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	09/26/2024

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 2 of 5 residents (Resident#4 and Resident #5) reviewed for abuse and neglect, in that: Facility staff member, LVN A did not implement facility abuse policy related to reporting abuse to the Administrator when Resident #4 and Resident #5 got into an altercation on 05/21/24. This failure could place residents at risk of abuse and neglect. The findings included: Record review of Resident #4's face sheet, dated 09/26/24, reflected the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: Alzheimer disease (progressive disease that destroys memory and other important mental functions) with late onset, flaccid hemiplegia (one side of the body is completely and permanently paralyzed) affecting right dominant side, dysphagia oropharyngeal phase (difficulty swallowing). Record review of Resident #4's state optional minimum data set assessment (MDS), dated [DATE], reflected Resident #4 was rarely/never understood and did not have a BIMS conducted. Record review of Resident #4's care plan with an initiated date of 07/11/23 reflected 5/21/24 - [Resident #4] was pulled off from bed by resident A [SIC]. As per resident A, he felt confused while looking for his bed and pulled resident on bed B off of bed. with an initiated date of 07/21/23 and a revision date of 08/12/24. (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 09/26/2024
NAME OF PROVIDER OR SUPPLIER Starr County Nursing and Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 5260 Brand St Rio Grande City, TX 78582	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of resident #4's nursing note written by LVN A with an effective date of 05/21/24 at 2:19am stated, CNA notified SN (staff nurse) that both residents in room were in a physical altercation. Sn went to room to assess. [Resident #5] was sitting on his right side of his bed. Bed at mid position with wheels locked, call light within reach. [Resident #4] was on the right side to his bed on the floor facing down with [Resident #5's] cane under him. Bed at lowest position with call light within reach. Resident is nonverbal, when asked if he hit [Resident #5] resident shook his head side to side. When asked if [Resident #5] hit him, resident nodded his head up and down. When asked if [Resident #5] dragged him off of bed, resident nodded head up and down. head to toe assessment down [SIC] while resident was lying on floor. No visible injuries noted. With assistance by CNAs, readjusted resident to sitting position on floor, head to toe assessment done, noted redness to left forearm, redness to right flank, and redness to right side of face. With assistanceof cnas, transferres [SIC] resident back on to bed. Head to toe assessment done again, redness to left forearm noted, redness to right flank, and redness to right side of face noted at the time. Resident denies pain and shows no nonverbal cues of pain. Resident is smiling back at sn. Bed at lowest position with call light within reach. Pending to notify RP and PCP. Record review of Resident #4's weekly skin evaluation dated 05/21/24 reflected, redness to left knee, left hand and right hand. Record review of Resident #5's face sheet, dated 09/26/24, reflected the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: Blindness (lack of vision) right eye category 3 (visual acuity of worse than 3/60 and better than 1/60), blindness (lack of vision) left eye category 3 (visual acuity of worse than 3/60 and better than 1/60), paranoid schizophrenia (paranoia that feeds into delusions and hallucinations), bipolar disorder (extreme shifts in mood), current episode mixed, severe, with psychotic features, schizoid personality disorder (avoiding social activities and interacting with others) Record review of Resident #5's state optional minimum data set assessment (MDS), dated [DATE], reflected Resident #5 had a BIMS score of 06 indicating he had severe cognitive impairment. Record review of Resident #5's care plan with an initiated date of 08/11/22 reflected 5/21/24 - [Resident #5] stated he felt confused while looking for his bed and pulled resident on bed B off of the bed. with an initiated date of 06/19/23 and a revision date of 05/23/24. Record Review of Resident #5's nursing notes dated 05/21/24 stated, Sn was walking out of storage when cna notified sn that both residents in room were in a physical altercation. Sn went to room to assess. [Resident #5] was sitting on his right side of his bed. Bed at mid position with wheels locked, call light within reach. [Resident #4] was on the right side to his bed on the floor facing down with [Resident #5's] cane under him. Bed at position with call light within reach. Resident stated he was lost and confused looking for his bed, stated he got to his bed someone hit him. Resident stated he hit person back with his cane and dragged him from bed. When asked if resident also fell to the floor, resident stated yes, denies any pain, no loss of consciousness [SIC], stated he hit his right temporal. Resident fell when he pulled [resident #4] from bed. Resident stated he got himself up and sat down to the right of his bed. Head to toe assessment done, redness to right temporal noted. No other injuries noted, denies pain or discomfort at the time. Good range of motion noted to BUE and BLE. Able to verbilize [SIC] needs at the time. Offered pain medication, denied at the time. Reoiented [SIC] and reeducated resident on the importance on not being violent and or physical. [Resident #5] denied hitting resident first after being reeducated. Pending to notify RP and PCP. (continued on next page)

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 09/26/2024
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's weekly skin evaluation dated 05/21/24 reflected, redness to left temporal at the time. During an interview with Resident #5 on 09/24/24 at 11:10 am he stated he did not recall an incident specifically with Resident #4 or any resident. During an interview with Resident #4 on 09/24/24 at 11:42am he was unable to clearly answer questions due to limited gestures used for communication. During an interview with CNA B on 09/25/24 at 1:24pm she stated there was one night that she responded to a scream from a resident who had told her he heard Resident #5 scream and went to go check along with CNA B. CNA B stated everyone went to go assess the situation and saw Resident #5 angry and was stating that Resident #4 was in his bed, however CNA B stated at that time Resident #4 was actually in his correct bed and Resident #5 was confused. CNA B stated they had spoken to Resident #5, and he had told them the whole situation. CNA B stated they believed Resident #5 tried to push Resident #4 off the bed. CNA B stated LVN A went to assess the residents for any injuries. CNA B stated she was not sure who LVN A notified of the altercation. During an interview with LVN A on 09/25/24 at 3:36pm who stated she stated she could not recall the exact date but stated she was notified by an aide that there had been a fight with Resident #4 and Resident #5 and Resident #4 was on the floor. LVN A stated when she entered the room Resident #4 was on the floor and Resident #5 was sitting on his bed. LVN A stated Resident #4 was found to have some redness to his face, arm and somewhere on his abdomen and Resident #5 had some redness to his face. LVN A stated she completed her risk management/incident report documents for both residents and had completely forgotten to make the appropriate notifications. LVN A stated she went home and later that morning received a call from the facility after they had reviewed the risk management documents in the morning and asked her what happened. LVN A stated she had to return to the facility that morning and complete the report and notify the police and appropriate parties. LVN A stated the facility did write her up due not making the appropriate notifications. During a follow up interview with LVN A on 09/25/24 at 4:48pm who stated the abuse coordinator was responsible for training staff over abuse and the reporting process however she was unable to recall who the abuse coordinator was. LVN A stated incidents of abuse should be reported to the DON, the resident's family and the doctor. LVN A stated she considered the altercation between Resident #4 and Resident #5 as abuse and stated it should have been reported to the DON, Administrator and MD/NP. LVN A stated she had not reported it because she lost track of time and had forgotten. LVN A stated it was important to report abuse because of the change in condition to the residents and safety. LVN A stated she had been trained over the facility abuse policy both at orientation and after the altercation with Resident #4 and Resident #5 and stated it said to report immediately. LVN A stated she did not follow the facility abuse policy. LVN A stated she monitored residents to ensure they were free from abuse and neglect by completing her observations of the residents and how they get along with others and their interactions with aides and the care the aides were providing. LVN A stated not reporting incidents of abuse could negatively impact the residents because if it is not reported then no interventions would be put place, and residents can decline emotionally and physically if in an environment of abuse and neglect. (continued on next page)

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER: Starr County Nursing and Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 5260 Brand St, Rio Grande City, TX 78582	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 09/25/24 at 5:10pm who stated staff had been trained over abuse and the reporting process by her on a regular basis. The administrator stated she was the abuse coordinator and stated staff should report incidents of abuse to her. The Administrator stated there was a resident to resident altercation with Resident #4 and #5 when Resident #5 was confused and believed he was getting into his own bed when it was Resident #4's bed. When this occurred Resident #4 became combative defending himself and he and Resident #5 got into an altercation when then Resident #5 pulled Resident #4 out of the bed and onto the floor. The Administrator stated both residents were assessed by LVN A with slight redness to left knee, left and right hand for Resident #4 and slight redness to the temporal area for Resident #5, the Administrator stated neither resident voiced pain at time of assessment. The Administrator stated LVN A completed the appropriate risk management/incident report documentation but failed to make the appropriate notifications. The Administrator stated she got report during their morning meeting on 05/21/24 at around 9:00am that an incident occurred around 2am that morning. The Administrator stated she made a self-report on 05/21/24 at 9:30am after becoming aware of incident. The Administrator stated LVN A should have reported the altercation between Resident #4 and #5 to herself and the DON. The Administrator stated she did not know why LVN A did not report the incident and stated although she was a new employee she had been trained over reporting upon orientation. The Administrator stated due to Resident #4 and Resident #5's BIMS score and confusion she did not consider the altercation between Residents #4 and #5 abuse and stated Resident #5 stated he did not mean to hurt anyone and had thought someone was in his bed and when he felt someone fight back, he became defensive. The Administrator stated it was important to report abuse to the appropriate parties to prevent abuse and ensure patient safety. The Administrator stated the facility policy was similar to the regulations in place and stated all allegations should be reported to administrator and state agencies immediately and no later than 2 hours after if it's from abuse and no later than 24 hours if the incident did not involve abuse. The Administrator stated LVN A did not follow the facility policy. The Administrator stated she monitored residents to ensure they were free from abuse by ensuring direct care staff, leadership team and the physicians completed their rounds and reported any changes. The Administrator stated residents were also educated on how to report by her and through their resident council meetings. The Administrator stated not reporting incidents of abuse could negatively impact the resident because it puts them at risk if it was not reported. During an interview with the DON on 09/25/24 at 6:45pm who stated she had started to work at the facility on 07/01/24 and was not working at the facility at time of the incident between Resident #4 and Resident #5 in May 2024. Record review of facility in-services reflected LVN A had been trained over reporting incidents on 05/06/24. Record review of a document titled, EMPLOYEE COUNSELING REPORT reflected on 05/21/24 LVN A received counseling over her failure to report an incident in a timely manner. Record review of facility policy titled Abuse, Neglect and Exploitation with an implementation date of 08/15/22 included a section titled, Reporting/Response that included the following verbiage: A. The facility will have written procedures that include: (continued on next page)

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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

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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 09/26/2024
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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 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45737

Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (which included to the State Survey Agency) in accordance with State law through established procedures for 2 of 5 residents (Resident #4 and Resident #5) reviewed for reporting alleged allegation of abuse.

Facility staff member, LVN A did not report to the Administrator within 2 hours when Resident #4 and Resident #5 got into an altercation.

This failure could place residents at risk for undetected abuse, neglect and/or decline in feelings of safety and well-being.

The findings included:

Record review of Resident #4's face sheet, dated 09/26/24, reflected the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: Alzheimer disease (progressive disease that destroys memory and other important mental functions) with late onset, flaccid hemiplegia (one side of the body is completely and permanently paralyzed) affecting right dominant side, dysphagia oropharyngeal phase (difficulty swallowing).

Record review of Resident #4's state optional minimum data set assessment (MDS), dated [DATE], reflected Resident #4 was rarely/never understood and did not have a BIMS conducted.

Record review of Resident #4's care plan with an initiated date of 07/11/23 reflected 5/21/24 - [Resident #4] was pulled off from bed by resident A [SIC]. As per resident A, he felt confused while looking for his bed and pulled resident on bed B off of bed. with an initiated date of 07/21/23 and a revision date of 08/12/24.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of resident #4's nursing note written by LVN A with an effective date of 05/21/24 at 2:19am stated, CNA notified SN (staff nurse) that both residents in room were in a physical altercation. Sn went to room to assess. [Resident #5] was sitting on his right side of his bed. Bed at mid position with wheels locked, call light within reach. [Resident #4] was on the right side to his bed on the floor facing down with [Resident #5's] cane under him. Bed at lowest position with call light within reach. Resident is nonverbal, when asked if he hit [Resident #5] resident shook his head side to side. When asked if [resident #5] hit him, resident nodded his head up and down. When asked if [Resident #5] dragged him off of bed, resident nodded head up and down. head to toe assessment down [SIC] while resident was lying on floor. No visible injuries noted. With assistance by CNAs, readjusted resident to sitting position on floor, head to toe assessment done, noted redness to left forearm, redness to right flank, and redness to right side of face. With assistanceof cnas, transferres [SIC] resident back on to bed. Head to toe assessment done again, redness to left forearm noted, redness to right flank, and redness to right side of face noted at the time. Resident denies pain and shows no nonverbal cues of pain. Resident is smiling back at sn. Bed at lowest position with call light within reach. Pending to notify RP and PCP. Record review of Resident #4's weekly skin evaluation dated 05/21/24 reflected, redness to left knee, left hand and right hand. Record review of Resident #5's face sheet, dated 09/26/24, reflected the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: Blindness (lack of vision) right eye category 3 (visual acuity of worse than 3/60 and better than 1/60), blindness (lack of vision) left eye category 3 (visual acuity of worse than 3/60 and better than 1/60), paranoid schizophrenia (paranoia that feeds into delusions and hallucinations), bipolar disorder (extreme shifts in mood), current episode mixed, severe, with psychotic features, schizoid personality disorder (avoiding social activities and interacting with others) Record review of Resident #5's state optional minimum data set assessment (MDS), dated [DATE], reflected Resident #5 had a BIMS score of 06 indicating he had severe cognitive impairment. Record review of Resident #5's care plan with an initiated date of 08/11/22 reflected 5/21/24 - [Resident #5] stated he felt confused while looking for his bed and pulled resident on bed B off of the bed. with an initiated date of 06/19/23 and a revision date of 05/23/24. Record Review of Resident #5's nursing notes dated 05/21/24 stated, Sn was walking out of storage when cna notified sn that both residents in room were in a physical altercation. Sn went to room to assess. [Resident #5] was sitting on his right side of his bed. Bed at mid position with wheels locked, call light within reach. [Resident #4] was on the right side to his bed on the floor facing down with [Resident #5's] cane under him. Bed at position with call light within reach. Resident stated he was lost and confused looking for his bed, stated he got to his bed someone hit him. Resident stated he hit person back with his cane and dragged him from bed. When asked if resident also fell to the floor, resident stated yes, denies any pain, no loss of consciousness [SIC], stated he hit his right temporal. Resident fell when he pulled [Resident #4] from bed. Resident stated he got himself up and sat down to the right of his bed. Head to toe assessment done, redness to right temporal noted. No other injuries noted, denies pain or discomfort at the time. Good range of motion noted to BUE and BLE. Able to verbilize [SIC] needs at the time. Offered pain medication, denied at the time. Reoiented [SIC] and reeducated resident on the importance on not being violent and or physical. [Resident #5] denied hitting resident first after being reeducated. Pending to notify RP and PCP. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's weekly skin evaluation dated 05/21/24 reflected, redness to left temporal at the time. Record Review of TULIP (HHSC online incident reporting application) on 09/24/24 at 11:00 AM revealed a self-report received by the facility on 05/21/24 at 9:58AM regarding the altercation with Resident #4 and Resident #5, more than 2 hours after the altercation occurred. During an interview with Resident #5 on 09/24/24 at 11:10 am he stated he did not recall an incident specifically with Resident #4 or any resident. During an interview with Resident #4 on 09/24/24 at 11:42am he was unable to clearly answer questions due to limited gestures used for communication. During an interview with CNA B on 09/25/24 at 1:24pm she stated there was one night that she responded to a scream from a resident who had told her he heard Resident #5 scream and went to go check along with CNA B. CNA B stated everyone went to go assess the situation and saw Resident #5 angry and was stating that Resident #4 was in his bed, however CNA B stated at that time Resident #4 was actually in his correct bed and Resident #5 was confused. CNA B stated they had spoken to Resident #5, and he had told them the whole situation. CNA B stated they believed Resident #5 tried to push Resident #4 off the bed. CNA B stated LVN A went to assess the residents for any injuries. CNA B stated she was not sure who LVN A notified of the altercation. During an interview with LVN A on 09/25/24 at 3:36pm who stated she stated she could not recall the exact date but stated she was notified by an aide that there had been a fight with Resident #4 and Resident #5 and Resident #4 was on the floor. LVN A stated when she entered the room Resident #4 was on the floor and Resident #5 was sitting on his bed. LVN A stated Resident #4 was found to have some redness to his face, arm and somewhere on his abdomen and Resident #5 had some redness to his face. LVN A stated she completed her risk management/incident report documents for both residents and had completely forgotten to make the appropriate notifications. LVN A stated she went home and later that morning received a call from the facility after they had reviewed the risk management documents in the morning and asked her what happened. LVN A stated she had to return to the facility that morning and complete the report and notify the police and appropriate parties. LVN A stated the facility did write her up due not making the appropriate notifications. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview with LVN A on 09/25/24 at 4:48pm who stated the abuse coordinator was responsible for training staff over abuse and the reporting process however she was unable to recall who the abuse coordinator was. LVN A stated incidents of abuse should be reported to the DON, the resident's family and the doctor. LVN A stated she considered the altercation between Resident #4 and Resident #5 as abuse and stated it should have been reported to the DON, Administrator and MD/NP. LVN A stated she had not reported it because she lost track of time and had forgotten. LVN A stated it was important to report abuse because of the change in condition to the residents and safety. LVN A stated she had been trained over the facility abuse policy both at orientation and after the altercation with Resident #4 and Resident #5 and stated it said to report immediately. LVN A stated she did not follow the facility abuse policy. LVN A stated she monitored residents to ensure they were free from abuse and neglect by completing her observations of the residents and how they get along with others and their interactions with aides and the care the aides were providing. LVN A stated not reporting incidents of abuse could negatively impact the residents because if it is not reported then no interventions would be put place, and residents can decline emotionally and physically if in an environment of abuse and neglect. During an interview with the Administrator on 09/25/24 at 5:10pm who stated staff had been trained over abuse and the reporting process by her on a regular basis. The administrator stated she was the abuse coordinator and stated staff should report incidents of abuse to her. The Administrator stated there was a resident to resident altercation with Resident #4 and #5 when Resident #5 was confused and believed he was getting into his own bed when it was Resident #4's bed. When this occurred Resident #4 became combative defending himself and he and Resident #5 got into an altercation when then Resident #5 pulled Resident #4 out of the bed and onto the floor. The Administrator stated both residents were assessed by LVN A with slight redness to left knee, left and right hand for Resident #4 and slight redness to the temporal area for Resident #5, the Administrator stated neither resident voiced pain at time of assessment. The Administrator stated LVN A completed the appropriate risk management/incident report documentation but failed to make the appropriate notifications. The Administrator stated she got report during their morning meeting on 05/21/24 at around 9:00am that an incident occurred around 2am that morning. The Administrator stated she made a self-report on 05/21/24 at 9:30am after becoming aware of incident. The Administrator stated LVN A should have reported the altercation between Resident #4 and #5 to herself and the DON. The Administrator stated she did not know why LVN A did not report the incident and stated although she was a new employee she had been trained over reporting upon orientation. The Administrator stated due to Resident #4 and Resident #5's BIMS score and confusion she did not consider the altercation between Residents #4 and #5 abuse and stated Resident #5 stated he did not mean to hurt anyone and had thought someone was in his bed and when he felt someone fight back, he became defensive. The Administrator stated it was important to report abuse to the appropriate parties to prevent abuse and ensure patient safety. The Administrator stated the facility policy was similar to the regulations in place and stated all allegations should be reported to administrator and state agencies immediately and no later than 2 hours after if it's from abuse and no later than 24 hours if the incident did not involve abuse. The Administrator stated LVN A did not follow the facility policy. The Administrator stated she monitored residents to ensure they were free from abuse by ensuring direct care staff, leadership team and the physicians completed their rounds and reported any changes. The Administrator stated residents were also educated on how to report by her and through their resident council meetings. The Administrator stated not reporting incidents of abuse could negatively impact the resident because it puts them at risk if it was not reported. (continued on next page)

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	09/26/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 09/25/24 at 6:45pm who stated she had started to work at the facility on 07/01/24 and was not working at the facility at time of the incident between Resident #4 and Resident #5 in May 2024. Record review of facility in-services reflected LVN A had been trained over reporting incidents on 05/06/24. Record review of a document titled, EMPLOYEE COUNSELING REPORT reflected on 05/21/24 LVN A received counseling over her failure to report an incident in a timely manner. Record review of facility policy titled Abuse, Neglect and Exploitation with an implementation date of 08/15/22 included a section titled, Reporting/Response that included the following verbiage: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.