| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675689 | A. Building<br>B. Wing | 11/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Village Healthcare and Rehabilitation | 615 N Ware Rd<br>McAllen, TX 78501 |

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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(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 |
|---|---|---|
| | | |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure there was a valid reason for discharge and a resident's physician order for discharge was documented when a discharge was conducted for four Residents (R #4, R #5, R #6, and R #7) of seven Residents whose discharge orders were reviewed, in that: The facilty failed to document a reason for discharge and a physician's discharge order for Resident's #4, #5, #6, and #7 prior to discharge. This failure could place residents at risk of diminished continuity of care and unsafe and/or improper discharges. The findings include:Resident #4In a record review of R #4's Face Sheet dated 11/04/25 documented an [AGE] year-old female initially admitted on [DATE] and discharged on07/11/25 with the diagnoses of: Vascular Dementia (a type of dementia caused by damage to the blood vessels in the brain), Delusional Disorders (a type of serious mental illness called a psychotic disorder the inability to tell what is real from what is imagined), Mood Disorder (A group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood), and Alzheimer's Disease with late on set (a progressive disease that destroys memory and other important mental functions). Record review of R 4#'s care plan dated 07/16/25 revealed resident has an elopement risk and wanderer related to impaired safety awareness, resident wanders aimlessly. Intervention included distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Potential for a behavior problem potential for mood problem secondary to moods disorder administer medications as ordered. Monitor and document for side effects and effectiveness. Record review of R #4's discharged Minimum Data Set (MDS) dated [DATE] revealed she had a brief interview of mental status score of 0-severe cognitive impairment difficulty with attention, orientation, and memory. R #4 mood interview revealed she had presented symptoms of depression, no interest in activities, trouble concentrating, with a frequency of 7 to 10 days. R #4 had behaviors of rejecting care and needed supervised assistance completing ADL's. Health conditions revealed she had two or more falls with no injury observed. The active discharge plan was occurring for the resident to return to the community indicated yes. A referral was made to the Local Contact Agency. Record review of R #4's Progress notes dated 07/11/25 revealed Resident scheduled to be transferred to a new facility the nurse practitioner and responsible party were made aware. Discharge instructions given to the nurse at the new facility, voiced understanding, medications sent with patient picked up by their transportation via wheelchair. R #4's discharge note revealed reason for discharging as just Transferring to new facility. Record review of R #4's physician orders dated 07/11/25 revealed no documentation of the discharged ordered by the physician the endangerment of the safety or health of R #4.Record review of R#4's clinical record from 06/13/25 to 07/11/25 revealed there was no reason for discharge documented. In an interview on 11/05/25 at 8:45 A.M., FM #1 of R #4 stated the facility told the family on the same day of the transfer the reason why R#4 was being transferred. The facility staff member stated because the facility had to start remolding the next day. FM #1 stated she went the next day no remolding was being done. FM #1 stated she also went to the facility a week later and saw another resident was in of R #4's room, and all residents were eating in the dining room of the locked unit. FM #1 stated she was not given a choice of what facilities R #4 could go. FM #1 stated another FM #2 was there and witnessed the staff coming into the room removing things from the room and putting them in a trash bag. FM #1 stated FM #3 then arrived at the time the facility was putting R #4 in the van and transferring her. FM #1 stated no paperwork was given to anyone to sign and no instructions were given, not anything. Resident #5Record review of R #5's Face Sheet dated 07/11/25 documented an [AGE] year-old female initially admitted on [DATE] and discharge date of 07/11/25 with the diagnoses of Alzheimer's Disease with late on set (a progressive disease that destroys memory and other important mental functions), Dementia (A group of thinking an social symptoms that interferes with daily functioning),Muscle weakness, and Cognitive communication deficit(a communication challenge resulting from impaired thinking skills like attention, memory, and problem-solving, rather than a language or speech problem). Record review of R #5's discharge MDS dated [DATE] revealed a BIMS score of 3. R #5 mood was depressed with little interest or pleasure in doing things. No behaviors of wandering took were presented or frequent. R#5's functional abilities reveal supervision need in areas of personal hygiene and in some areas was independent like transferring to shower or toilet. R#5 had history of falls with no injury. The active discharge plan was occurring for the resident to return to the community indicated yes. A referral was made to the Local Contact |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide and document sufficient preparation and orientation of resident representative to ensure safe and orderly transfers or discharges from the facility for 5 of 5 residents (Resident #2, Resident #4, Resident #5, Resident #6, and Resident #7) reviewed for transfer and discharge. The facility failed to notify the residents and their responsible parties of the transfers or discharges with the reasons for the move in writing in a language and manner they understand. This failure placed residents at risk of not receiving an advocate who could inform them of their options, rights, and the added protection from being inappropriately transferred or discharged .The findings included: 1. Record review of Resident #2's face sheet, dated 11/05/2025, revealed a [AGE] year-old female re-admitted to the facility on [DATE]. Pertinent diagnoses included Type 2 Diabetes (a chronic condition which affects how your body metabolizes sugar, or glucose, leading to high blood sugar levels and various health complications), Myocardial Infarction (commonly known as a heart attack, occurs when blood flow to a part of the heart muscle was blocked, leading to tissue damage), Alzheimer's Disease (a progressive disorder which was the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes), Dementia (a condition which affects memory, thinking, and the ability to perform daily activities), Hallucinations (perception of having seen, heard, touched, tasted or smelled something which wasn't actually there), and Paranoid Personality Disorder (a mental health condition characterized by a pervasive pattern of distrust and suspicion of others, often without sufficient reason). Record review of Resident #2's annual MDS, dated [DATE], revealed a BIMS score of 10, which indicated moderately impaired cognition. Resident #2's discharge MDS, dated [DATE], revealed Resident #2 had an unplanned discharge (MDS section A0310) to a short-term general hospital (MDS section A2105) with an acute change in mental status (MDS section C1310). Section Q of the MDS discharge assessment, dated 10/24/2025, Section A0310. F. indicated discharge assessment with return anticipated; G. indicated unplanned discharge. Section A2105 Discharge status indicated Resident #2 discharged to a short-term general hospital. Section Q0400 indicated no discharge planning. Record review of Resident #2's care plan, dated 09/30/2025, revealed Resident #2 had Delirium or an acute confusional episode related to hallucinations and paranoia. The facility attempted to send Resident #2 to the emergency room for evaluation and treatment, but the resident refused. The care plan dated 10/23/2025 revealed Resident #2 was paranoid and thought kitchen staff were looking in her window, poisoning her, and raping her. Resident #2 refused to go to the emergency room and refused counseling services. Interventions included discussing concerns, fears, and/or issues with family or caregivers, and caregiver to provide opportunity for positive interaction. Resident #2 continued to refuse medications and recommendations from the physician. There was a care plan for pre-discharge that was established on 09/01/2024, but that care plan had not been revised since 09/04/2024. Record review of Resident #2's progress note, dated 10/24/2025, revealed Resident #2 was transferred to the ER on [DATE] via stretcher due to hallucinations, delusions, and paranoia which began on 10/20/2025. Progress note also revealed the RP was notified. Record review of Resident #2's physician orders, dated 10/24/2025, revealed Resident #2 was transferred to the ER for medical clearance with section 28. In an interview on 11/05/2025 at 4:53 PM, Resident #2's family member stated they were not told their family member was getting transferred or discharged until it happened. They stated the SW was supposed to call them back regarding all the details of where their family member went, and when their family member would get to return, but no one ever called them back. They also stated they were never given any written discharge or transfer notifications or paperwork regarding their family member. 2. Record review of Resident #4's face sheet, dated 11/0420/25, revealed an [AGE] year-old female initially admitted on [DATE]. Pertinent diagnoses included Vascular Dementia (a type of dementia caused by damage to the blood vessels in the brain), Delusional Disorders (a type of serious mental illness called a psychotic disorder the inability to tell what is real from what is imagined), Mood Disorder (A group of conditions of mental and behavioral disorder where the main underlying characteristic is a disturbance in the person's mood), and Alzheimer's Disease with late on set (a progressive disease that destroys memory and other important mental functions). Record review of Resident #4's progress note, dated 07/11/2025, revealed Resident #4 was scheduled to be transferred to a new facility, and the nurse practitioner and responsible party were made aware. Discharge instructions were given to the nurse at the new facility, and medications were sent with Resident #4. Resident #4's discharge |