

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 07/12/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on observation, interview, and record review, the facility failed to honor residents' right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents, for 1 of 24 residents (Resident #24) reviewed for needs and preferences, in that:</p> <p>On 07/09/2024 at 11:14 AM Resident #24 was left in her bedroom, in her bed with the call light button underneath her left back. Resident #24 was semi-paralyzed on her left side and could not reach the call light button.</p> <p>This failure could place residents at risk for harm by not honoring residents' individualized needs and preferences.</p> <p>The findings included:</p> <p>Record review of Resident #24's admission record dated 07/11/2024, revealed an admitted [DATE] with diagnoses which included left sided hemiparesis (left sided semi paralysis), contractures of left elbow and hand (a condition that causes one or more fingers to bend toward the palm of the hand. The affected fingers and or elbow can't straighten completely), and schizophrenia (a serious mental health condition that affects how people think, feel, and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior).</p> <p>A record review of Resident #24's quarterly MDS assessment dated [DATE], revealed Resident #24 was a [AGE] year-old female admitted for long term care. Resident #24 was assessed as medically complex and needed supports for schizophrenia. Resident #24 was assessed with a BIMS score of 09 out of a possible 15 which indicated severe cognitive impairment.</p> <p>A record review of Resident #24's care plan dated 07/11/2024, revealed, Resident #24 had an actual fall and injuries related to a previous fall, dementia, and generalized muscle weakness . Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed . The resident needs a safe environment with . a working and reachable call light</p> <p>A record review of Resident #24's physicians orders dated 07/11/2024 revealed the physician ordered Resident #24 to receive nursing facility care.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 455390
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 07/09/2024 at 11:14 AM Resident #24 presented in her bedroom, laying in her bed with the call light button underneath her left back. Resident #24 stated she did not know where her call light was. Further observation revealed the call light was underneath Resident #24's left side back. Resident #24 stated she could not reach the call light , I cannot use my left side . I cannot turn.</p> <p>During an observation and interview on 07/09/2024 at 11:16 AM CNA I stated she observed Resident #24 with her call light underneath her left side back and stated, I don't know why they did that. CNA I repositioned the call light across Resident #24 and stated, this is what I do, I place the call light across her. Further observation revealed Resident #24 could hold the call light button with her right hand.</p> <p>During an interview on 07/11/2024 at 03:10 PM the Maintenance Director stated he was not aware the call light for Resident #25's room was not working and would correct the problem as soon as possible.</p> <p>During an interview on 07/12/2024 at 11:00 AM the regional DON RN C stated the facility's call light system should be available and functioning for all residents. RN C stated the facility did not have a policy for the nurse call light system and the facility followed the CMS and state agency guidelines for the nurse call light system.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents have a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 1 of 1 facility reviewed for safe, clean, comfortable environment, in that:</p> <ol style="list-style-type: none"> 1. In room [ROOM NUMBER], there were loose tiles around the toilet, the bolt securing the toilet to the flood was rusted, there was an excessive accumulation of dust and debris on top of the mirror above the sink and paper towel dispenser, and the vent located on the wall across from the bathroom had a large accumulation of dust surrounding each opening. 2. A light above the sink in the Secured Unit shower room was not functioning. 3. In the bathroom of room [ROOM NUMBER], the toilet seat had a broken hinge. 4. In room [ROOM NUMBER], there were broken window blinds, there were large water marks on the ceiling panels of the bathroom, and the ceiling exhaust fan in the bathroom was separated from the ceiling. 5. In room [ROOM NUMBER], 2 of the 3 lights in the bathroom above the sink were not functioning, and the toilet was not properly secured to the floor allowing the toilet to move in place. <p>These failures could place residents who reside at the facility at risk of decreased quality of life due to living spaces in need to repairs.</p> <p>The findings were:</p> <ol style="list-style-type: none"> 1. Observation on 07/09/2024 at 11:10 AM in room [ROOM NUMBER] revealed four loose tiles around the toilet, and the bolt securing the toilet to the floor was rusted and not covered with a plastic cap. Further observation revealed an excessive accumulation of dust and debris on top of the mirror above the sink and paper towel dispenser. The vent located on the wall across from the bathroom had a large accumulation of dust surrounding each opening. <p>During an interview on 07/09/2024 at 11:11 AM, the resident in room [ROOM NUMBER] stated, dirty, dirty over and over and stated the dirt made her upset. The resident appeared visibly anxious as she pointed to several areas on the floor and walls inside the bathroom with visible dirt and dust.</p> <p>During an interview on 07/12/2024 at 11:20 AM , the Corporate RN stated the tiles on the floor required replacing and there was excessive dust in the bathroom that should not be there. The Corporate RN stated she heard the resident in room [ROOM NUMBER] complain about the dirt and it was apparent the resident was bothered by it. The Corporate RN also noted the vent outside the bathroom had an accumulation of debris indicating it had not been cleaned.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/12/2024 at 11:45 AM, the Maintenance Director stated he was waiting on tiles to replace the ones in the bathroom of room [ROOM NUMBER]. He also stated the entire area around the toilet needed to be re-caulked and he would take care of that as well.</p> <p>During an interview on 07/12/2024 at 11:50 AM, the Housekeeping Supervisor, stated room [ROOM NUMBER] needed additional cleaning service and it would be addressed.</p> <p>2. During an observation tour on the 500 Hall on 07/10/24 from 9:55 AM. to 10:25 AM with the Maintenance Director revealed the following:</p> <p>a. The Secured Unit shower room had a 1 of 3 lights above the sink that were not working.</p> <p>b. Resident room [ROOM NUMBER] had a bathroom toilet with a broken seat hinge.</p> <p>3. During an observation tour on the 2300 Hall on 07/10/24 from 9:55 AM to 10:25 AM revealed the following:</p> <p>a. room [ROOM NUMBER] had 11 broken window blind slats.</p> <p>b. room [ROOM NUMBER] had a bathroom ceiling panel measuring approximately 25 x 46 inches that had water markings on the panel.</p> <p>c. room [ROOM NUMBER] had a bathroom ceiling exhaust fan that was separated from the ceiling.</p> <p>d. room [ROOM NUMBER] had 2 of 3 lights above the sink that were not working.</p> <p>e. room [ROOM NUMBER] had a bathroom toilet that was not properly seated allowing the toilet to move in place.</p> <p>During an interview with the Maintenance Director on 7/10/24 at 10:15 AM, the Maintenance Director stated that he would repair all of the maintenance concerns revealed during the observation tour. The Maintenance Director stated that the repairs would improve resident safety and homelike environment.</p> <p>During an interview with the Administrator on 7/10/24 at 10:30 AM, the Administrator stated that completing the maintenance repairs would improve the resident's quality of life.</p> <p>Record review of the facility's policy on Preventative Maintenance/Work-Order Request, dated 2003, revealed, The facility will repair or replace damaged/broken equipment or building amenities as needed.</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** 41937</p> <p>Based on observation, interview, and record review, 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 10 of 24 residents (Residents #3, #4, #8, #11, #14, #19, #24, #33, #39, and #46) reviewed for the provision of routine and emergency drugs and biologicals, in that:</p> <ol style="list-style-type: none"> On [DATE] at 10:54 AM MA B administered Resident #3's baclofen 1 hour and 53 minutes late, and the resident's torsemide (a diuretic used to treat swelling), buspirone, and gabapentin (a medication to treat nerve pain) 53 minutes late. On [DATE] at 10:46 AM MA B administered Resident #4's clonazepam (a medication used to treat anxiety) 1 hour and 46 minutes late. On [DATE] at 11:18 AM MA B administered Resident #8's buspirone (a medication to treat anxiety) 2 hours and 18 minutes late. On [DATE] at 11:22 AM MA B administered Resident #11's hydralazine 2 hours and 55 minutes late. On [DATE] at 12:02 PM MA B administered Resident #14's buspirone, memantine (a medication to treat dementia), and acetaminophen (a medication to treat pain) 2 hours and 2 minutes late. On [DATE] at 10:26 AM RN H administered Resident #19's insulin 2 hours and 26 minutes late and after her breakfast meal. On [DATE] at 11:55 AM MA B administered Resident #33's hydralazine (a medication to lower blood pressure) 2 hours and 55 minutes late. On [DATE] at 11:05 AM MA B administered Resident #39's baclofen and metoprolol 2 hours and 5 minutes late. On [DATE] at 10:56 AM MA B administered Resident #46's baclofen (a muscle relaxer) and oxcarbazepine (a medication to treat bi-polar disorder) 1 hour and 56 minutes late. The facility maintained for potential administration and stored an expired insulin injection pen for Resident #24. <p>These failures could place residents at risk for harm by adverse reactions and not receiving the intended therapeutic effects of their medications.</p> <p>The findings included:</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 observation and interview on [DATE] at 11:10 AM revealed MA B at her medication cart reviewing the electronic medication administration records for the second floor. The electronic medication administration records were highlighted in red. MA B stated the reds indicated medications were past the prescribed administration time and were late. MA B identified the following residents with upcoming late medication administrations: Resident #3, #4, #8, #11, #14, #33, #39, and #46. MA B stated she had not reported the upcoming late medication administration to her supervisors.</p> <p>1. Record review of Resident #3's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included muscle weakness, chronic kidney disease, anxiety, and knee fractures (right and Left).</p> <p>Record review of Resident #3's quarterly MDS assessment, dated [DATE], revealed Resident #3 was a [AGE] year-old female admitted for long term care, assessed as medically complex, and assessed with a BIMS score of 10 out of 15 which indicated moderate cognitive impairment. Further review revealed Resident #3 received diuretic and an anti-anxiety drugs identified as high Risk.</p> <p>Record review of Resident #3's care plan, dated [DATE], revealed, The resident uses anti-anxiety medications . Give anti-anxiety medications ordered by physician . The resident has a potential for uncontrolled pain . The resident is on diuretic therap . Administer medications as ordered .</p> <p>Record review of Resident #3's physicians orders, dated [DATE], revealed the physician ordered Resident #3 to receive baclofen 5 mg three times a day at 08:00 AM, 12:00 PM, and 08:00 PM; buspirone 10 mg twice a day at 09:00 AM and 05:00 PM; torsemide 20 mg twice a day at 09:00 AM and 05:00 PM; and gabapentin 900 mg twice a day at 09:00 AM and 05:00 PM.</p> <p>Record review of the facility's Medication Admin Report, dated [DATE], revealed on [DATE] at 10:54 AM MA B administered Resident #3's baclofen 1 hour and 53 minutes late; torsemide (a diuretic used to treat swelling), buspirone, and gabapentin (a medication to treat nerve pain) 53 minutes late.</p> <p>2. Record review of Resident #4's admission record, dated [DATE] revealed an admitted [DATE] with diagnoses which included generalized anxiety disorder.</p> <p>Record review of Resident #4's quarterly MDS assessment, dated [DATE], revealed Resident #4 was a [AGE] year-old female admitted for long term care, assessed as medically complex, and assessed with a BIMS score of 07 out of 15 which indicated severe cognitive impairment. Further review revealed Resident #4 was diagnosed with anxiety disorder.</p> <p>Record review of Resident #4's care plan, dated [DATE], revealed, Resident #4 has potential to demonstrate physical behaviors r/t Poor impulse control. Resident will grab other residents and employees and not let go . Administer medications as ordered .</p> <p>Record review of Resident #4's physicians orders, dated [DATE], revealed the physician ordered Resident #4 to receive clonazepam 2 mg three times a day at 08:00 AM, 02:00 PM, and 08:00 PM.</p> <p>Record review of the facility's Medication Admin Report, dated [DATE], revealed on [DATE] at 10:46 AM MA B administered Resident #4's clonazepam (a medication used to treat anxiety) 1 hour and 46 minutes late.</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>3. Record review of Resident #8's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included generalized anxiety disorder.</p> <p>Record review of Resident #8's quarterly MDS assessment, dated [DATE], revealed Resident #8 was an [AGE] year-old female admitted for long term care, assessed as medically complex, and assessed with a BIMS score of 00 out of 15 which indicated severe cognitive impairment. Further review revealed Resident #8 was diagnosed with anxiety.</p> <p>Record review of Resident #8's care plan, dated [DATE], revealed, The resident requires psychotropic medications for diagnosis of anxiety and insomnia . Administer medications as ordered .</p> <p>Record review of Resident #8's physicians orders, dated [DATE], revealed the physician ordered Resident #8 to receive buspirone 15 mg for agitation, three times a day, at 08:00 AM, 02:00 PM, and 08:00 PM.</p> <p>Record review of the facility's Medication Admin Report, dated [DATE], revealed on [DATE] at 11:18 AM MA B administered Resident #8's buspirone 2 hours and 18 minutes late.</p> <p>4. Record review of Resident #11's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included hypertension (high blood pressure).</p> <p>Record review of Resident #11's quarterly MDS assessment, dated [DATE], revealed Resident #11 was a [AGE] year-old female admitted for long term care, assessed as medically complex, and assessed with a BIMS score of 03 out of 15 which indicated severe cognitive impairment. Further review revealed Resident #11 was diagnosed with high blood pressure.</p> <p>Record review of Resident #11's care plan, dated [DATE], revealed, The resident has hypertension . Give anti-hypertensive medications as ordered .</p> <p>Record review of Resident #11's physicians orders, dated [DATE], revealed the physician ordered Resident #11 to receive hydralazine 50 mg, three times a day, at 08:00 AM, 02:00 PM, and 08:00 PM.</p> <p>Record review of the facility's Medication Admin Report, dated [DATE], revealed on [DATE] at 11:22 AM MA B administered Resident #11's hydralazine 2 hours and 55 minutes late.</p> <p>5. Record review of Resident #14's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included dementia with mood disturbance (not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and low back pain.</p> <p>Record review of Resident #14's quarterly MDS assessment, dated [DATE], revealed Resident #14 was an [AGE] year-old female admitted for long term care, assessed as medically complex, and assessed with a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. Further review revealed Resident #14 was diagnosed with anxiety, dementia and chronic pain.</p> <p>Record review of Resident #14's care plan, dated [DATE], revealed, The resident has a potential for uncontrolled pain. Administer medications as ordered .</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>Record review of Resident #14's physicians orders, dated [DATE], revealed the physician ordered Resident #14 to receive buspirone 15 mg for agitation, three times a day, at 09:00 AM, 01:00 PM, and 09:00 PM; memantine 5 mg twice a day at 09:00 AM and 08:00 PM, and acetaminophen 325mg 4 times a day at 09:00 AM, 01:00 PM, 05:00 PM, and 09:00 PM.</p> <p>Record review of the facility's Medication Admin Report, dated [DATE], revealed on [DATE] at 12:02 PM MA B administered Resident #14's buspirone, memantine, and acetaminophen 2 hours and 2 minutes late.</p> <p>6. Record review of Resident #19's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included type II diabetes (the body's inability to use sugar in the blood stream which causes disease).</p> <p>Record review of Resident #19's Quarterly MDS assessment, dated [DATE], revealed Resident #19 was a [AGE] year-old female admitted for long term care. Resident #19 was assessed as medically complex and needed supports for her diabetes which included therapeutic diets and insulin injections. Resident #19 was assessed with a BIMS score of 07 out of a possible 15 which indicated severe cognitive impairment.</p> <p>Record review of Resident #19's care plan, dated [DATE] revealed, Resident #19 has Diabetes Mellitus . will be free from any s/sx of hyperglycemia (high blood sugar) through the review date. Date Initiated: [DATE] . Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness .</p> <p>Record review of Resident #19's physicians orders, dated [DATE], revealed the physician ordered Resident #19 to receive insulin aspart (a man made hormone to help the body use the sugar in the blood stream) via an injection below the skin before meals. The order read to measure the blood sugar and then to give the insulin per a sliding scale according to the blood sugar reading as follows: Inject as per sliding scale: if 150 - 199 = 2 units; 200 - 249 = 4 units; 250 - 299 = 6 units; 300 - 399 = 10 units if BS over 400 give 10 units and notify PCP/NP for further instructions subcutaneously (under the skin) before meals, subcutaneously with meals for [Diabetes Mellitus].</p> <p>During an observation and interview on [DATE] at 10:26 AM revealed RN H assessed Resident #19's blood sugar as 241 mg/DL (milligrams per deciliter) and injected Resident #19 with 2 units of insulin aspart per the physician's order. RN H stated she was late for the insulin administration due to her schedule and the DON. RN H stated she arrived for work 1 hour late, at 08:00 AM, and the DON was the nurse on duty for Resident #19. RN H stated she assumed nursing duties for residents on the second floor from the DON at 08:00 AM. RN H stated she had not received the report Resident #19 had not been administered her insulin. RN H stated she was in the process of assessing residents for their medications and recognized Resident #19 had not been administered her insulin prior to receiving her breakfast. RN H stated she assessed Resident #19 with a blood sugar of 241 and administered her insulin per the sliding scale, hours late.</p> <p>During an interview on [DATE] at 01:15 PM the DON stated she was the nurse on duty for Resident #19, this morning ([DATE]). The DON stated she had not administered Resident #19's insulin because, I did not see her eat breakfast.</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>7. Record review of Resident #33's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included hypertension (high blood pressure).</p> <p>Record review of Resident #33's quarterly MDS assessment, dated [DATE], revealed Resident #33 was a [AGE] year-old male admitted for long term care, assessed as medically complex, and assessed with a BIMS score of 12 out of 15 which indicated moderate cognitive impairment. Further review revealed Resident #33 was diagnosed with high blood pressure.</p> <p>Record review of Resident #33's care plan, dated [DATE], revealed, The resident has hypertension r/t prior CVA (cardio vascular accident - stroke), heart failure . Give anti-hypertensive medications as ordered .</p> <p>Record review of Resident #33's physicians orders, dated [DATE], revealed the physician ordered Resident #33 to receive hydralazine 100 mg, three times a day, at 08:00 AM, 02:00 PM, and 08:00 PM.</p> <p>Record review of the facility's Medication Admin Report, dated [DATE], revealed on [DATE] at 11:55 AM MA B administered Resident #33's hydralazine 2 hours and 55 minutes late.</p> <p>8. Record review of Resident #39's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included hyponatremia (low salt blood levels) and hypertension (high blood pressure).</p> <p>Record review of Resident #39's quarterly MDS assessment, dated [DATE], revealed Resident #39 was a [AGE] year-old male admitted for long term care, assessed as medically complex, and could not be assessed for a BIMS score and was assessed as having moderately impaired cognitive skills for daily decision making. Further review revealed Resident #39 was diagnosed with anxiety disorder and high blood pressure.</p> <p>Record review of Resident #39's care plan, dated [DATE], revealed, Resident #39 has hypertension . Give anti-hypertensive medications as ordered .</p> <p>Record review of Resident #39's physicians orders, dated [DATE], revealed the physician ordered Resident #39 to receive baclofen 20 mg, three times a day for muscle spasm, at 08:00 AM, 02:00 PM, and 08:00 PM and metoprolol 25 mg for high blood pressure, Give 1 tablet by mouth three times a day, at 08:00 AM, 02:00 PM, and 08:00 PM.</p> <p>Record review of the facility's Medication Admin Report dated [DATE], revealed on [DATE] at 11:05 AM MA B administered Resident #39's baclofen and metoprolol 2 hours and 5 minutes late.</p> <p>9. Record review of Resident #46's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included bi-polar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and chronic pain.</p> <p>Record review of Resident #46's quarterly MDS assessment, dated [DATE], revealed Resident #46 was a [AGE] year-old male admitted for long term care, assessed as medically complex, and assessed with a BIMS score of 15 out of 15 which indicated no cognitive impairment. Further review revealed Resident #46 was diagnosed with bi-polar disorder and chronic pain due to trauma.</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>Record review of Resident #46's care plan, dated [DATE], revealed, The resident is on Hypnotic Therapy . Administer medications as ordered . The resident has Paraplegia . Give medications as ordered .</p> <p>Record review of Resident #46's physicians orders, dated [DATE], revealed the physician ordered Resident #46 to receive baclofen 20 mg 1 tablet four times a day, at 08:00 AM, 12:00 PM, at 08:00 PM and at the hour of sleep, related to chronic pain and oxcarbazepine 750 mg twice a day at 08:00 AM and 08:00 PM.</p> <p>Record review of the facility's Medication Admin Report, dated [DATE], revealed on [DATE] at 10:56 AM MA B administered Resident #46's baclofen (a muscle relaxer) and oxcarbazepine (a medication to treat bi-polar disorder) 1 hour and 56 minutes late.</p> <p>During an interview on [DATE] at 11:00 AM the Regional DON stated medications should be administered at the times prescribed.</p> <p>10. Record review of Resident #24's admission record, dated [DATE], revealed an admitted [DATE] with diagnoses which included diabetes mellitus (the body's inability to use sugar in the blood stream causing disease).</p> <p>Record review of Resident #24's quarterly MDS assessment, dated [DATE], revealed the resident had a BIMS score of 09, which indicated moderate cognitive impairment, and was assessed as medically complex and needed supports for her diabetes which included therapeutic diets and insulin injections.</p> <p>Record review of Resident #24's care plan, dated [DATE], revealed, The resident has Diabetes Mellitus . will be free from any s/sx of hyperglycemia (high blood sugar) through the review date. Date Initiated: [DATE] . Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness .</p> <p>Record review of Resident #24's physicians orders, dated [DATE], revealed an order to receive insulin Glargine (a long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours) Inject 10 unit subcutaneously (under the skin) at bedtime related to diabetes mellitus .</p> <p>Observation on [DATE] at 12:35 PM of the second-floor nurses' medication cart revealed the medication cart contained Resident #24's Lantus injection pen. Observation of the insulin injection pen revealed the label to identify the medication as Resident #24's insulin Glargine injection pen. Further observation revealed the pen was dated [DATE] and read, use within 28 days after initial use .</p> <p>During an interview with LVN A on [DATE] at 12:35 PM, at the same time as the observation, LVN A stated the date of [DATE] signified the date the insulin pen was removed from refrigeration and placed into use for Resident #24. LVN A read the label as, use within 28 days after initial use . LVN A stated the pen was expired and would remove from the cart.</p> <p>Record review of a calendar revealed [DATE] was 31 days from [DATE].</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 with the Corporate DON (RN C) on [DATE] at 12:50 PM, the Corporate DON (RN C) stated Resident #24's Glargine injection pen should have been discarded on the 28th day after it was placed into service.</p> <p>Record review of the facility's policy titled, Recommended Medication Storage, dated ,d+[DATE], revealed, medications that require an open date as directed by the manufacturer should be dated when opened in a manner that is clear when the medication was opened. below is a list of medications that require a date when opening and the recommended time frame the medication should be used. this is not an all-inclusive list, and the manufacturers recommendations will supersede this list . insulin glargine . expires 28 days after initial use regardless of product storage .</p> <p>Record review of the facility's Medication Administration Procedures policy dated 2003, revealed, the five rights of medication (administration) should always be adhered to; 1. Right drug, 2. Right dose, 3. Right Resident, 4. Right time, 5. Right route .</p> <p>Record review of The Institute for Safe Medication Practices website, Guidelines for Timely Administration of Scheduled Medications (Acute) https://home.ecri.org/blogs/ismp-resources/guidelines-for-timely-administration-of-scheduled-medications-acute , accessed [DATE], titled, Guidelines for Timely Administration of Scheduled Medications revealed, . How to Use the Guidelines: These guidelines are applicable ONLY to scheduled medications (see definition section) . Definitions: 1. Scheduled medications include all maintenance doses administered according to a standard, repeated cycle of frequency (e.g., q4h, QID, TID, BID, daily, weekly, monthly, annually) . 2. Medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h) Administer these medications within 1 hour before or after the scheduled time .</p> <p>Record review of the National Library of Medicine's website, Nursing Rights of Medication Administration - NCBI Bookshelf (nih.gov) , accessed [DATE] titled Nursing Rights of Medication Administration updated [DATE], revealed, Definition/Introduction: Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration.[1] It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. These 'rights' came into being during an era in medicine in which the precedent was that an error committed by a provider was that provider's sole responsibility and patients did not have as much involvement in their own care.[2]; The five traditional rights in the traditional sequence include: . 'Right time' - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>27923</p> <p>41937</p> <p>Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments and permit only authorized personnel to have access to the keys for 1 of 2 medication rooms reviewed for medication storage, in that:</p> <p>The medication room on the second floor was left unattended and unlocked.</p> <p>This failure could place residents at risk for harm by not receiving the medications due to misappropriation.</p> <p>The findings included:</p> <p>Observation on 7/10/24 at 09:50 AM revealed the medication room on the facility's second floor, located at the beginning of the resident's hallway, was left unattended and unlocked. Further observation revealed multiple residents' medications which were stored inside the room. The medication room had a key latch door handle which was unlocked.</p> <p>During an interview on 07/10/2024 at 09:55 AM LVN A stated she was the nurse on duty for the second floor. LVN A stated she was busy serving Resident's breakfasts and was unaware the medication room was unattended and unlocked.</p> <p>During an interview on 7/10/24 at 10:00 AM MA B stated she was unaware the medication room was unattended and unlocked. MA B stated she was busy administering medications to residents.</p> <p>During an interview on 07/10/2024 at 10:35 AM the Administrator and RN C stated having a medication room which was unattended and unlocked would be a safety concern for residents.</p> <p>Record review of the facility's policy titled, Storage of Medication, dated 2003, revealed, . medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923</p> <p>41937</p> <p>Based on observations, interviews, and record reviews the facility failed to prepare and provide food and drink that was palatable, attractive, and at a safe and appetizing temperature, for 7 of 28 residents (Resident #13, #15, #17, #25, #37, #54, and #61) reviewed for palatable and appetizing food, in that:</p> <ol style="list-style-type: none"> 1. The facility served Resident #25 a breakfast meal 1 hour and 2 minutes after the kitchen delivered the meal, and the meal was cold and not palatable to the resident. 2. The facility served Resident #13 a breakfast meal 58 minutes after the kitchen delivered the meal, and the meal was cold and not palatable to the resident. 3. The facility served Resident #61 a breakfast meal 56 minutes after the kitchen delivered the meal, and the meal was cold and not palatable to the resident. 4. The facility served Resident #37 a breakfast meal 54 minutes after the kitchen delivered the meal, and the meal was cold and not palatable to the resident. 5. The facility served Resident #15 a breakfast meal 45 minutes after the kitchen delivered the meal, and the meal was cold and not palatable to the resident. 6. Residents #17 and #54 were food served cold food, and was not palatable to the resident. <p>These failures could place residents at risk for harm by demoralization, diminished quality of life, and weight loss.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. A record review of Resident #25's admission record dated 07/11/2024 revealed an admitted [DATE] with diagnoses which included muscle wasting. <p>A record review of Resident #25's quarterly MDS assessment dated [DATE] revealed Resident #25 was a [AGE] year-old male admitted for long term care. Resident #25 was assessed with a BIMS score of 15 out of 15 which indicated no cognitive impairment.</p> <p>A record review of Resident #25's care plan dated 07/11/2024 revealed, current diet: regular diet with regular texture and thin liquids . Monitor/record/report to MD signs and symptoms of malnutrition</p> <p>A record review of Resident #25's physicians orders dated 07/11/2024 revealed the physician ordered Resident #25 to receive nursing facility care.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. A record review of Resident #13's admission record dated 07/11/2024 revealed an admitted [DATE] with diagnoses which included muscle wasting.</p> <p>A record review of Resident #13's quarterly MDS assessment dated [DATE] revealed Resident #13 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 10 out of a possible 15 which indicated moderate cognitive impairment.</p> <p>A record review of Resident #13's care plan dated 07/11/2024 revealed, the resident has nutritional problem or potential nutritional problem current diet: regular with regular consistency fluids . Monitor/record/report to MD signs and symptoms of malnutrition</p> <p>3. A record review of Resident #61's admission record revealed an admitted [DATE] with diagnoses which included protein-calorie malnutrition.</p> <p>A record review of Resident #61's admission MDS assessment dated [DATE] revealed Resident #61 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 12 out of a possible 15 which indicated no cognitive impairment.</p> <p>A record review of Resident #61's care plan dated 07/11/2024 revealed, Potential Risk for Malnutrition . Notify the physician for any negative findings, abnormal labs, or resident non-compliance . Offer diet as ordered by the physician . Update food preferences as needed</p> <p>4. A record review of Resident #37's admission record dated 07/11/2024, revealed an admitted [DATE] with diagnoses which included protein-calorie malnutrition.</p> <p>A record review of Resident #37's quarterly MDS assessment dated [DATE] revealed Resident #37 was a [AGE] year-old female admitted for long term care and assessed with a BIMS score of 04 out of a possible 15 which indicated severe cognitive impairment.</p> <p>A record review of Resident #37's care plan dated 07/11/2024 revealed, Potential Risk for Malnutrition . Offer diet as ordered by the physician . Update food preferences as needed</p> <p>5. A record review of Resident #15's admission record dated 07/11/2024 revealed an admitted [DATE] with diagnoses which included protein-calorie malnutrition.</p> <p>A record review of Resident #15's quarterly MDS assessment dated [DATE] revealed Resident #15 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 09 out of a possible 15 which indicated moderate cognitive impairment.</p> <p>A record review of Resident #15's care plan dated 07/11/2024 revealed, current diet: regular diet, regular texture and thin liquids . Monitor/record/report to MD signs and symptoms of malnutrition</p> <p>6. A record review of Resident #17's face sheet dated 7/12/24 revealed Resident #17 was admitted on [DATE] had diagnoses's of primary glaucoma (a condition of increased pressure in the eye), end stage renal disease(a condition of significant kidney failure), and type 2 diabetes mellitus (a condition in which the body has difficulty controlling blood sugar).</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #17 quarterly MDS dated [DATE] revealed resident #17 with a BIMS of 15 indicating intact cognitive functioning.</p> <p>7. Record review of Resident #54's face sheet dated 7/12/24 revealed resident #54 was admitted on [DATE] with diagnoses of schizoaffective disorder (a condition having symptoms of delusions and hallucinations), major depressive disorder (a condition with symptoms of persistent low mood and self-esteem), and generalized anxiety disorder (a condition with severe ongoing anxiety).</p> <p>Record review of Resident #54's quarterly MDS assessment dated [DATE] revealed resident #54 with a BIMS score of 8 which indicated moderate cognitive impairment.</p> <p>During an observation on 07/09/2024 at 12:46 PM revealed CNA K was attending 13 residents in the second-floor dining room. Further observation revealed the kitchen delivered residents meals on open uncovered racks, although each individual meal was set upon plastic trays and covered plates.</p> <p>During an observation from 07/09/24 12:47 PM to 07/09/2024 at 01:30 PM revealed CNA's I and K along passed out meal trays to residents in the kitchen and then proceeded to pass out meals to residents who were in their rooms down their respective hallways. The last meal was observed to be passed out at 01:30 PM, 07/09/2024, by CNA I to Resident #25.</p> <p>During an observation and interview on 07/10/2024 at 07:35 AM through 07/10/2024 at 08:31 AM, revealed the kitchen delivered the breakfast meal at 08:15 AM. The meals were delivered on open uncovered racks, although each individual meal was set upon plastic trays and covered plates. LVN A was observed checking the meals for accuracy and was repositioning meals from one rack to another. LVN A stated she was checking the meals for accuracy of diet textures, likes, and dislikes, as well as allergies. LVN A stated she also repositioned trays from 1 rack to another to segregate the meals for residents who were not in the dining room. Residents in the dining room were heard to verbally call out Hurry up! Resident #4 was observed to call out and complain stating she could see her meal and complained hurry up . please Continued observation revealed no CNA's in the dining room. LVN A stated there were two CNA's, CNA I and CNA K, on duty for the 2nd floor.</p> <p>During an observation on 07/10/2024 at 08:32 AM revealed LVN A on the phone speaking to kitchen staff regarding meal errors. Continued observation revealed CNA I and CNA K arrived and continued repositioning residents' meal trays from one rack to another. Continued observation revealed on 07/10/2024 at 08:40 AM the 15 residents in the second-floor dining room were served their breakfast meals 25 minutes after the kitchen delivered the residents meals. Continued observation revealed CNA K, CNA I and LVN A continued serving residents in the dining room.</p> <p>During an observation on 07/10/2024 at 08:52 AM revealed the residents who were not in the dining room had their meal trays awaiting on the open uncovered racks by the dining room. Continued observation revealed Resident #15 ambulated, in his wheelchair, out of his room and approached MA B and complained his food was on the rack, it was getting cold, and he wanted his meal now. MA B replied, we have to wait . until the dining room gets served first .rules and regulations. Resident #15 continued complaining and stated I AM tired of getting cold food . I won't eat cold food! MA B continued to redirect Resident #15 and stated she would microwave residents' food if needed.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 07/10/2024 at 09:00 AM revealed CNA I and CNA K began serving residents meal trays continued observation revealed CNA I and CNA K began serving residents who were not in the dining room and were in their rooms, 45 minutes after the kitchen delivered the meals to the dining room.</p> <p>During an observation and interview on 07/10/2024 at 09:04 AM revealed Resident #15 leaving the second floor. Resident #15 stated he did not eat his meal, it was cold, I won't eat cold food, I am going to smoke a cigarette!</p> <p>During an observation and interview on 07/10/2024 at 09:09 AM revealed CNA K served Resident #37 her breakfast meal. Resident #37 stated her meal was cold and unappealing. Resident #37 stated she preferred to stay in her room and most of her meals were served cold. Resident #37 stated, this is a regular practice and happens almost every day for most meals especially breakfast.</p> <p>During an observation and interview on 07/10/2024 at 09:11 AM revealed CNA I served Resident #61 his breakfast meal. Resident #61 stated the food was cold.</p> <p>During an observation and interview on 07/10/2024 at 09:13 AM revealed CNA I served Resident #13 his breakfast meal. Resident #13 stated the food was cold and it usually is cold. Resident #13 stated the breakfast included a cold chorizo and egg taco served with hash browns.</p> <p>During an observation and interview on 07/10/2024 at 09:17 AM revealed Resident #25 was served the last meal tray 1 hour and 2 minutes after the kitchen delivered the meal. Resident #25 stated the meal was cold, the meals are always cold, something needs to be done</p> <p>During an interview on 07/10/2024 at 01:00 PM the facility Administrator stated he would be looking into improving the quality and timeliness of the meal service.</p> <p>During a group interview on 07/10/2024 at 02:30 PM at the Resident council meeting Resident #17 and Resident #54 stated meals served over the last several weeks have been served cold.</p> <p>During an observation of breakfast meal service on 7/11/24 at 08:10 AM revealed Residents' food trays were brought to the second-floor residents' hallway in an open food rack that was not covered.</p> <p>During an observation of breakfast meal service on 7/12/24 at 07:45 AM revealed that the Resident food trays were brought to the second-floor residents' hallway in an open food rack that was not covered.</p> <p>During an interview on 7/12/24 at 10:50 AM Resident #37 stated her meals served in her room have been served cold over the last several weeks. When asked about the meals being cold, she stated, I have had worse. When asked if she told the CNA nursing staff about the cold meals she stated, I don't want to hurt their feelings.</p> <p>Record review of the facility's undated admission packet, under the section entitled Food and Nutrition services revealed, We hope you enjoy the meals while you stay with us.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36232</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that:</p> <ol style="list-style-type: none"> The facility failed to store an opened bag of cereal in a sealed container in the dry storage room. The facility failed to ensure the chlorine sanitizer in the dish machine was at the minimum concentration necessary to sanitize dishes and utensils. <p>These deficient practices could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings were:</p> <ol style="list-style-type: none"> Observation on 07/09/2024 at 10:41 AM in the dry storage room revealed a 35-oz. bag of corn flakes cereal. The cereal was stored in a zip-locked bag that was not sealed. <p>During an interview on 07/09/2024 at 10:42 AM, the DM stated the zip locked bag should have been sealed to prevent the quality of the cereal from spoiling and potential contamination from rodents and pests. She further stated it was the responsibility of all dietary staff storing food in the dry storage room to properly seal, label and date all food items, and she trained all staff upon hire and throughout the year. All staff were up to date on food handler certification.</p> <ol style="list-style-type: none"> Observation on 07/09/2024 at 10:48 AM revealed DA J ran the facility's dish machine in the dish room. The dish machine was a low-temperature machine that used a chemical sanitizer to sanitize dishes and utensils. The machine reached 120 degrees Fahrenheit during the wash cycle. After the cycle was completed, DA J tested the chlorine level of the water in the dish machine by placing a chlorine test strip in the water. The test strip did not change color, indicating there was no chlorine sanitizer present during the sanitizing cycle of the machine. <p>Observation on 07/09/2024 at 10:51 AM revealed the DM ran the dish machine. After the cycle was completed, the DM tested the chlorine level of the water in the dish machine by placing a chlorine test strip in the water. The test strip did not change color, again indicating there was no chlorine sanitizer present. The DM checked the container of sanitizer on the floor next to the machine, adjusted the cap, ran the machine again, and manually pumped sanitizer using a switch on the machine. At the end of the cycle, the DM tested the chlorine level by placing a test strip in the water and the color of the strip changed to dark lavender, indicating a chlorine level between 50-100 ppm when compared to the color chart on the container of the test strips. This was within the acceptable range.</p> <p>During an interview on 07/09/2024 at 11:00 AM, the DM stated she checked the chlorine level earlier that morning when doing her rounds and there had been no issues. She believed there may have been an air bubble in the line preventing the proper flow of chlorine sanitizer into the machine.</p> <p>(continued on next page)</p>		

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 07/12/2024
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.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of temperature/sanitizer log for the month of July 2024 in the dish room revealed no discrepancies in temperatures or sanitizer levels.</p> <p>Record review of facility policy IC 00-7.0, Dishwashing Preparation and Dishwashing, 2012, revealed, The facility will complete the dishwashing process in a sanitary manner to provide clean and sanitary dishes and utensils. 2 Automatic dishwasher: Low temperature machine. d. Prior to washing the soiled dishes after a meal, the dish machine should be tested for proper temperature and PPM of sanitizing solution. The dish machine may need to be run empty for a few cycles to ensure the proper temperature is attained, and no dishes will be washed prior to achieving this standard. h. Facilities shall use an approved test kit to measure the parts per million (ppm) of the chemical solutions in the low temperature dish machine on a daily basis. Any abnormal test results shall be reported to the Dietary Service Manager. A ppm of 50 will be attained prior to dishes being washed.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization -Temperature, pH, Concentration, and Hardness.</p> <p>A chemical SANITIZER used in a SANITIZING solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under S7-204.11 Sanitizers, Criteria, shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows:</p> <p>(A) A chlorine solution shall have a minimum temperature based on the concentration and PH of the solution as listed in the following chart;</p> <p>mg/L pH 10 or Less pH 8 or Less</p> <p>25-49 120 degrees F 120 degrees F</p> <p>50-99 100 degrees F 75 degrees F</p> <p>4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration.</p> <p>Concentration of the SANITIZING solution shall be accurately determined by using a test kit or other device.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>36232</p> <p>Based on observation, interview and record review, the facility failed a to dispose of garbage and refuse properly for 1 of 2 Dumpsters (Dumpster #2) reviewed for disposal of garbage, in that:</p> <p>The facility failed to ensure Dumpster #2's door was completely shut, had a drain plug, and was free of pests.</p> <p>These deficient practices could place residents at risk for exposure to germs and diseases carried by vermin and rodents.</p> <p>The findings were:</p> <p>Observation on 07/11/2024 at 11:50 AM revealed Dumpster #2 did not have drainage plug, the door was open, and there were ants present.</p> <p>During an interview on 07/11/2024 at 11:51 AM, the DM stated the door to Dumpster #2 was open and should not have been, as it presented an unsanitary condition and an opportunity for the proliferation of rodents. The DM also noted the presence of ants crawling on the rear side of the Dumpster.</p> <p>During an interview on 07/11/2024 at 12:15 PM, the Maintenance Director stated the drain plug was missing from Dumpster #2 and he would ensure it was replaced. The DM also noted the presence of ants and indicated he would ensure the Dumpster was free of pests.</p> <p>During an interview on 07/11/2024 at 3:30 PM, the Administrator stated the facility did not have a policy on maintaining the Dumpsters and the dumpster area.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 5-501.113 Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the food establishment. 5-501.114 Using Drain Plugs. Drains in receptacles and waste handling units for refuse, recyclables, and returnables shall have drain plugs in place.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on observations, interviews, and record reviews the facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside and toilet and bathing facilities, for 1 of 24 residents (Resident #25) reviewed for call light accessibility and functionality, in that:</p> <p>On 07/09/2024 at 01:00 PM Resident #25 utilized his call light which did not illuminate the nurse call light directly outside and above of his room door.</p> <p>This failures could place residents at risk for harm by not receiving care and attention when their nurse call light system malfunctions and or is out of reach.</p> <p>The findings included:</p> <p>Record review of Resident #25's admission record dated 07/11/2024 revealed an admitted [DATE] with diagnoses which included left sided hemiparesis (left sided semi paralysis) and general anxiety disorder.</p> <p>A record review of Resident #25's quarterly MDS assessment dated [DATE] revealed Resident #25 was a [AGE] year-old male admitted for long term care, assessed as medically complex, and needed support for his diagnosed schizophrenia, semi paralysis, and anxiety. Resident #25 was assessed with a BIMS score of 15 out of 15 which indicated no cognitive impairment.</p> <p>A record review of Resident #25's care plan dated 07/11/2024 revealed, Resident #25 has Hemiplegia/Hemiparesis . Assist with ADLs/Mobility as needed . Reposition at least every 2 hours . Resident #25 has had an actual fall . Be sure Resident #25's call light is within reach and encourage Resident #25 to use it for assistance as needed . Resident #25 needs a safe environment with . a working and reachable call light</p> <p>A record review of Resident #25's physicians orders dated 07/11/2024 revealed the physician ordered Resident #25 to receive nursing facility care.</p> <p>During an observation and interview on 07/09/24 at 01:00 PM revealed the nurses station call light panel sounded a nurse call light alarm and illuminated the light designated for Resident #25's room. Further observation revealed the light immediately outside and above Resident #25's room was not illuminated. Resident #25 stated he needed assistance, and no one was coming to his aid.</p> <p>During an observation and interview on 07/09/2024 at 01:08 PM CNA I stated the call light above Resident #25's door was not working and entered Resident #25's room to answer his verbal shouts for care. CNA I stated she would report the call light failure to the maintenance director. CNA I stated she did not know how long the light was not functioning and stated she responded to Resident #25's verbal calls.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/11/2024 at 03:10 PM the maintenance director stated he was not aware the call light for Resident #25's room was not working and would correct the problem as soon as possible.</p> <p>During an interview on 07/12/2024 at 11:00 AM the regional DON RN C stated the facility's call light system should be available and functioning for all residents. RN C stated the facility did not have a policy for the nurse call light system and the facility followed the CMS and state agency guidelines for the nurse call light system.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>27923</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 1 facility reviewed for environmental concerns, in that:</p> <p>The ceiling fan in the Soiled Utility Room on th 2300 Hallway had dust and dirt particles in the vent slats.</p> <p>This deficient practice could place residents at risk of not living in a safe, functional, sanitary, and comfortable environment.</p> <p>The findings included:</p> <p>Observation on the 500 Hall on 07/10/24 from 9:55 AM to 10:25 AM with the Maintenance Director revealed the soiled utility room on the 2300 resident hallway had a ceiling fan measuring approximately 2 x 2 feet that had dust and dirt particles in the vent slats.</p> <p>During an interview with the Maintenance Director on 7/10/24 at 10:15 AM he stated that he would repair all of the maintenance concerns revealed during the observation tour. The Maintenance Director stated that the repairs would improve resident safety and homelike environment.</p> <p>During an interview with the Administrator on 7/10/24 at 10:30 AM he stated that completing the maintenance repairs would improve the resident's quality of life.</p> <p>Record review of the facility's policy on Preventative Maintenance/Work-Order Request, dated 2003, revealed, The acility will repair or replace damaged/broken equipment or building amenities as needed.</p> <p>36232</p>		