STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675717	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Rafael Nursing and Rehabiliation	3050 Sunnybrook Rd Corpus Chrisit, TX 78415

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 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. (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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NAME OF PROVIDER OR SUPPLIER San Rafael Nursing and Rehabiliation		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 Sunnybrook Rd Corpus Chrisit, TX 78415	

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan was developed and implemented within a timely manner for each resident consistent with resident rights to include measurable objectives and timeframes to meet residents medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for 2 residents (Resident #17 and Resident #9) of 5 residents whose care plans were reviewed. The facility failed to ensure Resident #17's comprehensive care plan was developed and implemented after starting anticoagulant (blood thinner) medication on 05/29/25. The facility failed to ensure Resident #9's care plan was revised to accurately reflect the most current anti-anxiety medication status. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services, and the implementation of a personalized plan of care to address their specific needs. Findings included:1.Record review of Resident #9's face sheet dated 09/25/2025 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Pertinent diagnoses included Generalized Anxiety Disorder and Schizoaffective Disorder, Bipolar Type (a mental health condition with both symptoms of schizophrenia [a chronic mental health condition characterized by disruptions in thought, perception, and behavior] and a mood disorder). Record review of Resident #9's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, which revealed intact cognition. The MDS assessment also revealed Resident #9 had active diagnoses of anxiety disorder and schizophrenia. Record review of Resident #9's physician orders, revised 07/11/2025, revealed an order for clonazepam (a medication used to treat anxiety disorders) 0.5 MG, give 1 tablet by mouth three times per day for schizophrenia bipolar disorder.Record review of Resident #9's comprehensive care plan, initiated 07/14/2024, revealed a care plan for anti-anxiety medication with interventions to include administer anti-anxiety medications as ordered by physician: administer clonazepam 0.5mg, give 1 tablet by mouth two times a day for anxiety. In an interview on 9/25/2025 at 12:45 PM, ADON-B stated Resident #9's care plan should have been updated to three times a day instead of twice a day. ADON-B stated the MDS nurse should have updated the care plan when the order changed since she was the one who updated clinical care plans, and if the care plans were not updated appropriately, a resident may not receive the care they needed. In an interview on 09/25/2025 at 3:45 PM, the MDS nurse stated the care plan should have been updated to reflect the clonazepam increasing from twice per day to three times per day, and she was not sure how or why it got missed. She stated it was ultimately her responsibility to update the clinical portion of the care plan so it showed the most current information for the resident, and if care plans were not updated accurately, residents may not get the care they needed. In an interview on 09/25/2025 at 3:55 PM, the DON stated the MDS nurse updated the clinical portion of the comprehensive care plan. He also stated sometimes the ADONs updated the care plans with acute issues discussed in the morning meeting, but ultimately it was the MDS nurse's responsibility to make sure the care plan was updated. The DON stated care plans were updated so staff had the most up to date and accurate information regarding a resident's care. 2.Record review of Resident #17's face sheet dated 09/24/25 reflected a [AGE] year-old-male with an original admission date of 09/17/21. Diagnoses included heart disease, hypertension (high blood pressure), and type two diabetes (insufficient insulin production in the body). Record review of Resident #17's physician orders dated 05/07/25 reflected: Lisinopril oral tablet 10 MG by mouth one time a day for hypertension. Hold if blood pressure is less than 110/60. Record review of Resident #17's care plan initiated on 05/15/25 did not reflect the use of antihypertension medications. Record review of Resident #17's quarterly MDS dated [DATE] reflected a BIMS of 13 (cognition intact) and an active diagnosis of hypertension. In an interview on 09/25/2025 at 3:15 pm, the MDS nurse stated the care plan should have been updated to reflect Resident #17's use of hypertensive medications. The MDS nurse stated she was not sure how or why it got missed but she was ultimately responsible for updating the clinical portion of the care plan, so it reflected the most current information. The MDS nurse stated if care plans were not updated accurately, residents may not get the care they needed. In an interview on 09/25/25 at 3:26 pm, the RMDS stated hypertensive medications should be care planned so staff are aware to monitor for signs and symptoms of hypertension. The RMDS stated care plans were reviewed daily but were audited approximately every 3 months. The RMDS could not state why Resident #17's hypertensive medications had not been care planned. In an interview on 09/25/2025 at 3:40 pm, the DON stated the MDS nurse updated the clinical portion of the comprehensive

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on Interviews and record reviews, the facility failed to ensure the director of nursing did not serve as a charge nurse when the facility had an average daily occupancy of 60 or higher for 4 days (08/03/25, 08/11/25, 09/08/25, and 09/14/25) reviewed for DON staffing in the last 2 months. The facility failed to ensure the DON did not work as a charge nurse for 4 different shifts in August and September 2025 while the average census was above 60. This failure could lead to dividing the DON's attention, preventing them from performing duties assigned to the DON leading to possible harm to a resident. The findings included:Record review of the daily clinical staff schedules revealed the DON was scheduled to work as charge nurse from 2:00 PM - 6:00 PM on 08/03/25 in the 100 hall, 6:00 AM - 6:00 PM on 08/11/25 in the 300 hall, 6:00 AM - 6:00 PM on 09/08/25 in the 100 hall, and 6:00 AM - 6:00 PM on 09/14/25 in the 300 hall. Record review of the resident census data from the facility revealed the daily census for 08/03/25 was 118, 08/11/25 was 121, 09/08/2025 was 116, and 09/14/25 was 116. In an interview with ADON B on 09/25/25 at 1:50 PM, ADON B stated a charge nurse was a nurse that was in charge of residents on a hall. ADON B stated there multiple charge nurses working at a time. ADON B stated there were typically 5 charge nurses working during the 6:00 AM - 6:00 PM shift and 3 charge nurses for 6:00 PM - 6:00 AM. ADON B stated the DON had come in and worked as a charge nurse when they were short-staffed. ADON B stated she had seen the DON working as a change nurse. ADON B stated the DON was used as a last resort to fill in as a charge nurse if they could not find anyone else. In an interview with the ADM on 09/25/25 at 3:09 PM, the ADM stated the DON has filled in as a charge nurse on the halls a few times. The ADM stated the DON was the last person on the list to call when a charge nurse was needed. The ADM stated they did not schedule the DON to work as a charge nurse ahead of time, but that he only ever filled in for another nurse. The ADM stated if the DON was scheduled on a daily basis to work as a charge nurse they would not be able to perform their DON duties effectively. In an interview with the DON on 09/25/25 at 3:28 PM, the DON stated he had worked as a nurse on the floor at the facility approximately four times in the past 2 months. The DON stated when he worked as a floor nurse he was not able to perform all of his responsibilities as a DON. The DON stated he was never scheduled to work on the floor ahead of time. The DON stated he would find out he was needed to fill in as a floor nurse about an hour before he was needed to be at the facility. A facility policy was requested from the ADM on 9/25/25 at 3:40 PM regarding the DON working as a charge nurse but the ADM stated the facility did not have a policy covering that.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 2 of 5 residents (Resident #2 and Resident #16) reviewed for pharmacy services. 1. The facility failed to administer Resident #2's Clonidine (a medication used to treat high blood pressure) per the prescribed order and blood pressure parameters in June of 2025. 2. The facility failed to administer Resident #16's Clonidine (a medication used to treat high blood pressure) per the prescribed order and blood pressure parameters in September of 2025. These failures could place residents at risk for complications and jeopardize their health and safety. Findings Included: 1.Record review of Resident #2's face sheet, dated 09/25/2025, revealed a [AGE] year-old female with an original admission date of 04/22/2025, and a current admission date of 09/05/2025. Pertinent diagnosis included Essential Primary Hypertension (high blood pressure). Record review of Resident #2's quarterly MDS assessment, dated 06/20/2025, revealed a BIMS score of 13, which revealed intact cognition. The MDS also revealed an active diagnosis of hypertension. Record review of Resident #2's physician orders, started 06/11/2025 and revised 07/22/2025, revealed an order for Clonidine 0.1 MG, give one tablet by mouth every 8 hours as needed for a systolic blood pressure greater than 170 or a diastolic blood pressure greater than 100. Record review of Resident #2's care plan for hypertension, initiated 06/23/2025 and revised 07/29/2025, revealed an intervention to give anti-hypertensive medications as ordered, to include Clonidine 0.1 MG. Record review of Resident #2's June 2025 MAR revealed Clonidine 0.1 MG, give one tablet by mouth every 8 hours as needed for a systolic blood pressure greater than 170 or a diastolic blood pressure greater than 100. The MAR also revealed Resident #2's day shift blood pressure on 06/21/2025 was 172/103, taken by LVN-D, but no prn Clonidine was administered. In an interview on 09/24/2025 at 3:00 PM, ADON-B stated LVN-D was a good nurse and always checked her residents blood pressures and administered their medication appropriately. ADON-B stated she was not sure why LVN-D did not administer Resident #2's blood pressure medication. She stated if a resident's blood pressure was already elevated, and they did not receive their blood pressure medication, and the blood pressure continued to rise, the resident could have had a stroke and possibly death. In an interview on 09/25/2025 at 2:30 PM, LVN-D stated she did not remember Resident #2 having an order for clonidine, but she remembered her having some issues with her blood pressure being elevated around this time. LVN-D stated she was not sure why she did not give the clonidine because she did not remember Resident #2's blood pressure ever being that elevated or the Clonidine order itself. She stated maybe she wrote the number down wrong or maybe she got distracted. LVN-D stated she did not recall Resident #2 ever complaining of signs or symptoms of excessively elevated blood pressure around this time, such as headache, dizziness, or chest pain. LVN-D stated if Resident #2's blood pressure had continued to rise, she could have had a stroke or heart attack. In an interview on 09/25/2025 at 3:55 PM, the DON stated nurses should always recheck an elevated blood pressure and administer any prn blood pressure medication the resident had. The DON also stated if a blood pressure was already elevated, and the prn medication was not administered, the blood pressure could have continued to rise, and the resident could have had a stroke. In an interview on 09/25/2025 at 4:33 PM, Resident #2 stated she took blood pressure medication for her blood pressure because sometimes it got high, and she stated the nurses at the facility was good about checking her blood pressure and giving her medication to her. Resident #2 denied remembering being told her blood pressure ever being 172/103 in June 2025, as well as she denied ever feeling or having symptoms of her blood pressure being that high such as headache, dizziness, or blurred vision. She stated she knew when her blood pressure was high and did not remember it being high. 2. Record review of Resident #16's face sheet dated 09/25/25 reflected a [AGE] year-old-male with an original admission date of 10/16/20. Diagnoses included acute chronic kidney failure, hypertension (high blood pressure), congestive heart failure (long-term condition in which the heart cannot pump blood well enough to meet the body's needs), and type two diabetes (insufficient insulin production in the body). Record review of Resident #16's care plan dated 12/12/23 reflected: Resident #16 had hypertension. Interventions included: Give anti-hypertensive medications as ordered. Record review of Resident #16's physician orders dated 03/06/25 reflected: Clonidine HCl oral tablet 0.1 by mouth every 6 hours as needed for a systolic greater than 160 and a diastolic greater than 100. Record review of Resident #16's blood pressure log reflected: 9/20/2025 08:20 164 / 66 mmHg; 9/20/2025 06:48 164 / 66 mmHg. Record review of Resident #16's September 2025 MAR reflected Clonidine HCl oral tablet 0.1 MG was not

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records that were accurately documented for 3 (Resident #1, Resident #2,and Resident #16) of 5 residents reviewed for medical records. 1. The facility failed to ensure Resident #1's vital signs were accurately documented in the MAR on 08/15/25.2. The facility failed to ensure Resident #2's blood pressure was accurately documented in the MAR during the month of September 2025.3. The facility failed to ensure Resident #16's blood pressure was accurately documented for the month of September 2025. These failures could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment. The findings included:1. Record review of Resident #1's face sheet dated 09/25/25 reflected a [AGE] year-old male with an original admission date of 11/03/23. Diagnoses included end stage renal disease (when the kidneys lose the ability to remove waste and balance fluids), hypertension (high blood pressure), anemia (low levels of healthy red blood cells to carry oxygen in the body), and type two diabetes (insufficient insulin production in the body). Record review of Resident #1's physician orders active as of 08/15/25 reflected in part: Vital signs twice daily, every day shift for 14 Days. Start date: 08/12/25. Vital signs twice daily in the evening for 14 Days. Start date: 08/12/25. Record review of Resident #1's August 2025 vital signs log reflected in part: 08/15/25 9:06 AM by LVN D: blood pressure 115/62, temperature 97.7, pulse 86, respiratory rate 18, and O2 sats 98. There was no other entry for 08/15/25 as Resident #1 was not in the facility again until 08/18/25 because he was admitted to the hospital on [DATE] at 11:38 AM. Record review of Resident #1's August MAR reflected in part: LVN D documented Resident #1's blood pressure as 115/62, temperature 97.7, pulse 86, respiratory rate 18, and O2 sats as 98 in the space for the 6:00 AM vital signs. LVN C documented Resident #1's blood pressure as 115/62, temperature 97.7, pulse 86, respiratory rate 18, and O2 sats as 98 in the space for the 6:00 PM vital signs. 2. Record review of Resident #2's face sheet dated 09/25/25 reflected a [AGE] year-old female with an original admission date of 04/22/25. Diagnoses included chronic kidney disease (when the kidneys are damaged and can't filter blood as well as they should), dependence on renal dialysis (process of filtering blood through a machine to remove excess water and toxins in the blood when the kidneys no longer function), hypotension (low blood pressure), hypertension (high blood pressure), and type 1 diabetes (a lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels). Record review of Resident #2's care plan reflected in part: Resident #2 had hypertension. Interventions included: Give anti-hypertensive medications as ordered. Resident #2 had episodes of hypotension (low blood pressure) at dialysis r/t end stage renal disease. Interventions included: Give medications as ordered. Monitor for side effects and effectiveness. Record review of Resident #2's physician orders reflected in part: HOLD medications on dialysis days, every day shift every Mon, Wed, Fri. Start date: 07/30/25 at 6:00 am. End date: 09/05/25 at 8:48 am. May hold medications on dialysis days. every shift every Mon, Wed, Fri related to Dependence on renal dialysis. Start date: 09/24/25 at 10:00 pm. Losartan Potassium Oral Tablet 50 MG (Losartan Potassium) Give 1 tablet by mouth two times a day for HTN Hold for Systolic BP <110 or HR<60. Start Date: 06/11/25 at9:00 am. D/C Date:09/05/25 at 8:48 am. Losartan Potassium Oral Tablet 50 MG (Losartan Potassium) Give 1 tablet by mouth two times a day for HTN. HOLD IF BP <110/60. Start date: 09/06/25 at 9:00 am. Record review of Resident #2's September 2025 blood pressure log and documentation of blood pressures for Losartan administration on the September 2025 MAR reflected in part: Log: 09/01/25 at 8:30 am 148/80 by LVN H MAR: 09/01/25 at 9:00 am: BP X by MA F. MAR: 09/01/25 at 5:00 pm: BP X by MA F. Log: 09/03/25- no 9:00 am or 5:00 pm blood pressure recorded. MAR: 09/03/25 at 9:00 am: BP X by MA F. MAR: 09/03/25 at 5:00 pm: BP X by MA F. Log: 09/08/25- no 9:00 am blood pressure recorded. MAR: 09/08/25 at 9:00 am: BP X by MA F. Log: 09/10/25 at 1:00 am 142/63 by ADON A. Log: 09/10/25 at 11:47 am 132/78 by LVN C. Log: 09/10/25- no 9:00 am or 5:00 pm blood pressure recorded. MAR: 09/10/25 at 9:00am: BP 142/63 by LVN C. MAR: 09/10/25 at 5:00 pm: BP 132/78 by LVN C. Log: 09/11/25- no 9:00 am blood pressure recorded. MAR: 09/11/25 at 9:00 am: BP 132/78 by LVN C. Log: 09/11/25 at 5:21 pm 122/77 by LVN C. MAR: 09/11/25 at 5:00 pm: BP 132/78 by LVN C. Log: 09/14/25 at 5:13 pm 177/58 by LVN G. Log: 09/15/25- no 9:00 am blood pressure recorded. MAR: 09/15/25 at 9:00 am: BP 177/58 by LVN C. Log: 09/15/25 at 5:12 pm 134/87 by LVN C. MAR: 09/15/25 at 5:00 pm: BP 177/58 by LVN C. Log: 09/16/25 at 12:13 am 142/84 by ADON A. Log: 09/16/25- no 9:00 am or 5:00 pm blood pressure recorded. MAR: 09/16/25 at 9:00 am: BP 142/84 by LVN C. MAR: 09/16/25 at 5:00 pm: BP 142/84 by LVN