STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675974	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medina Valley Health & Rehabilitation Center	913 Hwy 90 W Castroville, TX 78009

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	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** 41937 Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were 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 (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 2 of 8 residents (Residents #1 and #2) reviewed for reporting allegations of abuse and neglect. 1. LVN B and the Administrator heard an allegation of physical and sexual abuse on behalf of Resident #2 and failed to report the allegation to the state agency when Resident alleged CNA C was rough and hugged and kissed her. 2. CNA C and the Administrator heard an allegation of neglect on behalf of Resident #1 and failed to report the allegation to the state agency when CNA C transferred Resident #1 with a mechanical lift by herself without assistance which caused transient pain to Resident #1's head. These failures could place residents at risk for abuse and neglect. The findings included : 1. A record review of Resident #2's admission record dated 10/10/2024 revealed an admitted [DATE] with diagnoses which included dementia (an umbrella term used to describe a range of neurological conditions affecting the brain that worsen over time. It is the loss of the ability to think, remember, and reason to levels that affect daily life and activities), depression, and anxiety. A record review of Resident #2's quarterly MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 04 which indicated severely impaired cognition. Further review revealed Resident #2 was assessed as needing Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort and Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for assistance with activities of daily life. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #2's care plan dated 10/10/2024 revealed, The resident has an ADL self-care performance deficit. Receiving restorative services. Resident is refusing to participate in her restorative nursing services, she does not want to have these services . Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function A record review of the facility's human resource records for CNA C revealed CNA C was terminated 12/12/2023 related to failures following facility's policies and procedures. Further review of the employee counseling form dated 11/28/2023 revealed, Resident complained of staff member rushing her during care speaking too loudly resident feels like her space is being invaded and she is rushed. Further review of employee counseling form revealed a handwritten statement authored by LVN B, On 11/28/23 at 8:00 AM resident #2 was crying in bed saying to CNA's and myself to not allow CNA C to take care of her. Resident #2 stated when CNA (C) talks that she talks too loud to me, to the point of shouting. Resident (#2) stated CNA (C) gets upset and states stop when resident attempts to make to participate in her own care and that CNA (C) wants to do everything at a fast pace and stated rough the Resident (#2) stated CNA (C) likes to hug and kiss and make her feel uncomfortable Resident (C) comforted by this nurse (LVN B) and reassured will prevent CNA (C) providing care. A record review of the Texas Unified Licensure Information Portal website accessed 10/09/2024, revealed no evidence of allegations of abuse, neglect, and or exploitation regarding Resident #2 for 11/28/2023. During an interview on 01/10/2024 at 01:15 PM Resident #2 was unable to participate in an interview nor recall historical details. 2. A record review of Resident #1's admission record dated 10/10/2024 revealed an admitted [DATE] with diagnoses which included Parkinson's disease with dyskinesia (a chronic brain disorder that causes movement problems, mental health issues, and other health concerns - a general term for a range of movement disorders that involve involuntary muscle movements) and dementia (an umbrella term used to describe a range of?neurological conditions affecting the brain that worsen over time. It is the loss of the ability to think, remember, and reason to levels that affect daily life and activities). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was an [AGE] year-old male admitted for long term care and supports for Parkinson's disease and difficulty moving. Resident #1 was assessed with a BIMS score of 08 which indicated mild cognitive impairment and was assessed as needing Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity for assistance with transfers. A record review of Resident #1's care plan dated 10/10/2024 revealed, The Resident (#1) has an ADL self-care performance deficit r/t Dementia, Impaired balance . TRANSFERS: (TD) x 2 Staff (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's human resource records for CNA C revealed CNA C was terminated 12/12/2023 related to failures following facility's policies and procedures. Further review of the employee counseling form dated 12/08/2023 revealed, used (name brand mechanical lift) lift by herself potentially harming Resident . employee has been educated and in-serviced on transfer policy in the past Further review of employee counseling form revealed a handwritten statement authored by CNA C revealed, Putting patient in bed with (name brand mechanical lift) didn't have backup so I did it on my own. While the (name brand mechanical lift) was on bed, it flip side wide, patient (Resident #1) hit his head on top of headboard, no beak on head, no redness.) Further review of employee counseling form revealed a handwritten statement authored by RN D, This writer, was notified by CNA (C) that patient had bumped his head against the headboard during a transfer from wheelchair to bed. Assessment began observed no bumps or bruises patient denied pain or discomfort at this time. A record review of Resident #1's nursing progress notes revealed RN D documented, Progress Note Focus: Effective Date: 12/8/2023 21:45:00 Department: Nursing Position: Licensed Vocational Nurse Created By: (RN D) Created Date: 12/8/2023 21:46:39 Note Text: VS: 97.5, 18r, 116/72, 72p, 99%ra. Alerted by CNA (C) that pt bumped his head against the headboard during a transfer into bed, assessment begun, no bumps, bruises or redness observed at this time, pt is on Eliquis 5mg bid. Notified RP (name of representative) of clinical situation approx. 1912, RP verbalized understanding. Notified on call for MD (name of doctor) approx. 1923, informed of clinical situation, NP (name of nurse practitioner) ordered to follow incident report facility protocol and initiate neuro checks . During an interview on 10/11/2024 at 12:48 PM, the Administrator stated the facility had recognized a need to improve performance with reporting allegations of ANE in August 2024 and have developed a performance improvement plan and currently are awaiting the QAPI committee to review and approve the plan. The Administrator stated the facility had not recognized the allegations made on behalf of Resident #1 and Resident #2, although CNA C was terminated for her actions on both incidents (11/28/2023 and 12/08/2023) and had not reported the allegations of abuse or neglect to the state agency. A record review of the facility's undated Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy revealed, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: . Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations

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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 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** 41937 Based on interviews and record reviews the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 (Resident #1) residents reviewed for 2 person staff assistance with mechanical lift transfers. CNA C transferred Resident #1 by herself, with a mechanical lift, and caused Resident #1 transient head pain. Resident #1 was assessed as needing more than 1 staff assistance with all transfers. The non-compliance was identified as past non-compliance. The noncompliance began on 12/8/23 and ended on 12/11/23. The facility had corrected the non-compliance before the survey began. This failure could place residents at risk for harm by neglecting to provide more than 1 staff assistance with mechanical lift transfers. The findings included: A record review of Resident #1's admission record dated 10/10/2024 revealed an admitted [DATE] with diagnoses which included Parkinson's disease with dyskinesia (a chronic brain disorder that causes movement problems, mental health issues, and other health concerns - a general term for a range of movement disorders that involve involuntary muscle movements) and dementia (an umbrella term used to describe a range of neurological conditions affecting the brain that worsen over time. It is the loss of the ability to think, remember, and reason to levels that affect daily life and activities). Record review of Resident #1's MDS assessment dated [DATE] (closest assessment to time of incident) revealed a BIMS score of 8 which indicated a moderate cognitive impairment and a functional status which included substantial/maximimal assistance needed for sit-to-stand and chair/bed transfers. A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was an [AGE] year-old male admitted for long term care and supports for Parkinson's disease and difficulty moving. Resident #1 was assessed with a BIMS score of 08 which indicated mild cognitive impairment and was assessed as needing Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity for assistance with transfers. A record review of Resident #1's care plan dated 10/10/2024 revealed, The Resident (#1) has an ADL self-care performance deficit r/t Dementia, Impaired balance . TRANSFERS: initiated on 7/11/2022 and last revised on 8/30/2024 revealed the resident required a mechanical lift with two staff assistance for transfers (TD) x 2 Staff (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's human resource records for CNA C revealed CNA C was terminated 12/12/2023 related to failures following facility's policies and procedures. Further review of the employee counseling form dated 12/08/2023 revealed, used (name brand mechanical lift) lift by herself potentially harming Resident . employee has been educated and in-serviced on transfer policy in the past Further review of employee counseling form revealed a handwritten statement authored by CNA C revealed, Putting patient in bed with (name brand mechanical lift) didn't have backup so I did it on my own. While the (name brand mechanical lift) was on bed, it flip side wide, patient (Resident #1) hit his head on top of headboard, no beak on head, no redness.) Further review of employee counseling form revealed a handwritten statement authored by RN D, This writer, was notified by CNA (C) that patient had bumped his head against the headboard during a transfer from wheelchair to bed. Assessment began observed no bumps or bruises patient denied pain or discomfort at this time. A record review of Resident #1's nursing progress notes revealed RN D documented, Progress Note Focus: Effective Date: 12/8/2023 21:45:00 Department: Nursing Position: Licensed Vocational Nurse Created By: (RN D) Created Date: 12/8/2023 21:46:39 Note Text: VS: 97.5, 18r, 116/72, 72p, 99%ra. Alerted by CNA (C) that pt bumped his head against the headboard during a transfer into bed, assessment begun, no bumps, bruises or redness observed at this time, pt is on Eliquis 5mg bid. Notified RP (name of representative) of clinical situation approx. 1912, RP verbalized understanding. Notified on call for MD (name of doctor) approx. 1923, informed of clinical situation, NP (name of nurse practitioner) ordered to follow incident report facility protocol and initiate neuro checks. Record review of Resident #1's Neurochecks dated 12/08/2023 revealed a neuro assessments were conducted from 12/08/2023-12/11/2023 without any change documented to the residents baseline assessment. Record review of Resident #1's Kardex dated 10/30/2024 revealed: mechanical lift transfers x 2 .Transfers: (ext.) x 2 staff. During a joint interview on 10/11/2024 at 12:48 PM, with the Administrator and the DON, the administrator stated CNA C did transfer Resident #1 by herself on 12/08/2023 and was terminated for her actions on 12/12/2023. The Administrator and the DON stated the staff were in-serviced on more than 1 occasion over the past 10 months on more than 1 person assistance for all mechanical lifts. The Administrator stated the facility policy and expectation was for all staff to provide more than 1 person assistance with all mechanical lifts. During an interview on 10/30/2024 at 1:15 p.m., Resident #1 stated he could not remember the mechanical lift incident on 12/08/2023. Due to his cognitive status, Resident #1 was only able to answer limited yes/no questions. He indicated he did not have any concerns with being transferred with the mechanical lift. During an observation/interview on 10/30/2024 at 1:26 p.m., Resident #1 was observed transferring from wheelchair to bed using a mechanical lift. Two staff members LVN D and CNA E transferred the resident. During the observation both staff members worked together to maneuver and transfer the resident with no concerns for resident safety. Resident #1 appeared calm and comfortable during the transfer and answered yes to feeling safe during the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 10/30/2024 between the times of 10:30 AM and 4:00 PM with 15 CNA staff from all shifts including CNA's E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S, the staff stated they had been trained following Resident #1's 12/08/2024 incident on proper/safe use of mechanical lift transfers. The staff stated all mechanical lift transfers required the use of two staff persons without exception. Staff stated they were trained to get assistance from another CNA, a nurse or a member of management and were to wait for assistance before transferring via mechanical lift. During interviews on 10/30/2024 between the times of 10:30 AM and 4:00 PM with 3 charge nurses, LVN D, LVN B and LVN T stated they had received training on mechanical lift transfers. They stated they were trained to ensure CNA staff were utilizing 2 staff members to transfer residents who required mechanical lift transfers. During an interview on 10/30/2024 at 3:19 p.m., the DON stated on 12/08/2023 LVN D called her and informed Resident #1 hit his head on the headboard during a mechanical lift transfer. She stated she could not remember how the incident occurred, just that Resident #1 hit his head and there were no injuries. She stated neuro assessments were done for 72 hours post incident without any changes or injuries. She stated the charge nurse (unknown name) completed an assessment of Resident #1, a full skin check was done, vitals and neuros. She stated the RP and MD were both notified. She stated the MD ordered monitoring of neuros. She stated that there were no changes in Resident #1's neuro assessment. She stated she does not remember Resident #1 complaining of pain. She stated there was no redness to his skin, no bumps and no injuries. The DON stated CNA C did the transfer by herself. The DON stated when she was notified she told the charge nurse to tell CNA C to clock out and go home. The DON stated CNA C was suspended and went home immediately mid shift. She stated the next day CNA C called her and she (the DON) terminated her because she knew better. The DON stated CNA C admitted to doing the mechanical lift by herself. The DON stated she could not remember if CNA C told her why she did not wait for assistance. The DON stated CNA C had been trained on mechanical lifts prior to the incident. She stated she knew CNA C knew better because she had asked her (The DON) to assist before. The DON stated they conducted in-service training on two person transfers to nursing staff afterwards but she could not remember the exact date. The DON stated staff could review the residents Kardex or they could ask a nurse if they were unsure how a resident needed to be transferred. The DON stated her expectation was for mechanical lifts, two staff were required and the CNA should go find someone to assist. The DON stated she would rather a resident wait than to have someone fall. She stated safety was a priority. She stated two staff persons were important to ensure patient safety. During an interview on 10/30/2024 at 5:00 p.m., the Administrator stated LVN D reached out to her on 12/08/2023 and informed her CNA C completed a mechanical lift transfer by herself resulting in Resident #1 hitting his head on the headboard. She stated she was told the assessments were fine and Resident #1 did not have any injuries. The Administrator stated she told LVN D to tell the CNA to go home. She stated she told the CNA to go home because they had trained their staff to use two staff on mechanical lifts. She stated they were trained that even if they were the only CNA working on a hallway, that there were multiple staff to ask. She stated CNA C was suspended and she confirmed she had left the building. The Administrator stated the next day, she was terminated. The Administrator stated they completed in-service training on mechanical lift transfers and safety of mechanical lift transfers to direct staff following the incident. She stated all staff were made aware. She stated they explained to staff that they would be terminated because of the potential to hurt someone without a safety (second person) there. She stated she was monitoring staff by spot checking them while they were working. She stated staff know to spot check each other for the second person because they will be terminated otherwise. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a manufacturer instruction manual (undated) revealed: WARNING: Although (manufacturer name) recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case.: Record review of a facility in-service training for mechanical lift transfers were completed on 10/02/2023, 11/23/2023 and 12/11/2023 which included a copy of the facility policy for mechanical lift transfers. A policy was requested on 10/11/2024 at 12:48 PM and the policy was not provided. Attempts to reach CNA C on 10/30/2024 at 1:46 p.m. were unsuccessful and no return call was received prior to exit. Record review of a facility policy, titled Safe Resident Handling/Transfers (undated) revealed: 10. Two staff members must be utilized when transferring residents with a mechanical lift. 11. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hirer, annually and as the need arises or changes in equipment occur. 13. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. 14. Resident lifting and transferring will be performed according to the resident's individual plan of care. A record review of the facility's undated Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy revealed, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: . Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframe's required by federal requirements. 10. Protect residents from any further harm during investigations

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 8 residents (Resident #3) reviewed for catheter care. The facility failed to ensure LVN A used a sterile technique when flushing Resident #3's urinary catheter. This failure could place residents at risk for infection. The findings included: A record review of Resident #3's admission record revealed an admitted [DATE] with diagnoses which included obstructive and reflux uropathy (a condition when urine can't drain through the urinary tract, causing it to back up into the kidneys) and retention of urine. A record review of Resident #3's quarterly MDS assessment dated [DATE], revealed Resident #3 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 15 which indicated no cognitive impairment. Further review revealed Resident #3 was assessed with a urinary catheter. A record review of Resident #3's physician's orders dated 10/10/2024 revealed Resident #3 was prescribed a 100cc flush for their indwelling urinary catheter twice a day at 09:00 am and at 06:00 PM. The order read irrigate foley catheter with 100cc sterile water twice daily indefinitely two times a day for prevent build up blockage so urine can drain out. A record review of Resident #3's treatment administration record revealed LVN A flushed Resident #3's urinary catheter on 10/09/2024 at 09:00 AM. During an interview on 10/10/2024 at 10:22 AM, LVN A stated he was Resident #3's nurse and had flushed Resident #3's indwelling catheter on 10/09/2024. LVN A stated the flush was provided via a non-sterile piston syringe. A record review of a written statement dated 10/10/2024 authored by LVN A revealed, on 10/09/2024 I entered the room of my patient to irrigate his super pubic catheter based on the MD's orders of Irrigate 100cc sterile water twice daily indefinitely. I inadvertently grabbed a brand-new clean non-sterile syringe instead of a sterile syringe. The foley was flushed with 100cc of sterile water. The MD was made aware of the infraction and the patient was informed as well as the RP. During an interview on 10/10/2024 at 10:28 AM, ADON B stated the expectation for indwelling urinary catheters was for the procedure to use a sterile technique and the utilization of a non-sterile syringe would not be a sterile technique and could expose a resident to a potential infection . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/2024 at 11:00 AM, the DON stated LVN A had received training on sterile technique with irrigating indwelling catheters and expected LVN A to utilize a sterile technique. The DON stated Resident #3 could have potentially been exposed to infection, the physician had received a report, and was assessed with no signs and or symptoms of distress and would continue to be followed for adverse reactions . A record review of the facility's undated Catheter Irrigation policy revealed, urinary catheters may be irrigated to provide for and maintain constant urinary drainage or to administer medication. urinary catheters shall be irrigated by a licensed nurse under the orders of the physician