STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455390	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Nursing and Rehab-San Antonio	5027 Pecan Grove San Antonio, TX 78222

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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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interview and record review the facility failed to ensure that the comprehensive person-centered care plan described services that are furnished to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents (Resident #1) reviewed for care plans in that: 1. Resident #1's care plan did not indicate that Resident #1 was noncompliant with the facility smoking policy and did not indicate effective interventions for the noncompliance. 2. Resident #1's care plan did not indicate that Resident #1 had verbally disruptive and aggressive behaviors toward staff and others and did not indicate effective interventions for the behaviors. This deficient practice could affect residents with behaviors and/or residents who smoke due to these conditions not being identified in the care plan and not indicating effective interventions to the behaviors in the care plan. The findings were: Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included Bipolar Disorder (a mental illness characterized by alternating periods of elation and depression), Chronic Viral Hepatitis C (a virus that causes liver swelling and can lead to serious liver damage), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Anxiety (a feeling of worry, nervousness or unease, typically about an imminent event or something with an uncertain outcome). Record review of Resident #1's quarterly MDS assessment, dated 01/19/2025, revealed Resident #1 had a BIMS score of 13, indicating no cognitive impairment. 1. Record review of Resident #1 comprehensive care plan, date initiated 01/09/2024 and revised on 02/05/2025 revealed a care plan Resident smokes and is aware of designated smoking area. The goal of the care plan stated resident will be able to smoke without causing injury. Resident aware of smoke policy and will not violate smoking rules. The comprehensive care plan did not reveal a care plan that addressed Resident #1's noncompliance with the smoking policy or interventions to address the noncompliance. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note, dated 10/08/2024 at 5:49 a.m. by LVN G, revealed Resident pushed front door open, setting off alarm to let himself out. Resident is currently sitting out front smoking. Record review of Resident #1's late entry progress note, dated 11/09/2024 at 6:16 p.m. by the DON, revealed This nurse arrived to facility from lunch break and noted resident sitting at the edge of the front entrance area with a lit cigarette. Resident was reminded he is only to smoke in designated smoking areas as he was recently reeducated on in October 2024. Resident threw lit cigarette on ground and started to curse at this nurse and then stated, 'I am not a fu**ing child you can't tell me what to do.' Resident then proceeded to enter facility and continued cursing. Resident was asked not to curse in facility due to other residents being in close proximity, and several female residents stated they did not like it when he yells. Resident continued to curse as he got in the elevator and went to his room. Record review of Resident #1's progress note, dated 11/13/2024 at 3:51 p.m. by the Social Worker, revealed Social Worker engaged resident due to reports of smoking cigarettes during non-smoke break times and, outside of designated smoking area on 11/13/24. Resident stated, 'that is a lie, I did not smoke a cigarette when and where they say I did'. Social Worker requested a smoking policy be reviewed, updated, signed. Resident responded, 'I am not signing anything'. Social worker asked about smoking materials including lighters in which the resident stated, 'I do not have anything'. Record review of Resident #1's progress note, dated 11/20/2024 at 1:56 p.m. by the Social Worker, revealed Social worker engaged resident regarding reports of the resident keeping a cigarette lighter on his person. Resident stated, 'I gave it to staff'. Record review of Resident #1's progress note, dated 01/09/2025 at 11:37 a.m. by the Social Worker, revealed Facility informed resident of an immediate discharge due to continually violating smoking policies which endanger resident safety. Record review of Resident #1's late entry progress note, dated 01/09/2025 at 6:15 p.m. by the DON, revealed Resident noted by front door with lit cigarette in area that resident has been informed before of not being an appropriate smoking are. Resident had just had a conversation with DON, and another administrative staff regarding smoke break being a few min. late due to the inclement weather and having to ensure all residents are properly dressed. Resident went out front door and started smoking. When resident was asked to stop smoking in this area, resident stated yelling and curing at staff. Resident was informed that this was cause or immediate discharge. Resident stated he did not know where to go. Resident was informed that a 30-day discharge will be issued starting today 1/09/2025. 30-day notice is to be completed on 02/09/2025. Resident stated being aware and thanked both social worker and this DON for changing immediate discharge to a 30-day discharge. Record review of a facility document titled, [Facility Name] Health Care Center Policies, Information and Required Notices: Acknowledgement of Receipt of Policies, Information and Required Notices, listed Statement of Resident Rights and Smoking Policy. An acknowledgement at the bottom of the form stated, My signature below acknowledges that I have received copies of the above listed items as of the date of the signing of this form. The form is signed by Resident #1 on 07/01/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #1 comprehensive care plan, date initiated 07/09/2024 and revised 08/14/2024 revealed a care plan The resident has a mood problem r/t Bipolar Disorder, Current episode depressed, mild or moderate severity, unspecified. The goal, date initiated 07/09/2024 and revised 08/14/2024, stated the resident will have improved mood state through the review date. The care plan did not address Resident #1's verbal and physical aggression toward staff and interventions to address the aggression. Record review of Resident #1's progress note, dated 09/23/2024 at 12:00 a.m. by RN F, revealed At approximately 12:15 a.m. patient received his 12:00 a.m. scheduled dose of norco. After taking his medication resident threw his glass of water at this writer. Resident then states 'I will take my antibiotic now. The writer reminded resident that it was scheduled for 10 p.m. and he refused the medication. Resident then yelled and stated, 'you are a fucking liar'. This writer left room to obtain mediation. Resident then came out of his room in his wheelchair stood up and lunged forward swinging his closed fist at this writer. It was at this time CNA approached bother writer and resident attempting to de-escalate resident. The resident then redirected their aggression towards CNA, attempting to strike her as well. During this episode, the resident was shouting and making verbally abusive threats towards both myself and other staff members. Resident continue to yell at staff calling them 'stupid bitches'. Record review of Resident #1's progress note, dated 09/23/2024 at 12:30 a.m. by RN F, revealed 911 called to seek assistance with resident as resident was now a threat to staff and other residents' safety. Resident's behaviors were witnessed by several other residents who were sitting by nursing station and sitting on couch. Record review of Resident #1's progress note, dated 09/23/2024 at 1:15 a.m. by RN F, revealed EMS arrived and left as resident refused to go to the hospital for evaluation. Stated 'she is a fucking bitch, I have my rights'. 2:00 a.m. EMS did reach out to police and explained the need for an ED d/t threats, aggression and attempting to physically harm staff. 3:20 a.m. No police presence at this time. Resident can be heard laughing and saying, you are nothing but a fucking bitch' while in his room. Record review of Resident #1's progress note, dated 10/08/2024 at 6:19 a.m. by RN F, revealed Resident out of his room at nurses station being verbally aggressive, shouting 'fuck you. I don't know who the fuck you think you are. You are nothing but a stupid bitch. And what the fuck are you going to do about it? Huh what are you going to do? Exactly you are not going to do shit. Stupid bitch, you are not even a nurse. Go back to school'. As he was entering the elevator, he said 'once again I will be calling state to report you stupid bitch, fuck you'. ADON made aware. Record review of Resident #1's progress note, dated 10/19/2024 at 6:30 p.m. by LVN E, revealed Resident verbally aggressive towards staff and another resident. Redirected, refused to be redirected. Had to move another resident to 2300 hall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's progress note, dated 11/13/2024 at 3:50 p.m. by the DON, revealed Resident came to DON office with Transition Specialist [name], for [insurance company name]. Resident was yelling profanities at DON asking 'Hey [DON name] why are you lying to this lady'. DON asked resident what he was talking about, resident responded 'why are you saying I schedule my own transportation and appointments?' DON attempted to explain to resident that he has and continues to do this. Resident continued to yell profanities. [Transition specialist name] asked resident to please not yell and warned that he could possibly be asked to leave the facility due to his continued behaviors that are starting to be noticed by other residents. Record review of Resident #1's progress note, dated 02/03/2025 at 4:13 p.m. by LVN E, revealed resident refused pain medication stated only wants hydrocodone, resident refused vital signs. Resident started recording with phone and yelling and stating he is calling state to get me fired that he has fired everyone and will continue firing nurses, Resident pulling finger and making gestures. Record review of Resident #1's late entry progress note, effective date of 02/09/2025 at 9:32 p.m. by the DON, revealed Resident was reminded today at 12:30pm of discharge scheduled for today (2/9/2025). Resident stated he was never told about this. Resident reminded that he was reminded of his discharge on Wednesday 2/5/25 during his care plan meeting and resident was informed on 2/5/25 that [facility name] was contacted again about admitting resident. [Facility name] informed this DON that they would admit resident. When resident came out of his room he was packed up and stated 'call the cops cause I am just leaving. If they don't come I am going to F*** S***up. When police arrived resident was argumentative and stated 'they have to send me to [facility name]. At this point [police department name] officers asked resident again if he didn't want to call family. Resident stated no I want you to take me to jail. Officers issued an emergency for resident. When EMS arrived to transport resident to hospital for eval, resident started cursing at EMS and refused to be assessed. At this point a third officer arrived and Resident was informed that he will be transported by police instead of EMS. Officers loaded all resident belongings into their vehicles and resident was placed in the backs seat of the police car and transported for eval. Resident was given all paperwork to support his discharge. Resident was not allowed to take medication with him per [police department name]. Record review of a document titled, Notification of Emergency Detention, dated 02/09/2025, listed Resident #1 as name of person being detained. The document stated No comes [officer name], a peace officer with [police department name] of the State of Texas states as follows: 1. I have reason to believe and do believe [Resident #1 name] evidence mental illness. 2. I have reason to believe and do believe that the above-named person evidences a substantial risk of serious harm to himself/herself or others based upon the following: Consumer is diagnosed with schizophrenia, currently taking medications. Consumer is very combative with staff. 3. I have reason to believe and do believe that the above risk of harm is imminent unless the above-named person is immediately restrained. 4. My beliefs are based upon the following recent behavior, overacts, attempts, statements, or threats observed by me or reliably reported to me: consumer is constantly harassing staff and being verbally aggressive toward them. Harassing has gone to the point where staff are switching schedules due to the fear of caring for consumer. Consumer has been discharged from the facility. During an interview with LVN B, 02/12/2025 at 1:18 p.m., LVN B stated Resident #1 was verbally aggressive toward the nurses and CNA's and stated Resident #1 curses at the staff when he gets agitated and was very short tempered. LVN B stated staff would be walking on eggshells, we didn't want to upset him because he would start yelling and cursing at us. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN C, 02/12/2025 at 1:36 p.m., LVN C stated she was Resident #1's Charge Nurse and witnessed him yelling and cursing at staff. LVN C stated Resident #1 would sign out and go across the street, buy cigarettes and then try to smoke the cigarettes on the front patio and refuse to turn in his cigarettes and lighter when he got back inside the facility. LVN C stated Resident #1 told LVN C about 4 weeks ago that Resident #1 got in trouble for not following the smoking policy and was getting evicted and Resident #1 said he was refusing to turn in his lighter and cigarettes and was refusing to follow the rules. LVN C stated Resident #1 was very noncompliant and would go right outside the front door and try to smoke and refused to go to the right smoking area. LVN C also stated Resident #1 called staff racial slurs and yell and curse at staff if he got upset. During an interview with the Admission Coordinator, 02/12/2025 at 2:00 p.m., The Admissions Coordinator stated new admissions were provided copies of resident rights and the facility smoking policy. The Admissions Coordinator stated Resident #1 was very aggressive. You could hear him yelling and cursing at the staff in front of other residents. He would cuss in the foyer in front of people. He has cussed me out before and would follow me down the hall and curse at me and then stand outside of other resident rooms that I was in and scream and cuss at me. The Admissions Coordinator stated Resident #1 was noncompliant with the smoking policy as far as the times and the designated smoking areas. The Admissions Coordinator stated staff would try to redirect and would provide education on safe smoking and the danger of not smoking in the correct areas. During an interview with LVN D, 02/12/2025 at 1:43 p.m., LVN D stated Resident #1 was his own responsible party and regardless of him knowing the smoking policy, he would go out and smoke where he was not supposed to try and push the limit of what he was able to do. LVN D stated on 02/09/2025 Resident #1 stated he was going to discharge home with his family member. LVN D stated LVN D heard Resident on the phone with his family member later in the day and Resident #1 said he was not leaving and was yelling and cursing at the staff. LVN D stated the police department was notified, and Resident #1 became very argumentative with the officers and EMS. LVN D stated the police ended up taking him away and detaining him because he was ugly and cursing at them and EMS as well. LVN D stated she had received training on dealing with residents with difficult behaviors and noncompliant behaviors. During an interview with Resident #1, 02/12/2025 at 2:25 p.m., Resident #1 stated he was at [City name] Medical Behavioral Hospital and said, at least I am getting to see a psychiatrist. Resident #1 stated he was aware of the smoking policy and stated he was notified of his discharge notice due to not being compliant with the smoking policy. Resident stated he did not know why the police detained him and stated the police told him they were putting him on a three day hold for threatening people and took him to a hospital and then transferred him to the behavioral hospital. Resident #1 said hospital case manager was working with him to find alternate placement after he is discharged from the behavioral hospital. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON, 02/13/2025 at 10:00 a.m., the DON stated Resident #1 was noncompliant with the smoking policy and stated Resident #1 also displayed aggressive behaviors toward staff. The DON stated Resident #1's care plan should have been updated to reflect the smoking noncompliance and the aggressive behaviors. The DON stated resident care plans should be updated at the time of a change in condition or behavior and stated the DON, ADON or MDS Nurse were responsible for updating and tweaking the care plan when there were changes in resident care or interventions. The DON stated staff would know what interventions were effective when addressing resident behaviors by reviewing the resident Kardex that would tell the person about certain behaviors to watch for and stated that information was pulled from the resident care plan. The DON stated the accuracy of a resident care plan was important because it is our guide for caring for our residents. It tells us what has and hasn't not been done for them and all of our care revolves are the care plan. The DON also stated the care plan was important so we can properly care for the resident do that hopefully the behavior does not get repeated and helps us look back to see what worked and it is our guideline to how to treat the resident. During an interview with the Social Worker, 02/13/2025 at 12:28 p.m., the Social Worker stated a resident care plan was comprehensive and should have been updated when there is a change of the intervention, a decline or physical or mental health or if the responsible party is verbalizing a revision that is needed. The Social Worker stated the MDS Nurse was usually responsible for updating the care plan and stated Resident #1's aggressive behaviors and smoking noncompliance should have been reflected in Resident #1's care plan. During an interview with the MDS Nurse, 02/13/2025 at 2:03 p.m., the MDS Nurse stated all disciplines were responsible for updating resident care plans and stated resident care plans should have been updated every time there was a change in the resident. The MDS Nurse stated the importance of the care plan was to give a picture of the residents that we take care of and shows the interventions that work and did not work. Record review of a facility document titled, Comprehensive Care Plan (Nursing Policy and Procedure Manual 03-18.0), stated Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drivees the type of care and services that a resident received. In situations where a resident's choice to decline care of treatment (e.g. due to preferences, maintain autonomy, etc.) poses a risk to the residents health or safety, the comprehensive care plan will identify the care or service being declined, the risk the declination poses to the resident, and efforts by the interdisciplinary team to educate the resident and the representative, as appropriate. The facility's attempt to find alternative means to address the identified risk/need should be documented in the care plan. The policy also stated, The comprehensive care plan will be- The resident's care plan will be reviewed after each admission, quarterly, annual and/or significant change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.