| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455390 | A. Building<br>B. Wing | 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Buena Vida Nursing and Rehab-San Antonio | 5027 Pecan Grove<br>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) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 residents (Resident #2, Resident#3, and Resident #4) reviewed of 29 residents reviewed for pharmaceutical services. The facility failed to ensure that Resident #2's, Resident #3's, and Resident #4's narcotic sheets were labeled in way to account for all medications dispensed by pharmacy. This facility failure could affect residents who take narcotics for pain and could result in misappropriation of medications or drug diversion.The Findings Include: 1. Record review of Resident #2's admission Record, dated 03/04/2026, revealed resident was a [AGE] year-old male and admitted to facility on 06/25/2025 with diagnoses of Muscle Weakness (often sudden reduction in strength where muscles cannot exert expected force), Dementia (progress decline in cognitive function severe enough to interfere with daily life), Spinal Stenosis (narrowing of spinal canal, often caused by age-related degeneration, bone spurs, or herniated discs, which compress nerves and the spinal cord), and Lack of Coordination and Unsteadiness on Feet (clumsy, uncoordinated voluntary movements often caused by damage to cerebellum or nervous system and balance disorder). Record review of Resident #2's Care Plan, dated 10/17/2025, revealed resident had care planned ?adverse medication effect and behavior monitoring', impaired mobility, gait/balance problems, and potential for uncontrolled pain. Record review of Resident #2's MDS, dated [DATE], revealed BIMS score of 14, depressed mood, walker or wheelchair for mobility depending on lower extremities and pain, partial assistance to max assistance for ADL's, and fractures and trauma. Record review of Narcotic Book on Medication Cart for hallways 2200/2500 on 03/05/2026, revealed Resident #2's Narcotic sheet for APAP/Codeine Tab 300-30mg tab was not labeled in a way to account for all medications dispensed by pharmacy. Observation of LVN A on 03/05/2026 at 6:38 am, surveyor witnessed LVN A change the documentation on Narcotic Sheet from ?card 1 of 2' to ?card 2 of 2' to match the numbering on the blister pack of medication. Interview on 03/05/2026 at 6:38 am LVN A stated that the numbers on the Narcotic Sheet for Resident #2 for the accounting of blister packs did not match what was written on the blister pack. Surveyor asked how this could affect residents and LVN A stated that they would not be able to accurately keep track of narcotics or when to reorder as the numbers were wrong. Interview on 03/05/2026 at 11:24 am, DON stated that she was initiating a plan of correction to address the concerns with all of the narcotic sheets. DON stated facility needed to follow policy and she had only been employed for a month and a half and she was actively working to address issues. 2. Record review of Resident #3's admission Record, 03/04/2026, revealed resident was a [AGE] year-old female and admitted to facility 11/26/2025 with diagnoses of Muscle Weakness and Wasting (often sudden reduction in strength where muscles cannot exert expected force), Polyneuropathy (chronic condition characterized by damage to multiple peripheral nerves, causing widespread numbness, tingling, weakness, and burning pain, typically starting in the feet and hands), and Cognitive Communication Deficit (often characterized by brain injury or neurological disease, characterized by impaired communication due to<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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | underlying cognitive issues like memory, attention and executive function). Record review of Resident #3's Care Plan, dated 01/26/2026, revealed resident had fracture of hip, care planned ?adverse medication effect and behavior monitoring', and potential for uncontrolled pain. Record review of Resident #3's MDS, dated [DATE], revealed a BIMS score of 07, mobility use of wheelchair, dependent to supervision assistance for ADL's, and indwelling catheter. Record review of Narcotic Book on Medication Cart for hallways 2200/2500 on 03/05/2026, revealed Resident #3's Narcotic Sheet for Tramadol HCL Tab 50mg was not labeled in a way to account for all medications dispensed by pharmacy. Interview on 03/05/2026 at 6:32 am LVN A stated that there was no labeling for Narcotic Sheet card count for Resident #3. The form had no documentation relating to this and LVN A stated that they would not be able to accurately keep track of narcotics or when to reorder as the numbers were wrong. Interview on 03/05/2026 at 11:24 am, DON stated that she was initiating a plan of correction to address the concerns with all of the narcotic sheets. DON stated facility needed to follow policy and she had only been employed for a month and a half and she was actively working to address issues. 3. Record review of Resident #4's admission Record, 03/04/2026, revealed resident was a [AGE] year-old male and admitted [DATE] with diagnoses of Cognitive Communication Deficit (often characterized by brain injury or neurological disease, characterized by impaired communication due to underlying cognitive issues like memory, attention and executive function), Pain, of Muscle Weakness and Wasting (often sudden reduction in strength where muscles cannot exert expected force), and Lack of Coordination and Unsteadiness on Feet (clumsy, uncoordinated voluntary movements often caused by damage to cerebellum or nervous system and balance disorder). Record review of Resident #4's Care Plan, dated 01/05/2026, revealed resident had hemiplegia/hemiparesis, ADL self-care deficit, limited physical mobility, and potential for uncontrolled pain. Record review of Resident #4's MDS, dated [DATE], revealed a BIMS score of 01, mobility use of wheelchair, and dependent to moderate assistance for ADL's. Record review of Narcotic Book on Medication Cart for hallways 2200/2500 on 03/05/2026, revealed Resident #4's Narcotic Sheet for APAP/Codeine Tab 300-30mg was not labeled in a way to account for all medications dispensed by pharmacy. Interview on 03/05/2026 at 6:27 am LVN A stated that there was no labeling for Narcotic Sheet card count for Resident #4. The form had no documentation relating to this and LVN A stated that they would not be able to accurately keep track of narcotics or when to reorder as the numbers were wrong. Interview on 03/05/2026 at 11:24 am, DON stated that she was initiating a plan of correction to address the concerns with all of the narcotic sheets. DON stated facility needed to follow policy and she had only been employed for a month and a half and she was actively working to address issues. |