

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Buena Vida Nursing and Rehab-San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 5027 Pecan Grove San Antonio, TX 78222	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957</p> <p>Based on observation, interviews and record reviews the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident for 1 of 17 (Resident #29) in that:</p> <p>The facility failed to honor Resident #29's right to present when Administrator A entered the resident's room and misappropriated personal items and threw them away in the trash.</p> <p>This failure could result in residents experiencing a decline in self-worth and quality of life.</p> <p>The findings were:</p> <p>Record review of Resident #29's face sheet, dated [DATE], revealed a [AGE] year-old female resident who was readmitted on [DATE] with diagnoses that included: end stage renal disease, anxiety, major depressive disorder, HTN (hypertension). Resident was her own RP.</p> <p>Record review of Resident #29's quarterly MDS dated [DATE] revealed BIMS score was 15 (cognitively intact).</p> <p>Record review of Resident# 29's Care Plan, undated, revealed the resident had major depression and interventions included: monitor feelings of worthlessness.</p> <p>Record review of facility's self report dated [DATE] revealed that on [DATE] at 3:12 PM Resident #29 complained that Administrator B threw out some of her personal belongings while she (the resident) was away at a dialysis appointment. Resident #29 reacted when she returned to the facility by crying and expressing feelings of being nothing. There were three witnesses to the incident on [DATE] (LVN B, LVN C and Hospitality Aide D).</p> <p>Record review of Resident #29's General Note noted dated [DATE] at 1:28 PM authored by Administrator A revealed: the administrator and housekeeping entered Resident #29's room to throw away trash and expired foods. The Administrator had informed Resident #29 about one month ago that the room needed to be cleaned. The administrator stated that clothing on the floor was sent to the laundry. [The General Note did not address the resident's right to be present and to consent]</p> <p>(continued on next page)</p>		

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #29's Dialysis Center Communication Form revealed on [DATE], Resident went to dialysis and returned; vital signs were normal and assessment completed on access port.</p> <p>Record review of facility's internal investigation file revealed:</p> <p>Employee [Administrator A] disciplinary Report revealing suspension on [DATE] for alleged abuse of a resident.</p> <p>Written Statements revealed:</p> <ul style="list-style-type: none"> o [DATE]: Housekeeper F wrote that the Administrator [A] was cleaned Resident #29's room and threw out trash. o [DATE]: ADON, wrote: Resident #29 was in emotional distress . The resident was upset and traumatized because items were thrown away from her room. o [DATE]: The Admissions Coordinator wrote: she follow-up with Resident #29 and the resident was still upset over items from her room thrown in trash bags. The Admission Coordinator in the written statement that the resident [#29] had sentimental value to some of the items thrown away. o [DATE]:Hospitality Aide D wrote: Resident #1 was upset over items thrown away from her room. The resident estimated the value of the items thrown away at \$300. The Administrator [A] told Resident #29 that items were thrown away and put in a trash bag. Resident #29 yelled at the administrator and the administrator left the scene. o [DATE]: LVN C wrote: Resident #29 was yelling at the Nurse Station and alleged that \$300 worth of items were thrown away from her room. The Resident and the administrator had a brief argument which resulted in the administrator going to her office and the resident to the dining hall. o [DATE]: Admissions Coordinator wrote: Resident #29 yelled at the administrator over items taken from her room. The resident was upset. o [DATE]: SW wrote: she witnessed resident [#29] and the administrator arguing over items thrown away from the resident's room. The resident was very upset. o [DATE]: Resident# 29 wrote: the items thrown away were valued at \$300 which included clothing and figurines and foodies. The resident stated, She made me feel like I was noting and that she could do whatever she want with my things. o ,d+[DATE]/:24: LVN B wrote: the resident [#29] was upset at the nurse station alleging that the administrator threw away items from her room. The administrator and the resident had a brief argument where the administrator stated she only threw away trash. The resident was visibly upset. o[DATE]: Activity Director wrote: she purchased for the resident [#29] some of the missing items at a local store. Receipt [DATE] from resident purchase of figurines worth \$69. Receipt [DATE] from resident purchase of figurines worth \$105. <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 1:45 PM, Corporate RN stated: the incident reported to HHS read resident complain[ed] that Administrator [A] threw out some of her personal belongings, making her feel like she was nothing and could just do whatever she wanted to do with her stuff. Corporate RN stated that an investigation revealed the Administrator [A] was cleaning trash and food and a bag with trash and clothing were removed from the room. The Corporate RN stated that initially the resident did not approve of the trash removal. The former administrator [A] showed the bag to the resident and the resident was able to remove some of her belongings. The Corporate RN added, the trash bag was thrown out and the resident claimed trinkets were missing. The facility purchased for the resident the missing trinkets [valued at \$172] and the resident was satisfied. The Corporate RN stated that she does not know why the former administrator[A] did not stop taking the trash out of the room because of resident rights and the resident was not present. The Corporate RN stated that if a resident said stop regarding a trash bag that may contained clothing the former administrator should have stopped and assess what other options were available. The Corporate RN stated the former administrator [A] was not terminated because of the incident; but rather other events at the time of the incident contributed to the administrator's suspension pending an investigation. The Corporate RN stated that she could not confirm the General Note dated [DATE] that Resident 29's clothing on the floor was sent to the laundry. Corporate RN stated at the time of the incident the resident was not present in the room when the Administrator[A]entered the room and threw out personal items from the room belonging to the resident. The Corporate RN stated that the actions of Administrator A on [DATE] could be considered a violation of resident rights.</p> <p>Observation and interview on [DATE] at 2:15 PM, Resident #29 was in her room, in bed, watching TV; alert and oriented to time, person, and place. The room was cluttered with many items to include: clothing, trinkets, trash, and bottle of apple juice on the floor; and other items on the window sill. The resident stated she had dialysis that morning ([DATE]). The resident stated, I was in dialysis on [DATE] in the morning and returned around 10:30 am-11:00 am .when I returned I went to the dining room and returned to my room in the afternoon .I saw that my red bag on the floor was missing and saw it near a trash bag near the kitchen .in the bag I had foodies .and Activity Director purchased about \$300 of staff [after the grievance was filed on [DATE]]. Resident added, the Administrator [A] threw away my crayons and color pencils and anything she felt was trash .this happened when I has not in the room . I did not give permission for the removal of items and I was not told the date of removal . I got angry and upset and went to the nurse's station .they did not tell me when they were going to clean my room .I was not present when they entered my room and did not give permission .I was upset .I was crying in the lobby .I wanted to be present if they wanted to clean my room .I never got clothing returned .they did not do anything .they threw away my colored pencils . I am still upset .I do not trust staff .[resident teared during the interview].</p> <p>During an interview on [DATE] at 3:19 PM, the ADON stated: [DATE] the resident's room [Resident #29] was search by the former administrator [A]. The ADON stated that the resident was not present when the room was searched on [DATE] and it is not right to search a resident's room without permission and throw out items . The ADON stated Resident #29 was upset on [DATE] because personal belongings were thrown out by the former Administrator [A]. The ADON expressed the opinion based on observations of the resident and monitoring for days after the incident the resident did not exhibit signs and symptoms of psychosocial harm. The ADON stated that the actions of the Administrator [A] could be a violation of resident rights; given the resident was not present.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a joint interview on [DATE] at 3:32 PM with Hospitality Aide D and LVN C, LVN C stated: they both saw Resident #29 crying at the Nurse Station on [DATE] between ,d+[DATE] PM. LVN C stated, the resident alleged that the Administrator [A] threw away stuff from her room without permission. LVN C and Hospitality D both stated that based on resident rights a staff member cannot enter a resident's room without permission and throw things away. Hospitality Aide D stated that Resident #29 cried about one hour. LVN C stated she [Resident #29] was pretty upset. Both the Hospitality Aide D and LVN C stated the resident was upset but did not show after the event signs and symptoms of psychosocial harm.</p> <p>During an interview on [DATE] at 3:39 PM, LVN B stated that he was present on [DATE] around ,d+[DATE] PM and the resident [Resident 329] was crying at the nurse station. LVN B stated, The resident was hollering and crying and alleged that the previous Administrator [A] had thrown away personal items; valued around \$300. LVN B stated, the Administrator [A] and Resident #2 had a brief encounter for less than a minute at the nurse station and the resident left for the TV room; the administrator returned to her office. LVN B stated that staff cannot enter and search a resident's room without a resident's permission and the resident being present. LVN B stated that the resident was upset but did not suffer psychosocial harm.</p> <p>During an interview on [DATE] at 4:16 PM, the DON stated: she was not present at the time of the incident. The DON stated, the facility attempted to recover some of Resident #29's missing items and purchased for Resident #29 items of similar value costing \$170. The DON stated that no staff member can enter a resident's room without permission in violation of resident rights. The DON stated, the resident did not suffer psychosocial harm except at the time of the incident staff witnessed the resident crying.</p> <p>During an interview on [DATE] at 4:24 PM, the Administrator [E] stated: stated that permission was required to enter a resident's room and the resident should be present if a search of the room was planned. Administrator E stated that he could not give an explanation as to why Administrator A entered a resident's room without permission and the resident was not present and misappropriated personal property. The Administrator E stated the actions of Administrator A fell in the realm of resident rights.</p> <p>During an interview on [DATE] at 4:40 PM, the Activity Director stated she purchased \$170 of items for the resident after the incident on [DATE]; and the resident was satisfied with the purchase. The Activity Director stated that after the incident the resident did not reveal signs or symptoms of psychosocial harm.</p> <p>During telephone interview on [DATE] at 5:05 PM, the former Administrator [A] stated: she told the resident [#29] the previous week that hall 200 to include her room were going to be cleaned for trash and food items. The former administrator stated she went into Resident #29's room who was not present and threw away trash, expired foods, and sent dirty linen to the laundry room. The former administrator stated that around 12:30 PM she heard the resident yelling that someone had entered her room and threw away her items. The former administrator when asked about resident rights responded, the resident was not present when the cleaning of the room occurred. The former administrator stated that the resident was told that cleaning of her room would occur sometime in late [DATE]. The former administrator stated the resident did not like things thrown away. The former administrated stated that Resident [#29] room had to be cleaned out of safety and infection control concerns.</p> <p>(continued on next page)</p>		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's Resident [NAME] of Rights undated read: .You have the right to be free of interference, coercion, discrimination, or reprisal .You have the right to retain and use personal possessions . unless to do so would infringe upon the health and safety of other residents .		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957</p> <p>Based on interview and record review, the facility failed to treat residents with dignity and respect of personal possessions for 1 of 17 residents (Resident #17) reviewed for resident rights, in that:</p> <p>Hospitality Aide D turned off, on 12/23/23 at 3:44 PM, Resident #17's electronic monitoring device, a personal possession, without asking for permission to turn off the device.</p> <p>This deficient practice could affect residents who reside at the facility and result in a loss of personal property, frustration and loss of dignity.</p> <p>The findings were:</p> <p>Record review of Resident #17's face sheet, dated 6/27/24 revealed, a [AGE] year old male who was admitted on [DATE] and discharged [DATE] home with diagnoses that included: HEMIPLEGIA AND HEMIPARESIS (paralysis of one side of the body), FOLLOWING CEREBRAL INFARCTION (stroke), DEMENTIA, and PARANOID PERSONALITY DISORDER. Resident was his own RP.</p> <p>Record review of Resident #17's quarterly MDS dated [DATE] revealed a BIMS score of 10 (moderately impaired).</p> <p>Record review of Intake #472623, dated 12/13/23, the facility's self report revealed a family member alleged that staff would turn off Resident's electronic monitoring devise and would neglect the resident.</p> <p>Record review of Resident17's Care Plan, undated, revealed, the resident had sexual acting out behaviors, exposed himself, and was racially inappropriate. Interventions included medications, monitoring, and interacting with the resident in a positive manner. The CP also revealed that the resident was non-compliant with medications.</p> <p>Record review of Resident #17's Nurse Notes from 12/23/23 to 1/15/24 revealed that call lights were answered by staff and resident would engage in appropriate sexual behaviors directed at staff. [no mention of electronic devise turned off]</p> <p>Record review of Resident #17's Nurse Note dated 12/24/23 revealed that resident was calm and cooperative with a skin assessment. [intervention after a family member alleged the resident's camera was turned off on 12/23/23]</p> <p>Record review of Resident #17's skin assessment dated [DATE] revealed no injuries, bruises or skin tears .</p> <p>Record review of Resident #17's skin assessment on 12/26/24 revealed: skin intact.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #17's weekly nurse note dated 12/28/23 revealed: refuses meds, refused showers and refused care by CNAs .</p> <p>Record review of Resident #17's ADL sheets for the month of December 2023 revealed resident was given ADLs in bathing, toileting, changing, and peri-care. Resident did not refused ADLs.</p> <p>Observation of Resident #17's video dated 12/23/23 at 3:44 PM revealed Hospitality Aide D was observed adjusting resident's position in the bed while the resident had no brief on, on the left side of the bed, and the resident made some un-audio statements. Hospitality Aide D maneuvers to the right side of the resident's bed and hovers over the resident and responds to the resident with the question of what did you say? Hospitality Aide D then leaves the resident's bedside towards the camera and turned off resident's camera; and is seen with his hand over the camera lens, video stream then disconnected.</p> <p>During an interview on 7/1/24 at 3:11 PM, LVN G stated the resident was sexually inappropriate with staff; and would expose himself. LVN G stated that call lights were answered and she had no knowledge that any staff member would turn off the camera when interacting with the resident or providing treatments and services.</p> <p>During an interview on 7/2/24 at 8:20 AM, LVN C stated: the resident was sexually inappropriate with staff and received treatment with 2 staff present. Treatment and services given to the resident included: medication management with refusal of psychotropics, assessments and vital signs, monitoring , behavior management, and rehabilitation. LVN C stated that the resident was not neglected and discharged home. LVN C stated that she had no information that staff interfered with Resident #17 and denied him his dignity and denied the respect of personal possessions.</p> <p>During an interview on 7/2/24 at 8:25 AM, LVN B stated: the resident was sexually inappropriate with staff and received treatment with staff present. Treatment and services given to the resident included: medication management with refusal of psychotropics, assessments and vital signs, monitoring , behavior management, and rehabilitation. LVN B added that the resident also refused labs and medical recommendations. LVN B was not aware of any staff turning off the resident's camera as the resident's personal possession.</p> <p>During an interview on 7/2/24 at 1:31 PM, Hospitality Aide H stated he had interactions with the resident in December 2023 and he did not witness or perpetrate abuse against the resident. Hospitality Aide H stated that Resident #17 resident would unplug his camera. Hospitality Aide H stated that the resident never made any allegations of abuse.</p> <p>During an interview on 7/2/24 at 1:45 PM Hospitality Aide D stated he never witnessed or saw any staff being rough with Resident #17. Hospitality Aide D stated that no staff member turned off the resident's camera in the room. Hospitality Aide D stated that the resident never alleged abuse to him. Hospitality Aide D denied ever turning off Resident #17's camera and not respecting the resident's personal possessions.</p> <p>During an interview on 7/2/24 at 2:10 PM, the DON stated: the roommate was unplugging the camera; the facility responded by having the Resident #17 room by himself. Regarding rough treatment, the DON stated there was no evidence of the resident being abused. Preventative measures included: monitoring, and no roommate. Staff was in-service on abuse and neglect.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's Resident [NAME] of Rights undated read: .You have the right to be free of interference, coercion, discrimination, or reprisal .You have the right to retain and use personal possessions . unless to do so would infringe upon the health and safety of other residents .</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957</p> <p>Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property was provided for 1 of 17 residents (Resident #29) reviewed for misappropriation and exploitation, in that:</p> <p>The facility did not prevent Resident #29's personal belongings from being lost when the former Administrator (A) without the resident's permission or the resident being present removed personal items from the resident's room.</p> <p>This failure could affect residents and their responsible party by preventing them from having access to their personal effects and belongings.</p> <p>The findings included:</p> <p>Record review of Resident #29's face sheet, dated [DATE], revealed a [AGE] year-old female resident who was readmitted on [DATE] with diagnoses that included: end stage renal disease, anxiety, major depressive disorder, HTN (hypertension). Resident was her own RP.</p> <p>Record review of Resident #29's quarterly MDS dated [DATE] revealed BIMS score was 15 (cognitively intact).</p> <p>Record review of Resident #29's Care Plan, undated, revealed the resident had major depression and interventions included: monitor feelings of worthlessness.</p> <p>Record review of facility's self report dated [DATE] revealed that on [DATE] at 3:12 PM Resident #29 complained that Administrator B threw out some of her personal belongings while she (the resident) was away at a dialysis appointment. Resident #29 reacted when she returned to the facility by crying and expressing feelings of being nothing. There were three witnesses to the incident on [DATE] (LVN B, LVN C and Hospitality Aide D).</p> <p>Record review of Resident #29's General Note noted dated [DATE] at 1:28 PM authored by Administrator A revealed: the administrator and housekeeping entered Resident #29's room to throw away trash and expired foods. The Administrator had informed Resident #29 about one month ago that the room needed to be cleaned. The administrator stated that clothing on the floor was sent to the laundry.</p> <p>Record review of Resident #29's Dialysis Center Communication Form revealed on [DATE], Resident went to dialysis and returned; vital signs were normal and assessment completed on access port.</p> <p>Record review of facility's internal investigation file revealed:</p> <p>Employee [Administrator A] disciplinary Report revealing suspension on [DATE] for alleged abuse of a resident.</p> <p>Written Statements revealed:</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>o [DATE]: Housekeeper F wrote that the Administrator [A] was cleaned Resident #29's room and threw out trash.</p> <p>o [DATE]: ADON, wrote: Resident #29 was in emotional distress . The resident was upset and traumatized because items were thrown away from her room.</p> <p>o [DATE]: The Admissions Coordinator wrote: she follow-up with Resident #29 and the resident was still upset over items from her room thrown in trash bags. The Admission Coordinator in the written statement that the resident [#29] had sentimental value to some of the items thrown away.</p> <p>o [DATE]: Hospitality Aide D wrote: Resident #1 was upset over items thrown away from her room. The resident estimated the value of the items thrown away at \$300. The Administrator [A] told Resident #29 that items were thrown away and put in a trash bag. Resident #29 yelled at the administrator and the administrator left the scene.</p> <p>o [DATE]: LVN C wrote: Resident #29 was yelling at the Nurse Station and alleged that \$300 worth of items were thrown away from her room. The Resident and the administrator had a brief argument which resulted in the administrator going to her office and the resident to the dining hall.</p> <p>o [DATE]: Admissions Coordinator wrote: Resident #29 yelled at the administrator over items taken from her room. The resident was upset.</p> <p>o [DATE]: SW wrote: she witnessed resident [#29] and the administrator arguing over items thrown away from the resident's room. The resident was very upset.</p> <p>o [DATE]: Resident# 29 wrote: the items thrown away were valued at \$300 which included clothing and figurines and foodies. The resident stated, She made me feel like I was noting and that she could do whatever she want with my things.</p> <p>o ,d+[DATE]/:24: LVN B wrote: the resident [#29] was upset at the nurse station alleging that the administrator threw away items from her room. The administrator and the resident had a brief argument where the administrator stated she only threw away trash. The resident was visibly upset.</p> <p>o [DATE]: Activity Director wrote: she purchased for the resident [#29] some of the missing items at a local store. Receipt [DATE] from resident purchase of figurines worth \$69. Receipt [DATE] from resident purchase of figurines worth \$105.</p> <p>Record review of Resident #29's vitals taken On [DATE] at 10:31 AM revealed: normal ranges.</p> <p>Record review of Resident 29's Psychiatric Note authored by a community mental health provider dated [DATE] revealed: the resident did not exhibit any distress and denied depression. The report read: .Currently reports feeling well and denies having any problems with other residents. Depression: Patient denies symptoms of sad moods, loss of interest, fatigue, guilt, feelings of worthlessness, psychomotor agitation, psychomotor slowing, decreased concentration, suicidal ideation/intent/plan and appetite change. Patient denies a history of sad moods, loss of interest, fatigue, guilt, feelings of worthlessness, psychomotor agitation, psychomotor slowing, decreased concentration, suicidal ideation/intent/plan and appetite change . [psychotropic medications medication revealed] patient at this time is currently well controlled .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Buena Vida Nursing and Rehab-San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 5027 Pecan Grove San Antonio, TX 78222	
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 1:45 PM, Corporate RN stated: the incident reported to HHS read resident complain[ed] that Administrator [A] threw out some of her personal belongings, making her feel like she was nothing and could just do whatever she wanted to do with her stuff. Corporate RN stated that an investigation revealed the Administrator [A] was cleaning trash and food and a bag with trash and clothing were removed from the room. The Corporate RN stated that initially the resident did not approve of the trash removal. The former administrator [A] showed the bag to the resident and the resident was able to remove some of her belongings. The Corporate RN added, the trash bag was thrown out and the resident claimed trinkets were missing. The facility purchased for the resident the missing trinkets [valued at \$172] and the resident was satisfied. The Corporate RN stated that she does not know why the former administrator[A] did not stop taking the trash out of the room because of resident rights and the resident was not present. The Corporate RN stated that if a resident said stop regarding a trash bag that may contained clothing the former administrator should have stopped and assess what other options were available. The Corporate RN stated the former administrator [A] was not terminated because of the incident; but rather other events at the time of the incident contributed to the administrator's suspension pending an investigation. The Corporate RN stated that she could not confirm the General Note dated [DATE] that Resident #29's clothing on the floor was sent to the laundry. Corporate RN stated at the time of the incident the resident was not present in the room when the Administrator[A]entered the room and threw out personal items from the room belonging to the resident.</p> <p>Observation and interview on [DATE] at 2:15 PM, Resident #29 was in her room, in bed, watching TV; alert and oriented to time, person, and place. The room was cluttered with many items to include: clothing, trinkets, trash, and bottle of apple juice on the floor; and other items on the window sill. The resident stated she had dialysis that morning ([DATE]). The resident stated, I was in dialysis on [DATE] in the morning and returned around 10:30 am-11:00 am .when I returned I went to the dining room and returned to my room in the afternoon .I saw that my red bag on the floor was missing and saw it near a trash bag near the kitchen .in the bag I had foodies .and Activity Director purchased about \$300 of staff [after the grievance was filed on [DATE]]. Resident added, the Administrator [A] threw away my crayons and color pencils and anything she felt was trash .this happened when I has not in the room . I did not give permission for the removal of items and I was not told the date of removal . I got angry and upset and went to the nurse's station .they did not tell me when they were going to clean my room .I was not present when they entered my room and did not give permission .I was upset .I was crying in the lobby .I wanted to be present if they wanted to clean my room .I never got clothing returned .they did not do anything .they threw away my colored pencils . I am still upset .I do not trust staff .[resident teared during the interview].</p> <p>During an interview on [DATE] at 3:19 PM, the ADON stated: [DATE] the resident's room [Resident #29] was search by the former administrator [A]. The ADON stated that the resident was not present when the room was searched on [DATE] and it is not right to search a resident's room without permission and throw out items . The ADON stated Resident #29 was upset on [DATE] because personal belongings were thrown out by the former Administrator [A]. The ADON expressed the opinion based on observations of the resident and monitoring for days after the incident the resident did not exhibit signs and symptoms of psychosocial harm.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a joint interview on [DATE] at 3:32 PM with Hospitality Aide D and LVN C, LVN C stated: they both saw Resident #29 crying at the Nurse Station on [DATE] between ,d+[DATE] PM. LVN C stated, the resident alleged that the Administrator [A] threw away stuff from her room without permission. LVN C and Hospitality D both stated that based on resident rights a staff member cannot enter a resident's room without permission and throw things away. Hospitality Aide D stated that Resident #29 cried about one hour. LVN C stated she [Resident #29] was pretty upset. Both the Hospitality Aide D and LVN C stated the resident was upset but did not show after the event signs and symptoms of psychosocial harm.</p> <p>During an interview on [DATE] at 3:39 PM, LVN B stated that he was present on [DATE] around ,d+[DATE] PM and the resident [Resident 329] was crying at the nurse station. LVN B stated, The resident was hollering and crying and alleged that the previous Administrator [A] had thrown away personal items; valued around \$300. LVN B stated, the Administrator [A] and Resident #2 had a brief encounter for less than a minute at the nurse station and the resident left for the TV room; the administrator returned to her office. LVN B stated that staff cannot enter and search a resident's room without a resident's permission and the resident being present. LVN B stated that the resident was upset but did not suffer psychosocial harm.</p> <p>During an interview on [DATE] at 4:16 PM, the DON stated: she was not present at the time of the incident. The DON stated, the facility attempted to recover some of Resident #29's missing items and purchased for Resident #29 items of similar value costing \$170. The DON stated that no staff member can enter a resident's room without permission in violation of resident rights. The DON stated, the resident did not suffer psychosocial harm except at the time of the incident staff witnessed the resident crying.</p> <p>During an interview on [DATE] at 4:24 PM, the Administrator [E] stated: stated that permission was required to enter a resident's room and the resident should be present if a search of the room was planned. Administrator E stated that he could not give an explanation as to why Administrator A entered a resident's room without permission and the resident was not present and misappropriated personal property.</p> <p>During an interview on [DATE] at 4:40 PM, the Activity Director stated she purchased \$170 of items for the resident after the incident on [DATE]; and the resident was satisfied with the purchase. The Activity Director stated that after the incident the resident did not reveal signs or symptoms of psychosocial harm.</p> <p>During telephone interview on [DATE] at 5:05 PM, the former Administrator [A] stated: she told the resident [#29] the previous week that hall 200 to include her room were going to be cleaned for trash and food items. The former administrator stated she went into Resident #29's room who was not present and threw away trash, expired foods, and sent dirty linen to the laundry room. The former administrator stated that around 12:30 PM she heard the resident yelling that someone had entered her room and threw away her items. The former administrator when asked about resident rights responded, the resident was not present when the cleaning of the room occurred. The former administrator stated that the resident was told that cleaning of her room would occur sometime in late [DATE]. The former administrator stated the resident did not like things thrown away. The former administrated stated that Resident [#29] room had to be cleaned out of safety and infection control concerns.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's Resident [NAME] of Rights undated read: .You have the right to be free of interference, coercion, discrimination, or reprisal .You have the right to retain and use personal possessions . unless to do so would infringe upon the health and safety of other residents .</p> <p>Record review of facility's Abuse/Neglect policy dated [DATE] read: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42402</p> <p>Based on interview and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which are complete, and accurately documented for 1 of 7 residents (Resident #3) reviewed for completeness and accuracy.</p> <p>The facility failed to transcribe Resident #3's order for Morphine correctly.</p> <p>This deficient practice could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment.</p> <p>The findings were:</p> <p>Record review of Resident #3's face sheet, dated 6/20/2024 revealed, the resident was admitted initially on 7/132018 with readmission on 5/22/2024 with diagnoses that included: chronic systolic heart failure(specific type of heart failure that occurs in the heart's left ventricle. The left and right ventricles are the bottom chambers of the heart. In a person with systolic heart failure, the heart is weak, and the left ventricle can't contract (squeeze) normally when the heart beats), chronic obstructive pulmonary disease (a condition involving constriction of the airways and difficulty or discomfort in breathing), generalized anxiety disorder , major depressive disorder, dementia, and chronic pain.</p> <p>Record review of Resident #3's comprehensive MDS dated [DATE] revealed, the resident BIMS score was a 3 which indicated cognitively impaired.</p> <p>Record review of Resident #3's MAR dated 6/1/2024-6/30/2024 revealed Morphine give up to 1 ml, 20 mg Morphine in 1 ml liquid.</p> <p>Observation on 6/21/2024 of bottle of Morphine prescribed to Resident #3 read give up to 1 ml of 20 mg Morphine in 5 ml liquid. The bottle contained a concentration of Morphine 20 mg in 5 ml liquid. The EHR read Morphine give up to 1 ml, 20 mg Morphine in 1 ml liquid.</p> <p>Record review of Resident #3's Physician Orders provided by hospice dated revealed an order for Morphine give up to 1 ml, 20 mg Morphine in 1 ml liquid.</p> <p>During an interview on 6/21/2024 at 3:15 pm RN I stated she was aware of Resident #3 receiving Morphine for pain. She stated the concentration of the bottle of morphine that was being given was ok because the dose was correct. The documentation in Resident #3's EHR should have read the same as what the bottle had on it. She further revealed it is very important to have the correct concentration and documentation of medication so the resident received riggth amount ordered by physician.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/21/2024 at 5:15 PM The DON stated the morphine concentration from the bottle on the cart was for 20 milligrams in one ML. The DON stated the order read for 20 milligrams per five MLs. She further revealed the nurse who entered the order into the EHR should have transcribed the correct concentration. She stated Resident #1 was getting the right dosage it was just transcribed wrong in the EHR.</p> <p>During an interview on 6/21/2024 at 10:45 AM Hospice patient care manager stated the order from the hospice physician read Morphine give up to 1 ml, 20 mg Morphine in 1 ml liquid. The pharmacy sent a higher concentration (of Morphine in 5 ml of liquid) and the facility did not enter in to EHR of give up to 1 ml of 20 mg Morphine in 5 ml liquid.</p> <p>During a telephone interview on 6/21/2024 at 12:14 PM Hospice MD stated his order was for Morphine 20 mg/1 ml give up to 1 ml as needed. He further revealed he did not know why the concentration was different from the morphine bottle to the electronic record. This was a transcription error and not a medication error because the resident was receiving the right dose.</p> <p>During an interview on at 6/21/2024 2:15 PM primary care physician stated the resident had appropriate doses of morphine and he had no concerns with the dose of morphine. He stated did not know why the dose transcribed in EHR was incorrect, but the 20 mg/1ml morphine was an appropriate dose for the resident. Stated resident was fairly tolerant of opioids and need frequent doses for pain mgt at the end of his life.</p> <p>Record review of facility's policy titled: Medication Administration Procedures undated, section 20. The five rights of medication should always be adhered to. 1. Right drug, right dose, right resident, right time, right route.</p>