes if the resident had one non-injurious fall since admission/entry or reentry or prior assessment.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47828 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 2 of 7 residents (Resident #1 and Resident #3) reviewed for care plans, in that: 1. The facility failed to ensure Resident #1's care plan revised on 03/10/2024 reflected an injury for a witnessed fall on 02/15/2024. 2. The facility failed to ensure Resident #3's quarterly care plan dated 03/28/2024 reflected an un-witnessed fall he had on 02/29/2024. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The Findings included: 1. Record review of Resident #1's face sheet dated 07/18/24 reflected Resident #1 was admitted on [DATE] and was [AGE] years old. Resident #1 had diagnoses of subsequent encounter of fracture of shaft of humerus to right arm, muscle weakness, age-related osteoporosis, dementia, and mood disorder. Record review of Resident #1's Discharge MDS dated [DATE] reflected the resident: Short-term memory problem modified independence with some difficulty in new situations only. Required substantial/maximal assistance for self-care except eating and oral hygiene supervision/touching assistance, and upper body dressing partial/moderate assistance. Required substantial/maximal assistance for mobility. BIMS score of 1 which indicated Resident #1's cognition was severely impaired. Record review of Resident #1's comprehensive care plan reflected: Resident #1 had an actual fall r/t muscle wasting/atrophy, lack of coordination, and difficulty walking. 2/15/2024 1:30 witnessed fall, no injury. Date Initiated: 01/27/2024. Revision on: 03/10/2024 Interventions included: o 2/16/2024: Orthopedic Consult (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/17/24 at 4:34 pm interviewed MDS-RN - Care Management Specialist. She said that a fall with injury should be updated on the care plan by the ADON or DON. On 7/17/24 at 5:00 pm interviewed ADON-LVN D. She said that the fall on 2/15/24 initially was care planned without injury. She said that on 2/16/24, they received results of x-rays, and the injury should have been updated on the care plan. She looked up the resident's care plan and said the injury was not updated on care plan. She said that it should have been updated to fall with injury. She said that if the MDS and care plan are not updated, staff would not know that the care plan is current with the resident needs. 2. Record review of Resident #3's face sheet dated 07/17/2024 reflected an [AGE] year-old male with an admitted [DATE] and an original admitted [DATE]. Resident #3 was discharged on [DATE]. Resident #3's relevant diagnoses included cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it), Parkinson's Disease (a disorder of the central nervous system that affects movement), dementia (a group of thinking and social symptoms that interfere with daily functioning), diabetes (too much sugar in the blood), and lack of coordination. Record review of Resident #3's quarterly assessment dated [DATE] reflected no BIMS score which indicated Resident #3's cognition was severely impaired. Record review of Resident #3's quarterly care plan dated 03/28/2024 reflected [Resident #3] had an actual fall r/t muscle wasting/atrophy, lack of coordination, and difficulty walking on 04/01/2024 un-witnessed fall, with no injury and 04/10/2024 un-witnessed fall, laceration to posterior head. The un-witnessed fall he had on 02/29/2024 was not care planned. An interview on 07/17/2024 at 3:31 p.m., MDS-RN said she was new to her position and would rather have surveyor interview one of the facility's ADON's. An interview and observation on 07/17/2024 at 5:00 p.m., ADON-LVN D was observed checking Resident #3's electronic record and said after she reviewed his care plan that she was not sure if the un-witnessed fall Resident #3 had on 02/29/2024 had been care planned. She said the fall Resident #3 sustained on 02/29/2024 should have been care planned. ADON-LVN said she was going to check with MDS if it had been care planned. An interview on 07/17/2024 at 5:32 p.m., ADON-RD D said the un-witnessed fall Resident #3 had on 02/29/2024 had not been care planned. She was not able to say if Resident #3 had any negative outcome for the fall not being care planned because he had already been discharged . Record review of facility's Care Plan Revisions Upon Status Change policy dated 10/24/22 reflected: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change . f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. 49301