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	08/29/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the resident's status for 4 of 6 residents (Resident #7, Resident #8, Resident #10, and Resident #35) who were reviewed for resident assessments. 1.The facility failed to document Resident #7's use of anticonvulsant medication on the quarterly MDS assessment. 2. The facility failed to accurately code Resident #8's hypoglycemic medication on the quarterly MDS assessment.3. The facility failed to document Resident #10's use of antiplatelet medication on the quarterly MDS assessment.4. The facility failed to accurately code Resident #35's diagnosis of bipolar disorder on the quarterly MDS assessment. This failure could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1. Record review of Resident #7's admission sheet dated 10/16/2023 with an original date of 4/08/2020 documented a [AGE] year-old female resident with diagnoses including dementia, schizophrenia, diabetes mellitus, anxiety, hypertension (high blood pressure), bipolar disorder, depression, and hyperlipidemia (high cholesterol). Record review of Resident #7's MDS dated [DATE] documented a BIMS of 6 indicating severe cognitive impairment and recorded the use of antipsychotic, antianxiety, antidepressant, antiplatelet, and hypoglycemic medications. Further review of Resident #7's MDS revealed the assessment did not include the use of anticonvulsants, despite the resident receiving Lamotrigine and Depakote. Record review of Resident #7's order summary documented active orders for the psychotropic medications: -Lamotrigine 100 mg give by mouth one time a day for anxiety, with a start date of 04/22/2024.-Depakote 500 mg give one tablet by mouth two times per day related to biploar disorder, with a start date of 04/21/2024.-Sertraline 100 mg give on e tablet by mouth one time a day related to major depressive disorder, with a start date of 08/26/2024. -Zyprexa 20 mg give one by mouth one time a day related to schizophrenia, with a start date of 04/21/2024. Record review of Resident #7's July 2025 MAR documented the resident had been receiving Lamotrigine, Sertraline, Zyprexa, and Depakote as prescribed. Further review of the July MAR documented that Lamotrigine was ordered as Lamotrigine 100mg, give 1 tablet by mouth one time a day for anxiety. Sertraline was ordered as Sertraline 100mg give 1 tablet by mouth one time a day.give with 25mg tab to equal 125mg daily. Zyprexa was ordered as Zyprexa 20mg give 1 tablet by mouth one time a day. Depakote was ordered as Depakote 500mg give 1 tablet by mouth two times a day. Record review of Resident # 7's care plan, revision dated on 04/07/2025, documented ANTIPSYCHOTIC MEDICATIONS: The resident requires the use of antipsychotic medications r/t long-standing mental illness, dx Schizophrenia -depakote -lamotrigine. The care plan listed Depakote and Lamotrigine in the antipsychotic medication section. The care plan did not include monitoring for anticonvulsant medications. 2. Record review of Resident #8's admission sheet dated 3/28/2023 with an original date of 9/13/2017 documented a [AGE] year-old male resident with diagnoses including schizoaffective disorder, diabetes mellitus, dementia, depression, anxiety, insomnia, hypertension, and cerebral infarction (stroke). Record review of Resident #8's MDS assessment dated [DATE] documented a BIMS score of 14 indicating intact cognition and recorded the use antipsychotic, diuretic, and hypoglycemic medications. Further review of Resident #8's MDS revealed the assessment inaccurately recorded a total of one day for the (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	number of days that insulin injections were received during the last 7 days. Record review of Resident #8's order summary documented an active order for the hypoglycemic medication Trulicity (a glucagon-like peptide 1 [GLP-1] receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus). Further review of the order summary did not include an order for insulin. Record review of Resident #8's June 2025 MAR documented the resident had been receiving Trulicity as prescribed. Further review of the June MAR recorded Trulicity was ordered as Trulicity 3mg/0.5mL, Inject 3mg subcutaneously one time a day every 7 day(s) related to type 2 diabetes mellitus without complications. Record review of Resident #8's care plan documented a diagnosis of diabetes mellitus with interventions including Diabetes medications as ordered by doctor. Monitor/document for side effects and effectiveness. 3. Record review of Resident #10's admission sheet dated 8/13/2024 with an original date of 7/30/2024 documented a [AGE] year-old female resident with diagnoses including schizophrenia, diabetes mellitus, hyperlipidemia, depression, hypertension, and chronic obstructive pulmonary disease (a lung condition caused by damaged to the airways that limits air flow). Record review of Resident #10's MDS dated [DATE] documented a BIMS score of 13 indicating intact cognition and recorded the use of antipsychotic, antidepressant, hypnotic, anticoagulant, diuretic, opioid, and hypoglycemic medications. Further review of Resident #10's MDS revealed the assessment did not include the use of antiplatelet medications and inaccurately recorded the resident as receiving anticoagulant therapy. Record review of Resident #10's August 2025 MAR documented the resident had been receiving Aspirin as prescribed. Further review of the August MAR recorded Aspirin was ordered as Aspirin 81mg, give 1 tablet by mouth one time a day for heart health. Further review of the August MAR revealed Resident #10 did not have an order for an anticoagulant medication. Record review of Resident #10's care plan, dated 08/03/2024, documented The resident is on anticoagulant therapy. Further review of the care plan showed the assessment did not include monitoring for antiplatelet therapy. 4. Record review of Resident #35's admission sheet dated 7/01/2025 documented a [AGE] year-old male resident with diagnoses including dementia with behavioral disturbance, benign prostatic hyperplasia (enlarged prostate leading to difficulty urinating), and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Record review of Resident #35's order summary documented active orders for the psychotropic medication Risperdal (an atypical antipsychotic indicated for the treatment of schizophrenia, bipolar I disorder with acute manic or mixed episodes, and autism-associated irritability). Record review of Resident #35's July 2025 MAR documented the resident had been receiving Risperdal as prescribed. Further review of the July 2025 MAR documented Risperdal was ordered as Risperdal 1mg, give 0.5 tablet by mouth one time a day for bipolar and Risperdal 1mg, give 1 tablet by mouth at bedtime for bipolar, with a start date of 07/01/2025. Record review of Resident #35's MDS dated [DATE] documented a BIMS score of 14 indicating intact cognition and documented the use of antipsychotic, antidepressant, and opioid medications. Further review of Resident #35's MDS revealed the assessment did not include a diagnosis of bipolar disorder. Record review of Resident #35's care plan, revised dated on 07/18/2025, documented Adverse medication effect and behavior monitoring but did not specify the type of medication class to monitor. Further review of the care plan revealed the diagnosis of bipolar disorder was not included on the diagnosis list. In an interview with the MDS Coordinator on 8/29/25 at 10:01 AM, the MDS Coordinator stated if the MDS was not coded correctly or has missing information, they could miss a side effect of a medication. The MDS Coordinator went on to state they would not know if behaviors were mania or altered mental status, and a resident could have issues if someone did not know specific side effects of a medication to look for if something was wrong. The MDS Coordinator stated it was important for the MDS to be accurate so the facility could know what was going on with the whole resident. In an interview with the DON on 8/29/25 at 1:23 PM, the DON stated her expectation for the MDS was that it be accurate, complete, and detail-oriented. The DON went on to state the MDS is the whole picture of a resident, it encompasses everything, and if (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications and diagnoses were coded incorrectly, they needed to do some education with the staff. In an interview with the Regional Compliance Nurse on 8/26/25 at 12:58 PM, the Regional Compliance Nurse stated they did not have an MDS or assessment policy, and they followed the RAI manual. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2024 noted Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. and Code all high-risk drug class medications according to their pharmacological classification. and Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise the comprehensive care plan after each assessment for 5 of 6 residents (Residents #1, #4, #7, #10, and #35) reviewed for care planning. 1. The facility failed to ensure Resident #1's care plan was accurate to reflect that he was not a smoker.2. The Facility failed to ensure Resident #4's care plan reflected he was on dialysis. 3. The facility failed to ensure Resident #7's care plan was accurate and updated to reflect the type of psychoactive medications prescribed for Resident #7 and the specific side effect monitoring of those medications. 4. The facility failed to ensure Resident #10's care plan was accurate and updated to reflect the type of blood thinning medication Resident #10 was prescribed.5. The facility failed to ensure Resident #35's care plan was accurate and updated to reflect Resident #35's psychiatric diagnoses and psychoactive specific medication monitoring. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1. Record review of Resident #1's admission Record dated 08/28/2025, reflected a [AGE] year-old male admitted to the facility 07/09/2025. His diagnoses included other frontotemporal neurocognitive disorder (a group of neurodegenerative disorders associated with changes in the brain's frontal and temporal lobes which control functions related to personality, behavior, and language), pneumonia due to methicillin susceptible staphylococcus aureus (a bacterial infection of the lungs that can be treated with antibiotics), and schizophrenia (a mental health condition where people can experience a disconnection from reality, presenting with symptoms such as false beliefs and disorganized thinking). Record review of Resident #1's Smoking Assessment with an effective date of 07/28/2025 revealed he was unable to find the smoking areas, was unable to extinguish smoking materials or know how to dispose of ashes and was unable to smoke unattended. The assessment had a box checked indicating the evaluation has been explained to the family responsible party. There was no indication on the form, however, if the resident was a current smoker or had ever smoked. Record review of Resident #1's Care Plan, with date initiated 07/27/2025, indicated Resident Smokes with a goal of resident will be able to smoke without causing injury. Another entry on the same Care Plan with date initiated 08/13/2025 indicated Resident is a smoker with a goal of will smoke in designated areas without occurrence of injury over next 90 days. Record review of Progress Notes dated 07/09/2025 contained an admission Note that documented Resident Smokes: No. Observations of Resident #1 during the survey from 08/26/2025 through 08/29/2025, revealed resident sleeping or wandering in the secure unit with his arms crossed in front of him. Resident #1 was never observed in the smoking area with other residents. During an interview with LVN E on 08/29/2025 at 9:45 am, LVN E stated that Resident #1 was not a smoker and did not participate in many activities. During an interview with MDS Coordinator on 08/29/2025 at 10:01 am, MDS Coordinator stated she had only been employed in this facility for 2 months. The MDS stated, I review Care Plans and make sure the whole IDT team is in agreement with the needs of the residents. I am also part of the care conference team. In the first set of care plans, I go through the triggers and I do an assessment. I look at the resident as well as look at notes from the Treatment Nurse, weekly nurse assessment, etc. The MDS Coordinator stated that Resident #1 was not a smoker and this should not have been placed in the Care Plan. 2. Record review of Resident #4's admission record, dated 8/29/25 with an initial admission date of 12/13/2017 and readmission of 7/31/25 revealed an [AGE] year-old male resident with diagnoses that included end stage renal disease (the final stage of kidney failure), and type 2 diabetes mellitus (high blood sugar levels and insulin resistance) without complications. Record Review of Resident #4's quarterly MDS assessment, dated 7/31/25, reflected Resident #34 had severely impaired cognition for daily decision making and section O revealed he received dialysis while a resident. Record review of Resident #4's physician's order, dated 8/29/25, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed Resident #4 received dialysis every Monday, Wednesday, and Friday, with a start date of 8/1/25, and no end date. Record review of Resident #4's care plan, dated 8/28/25, revealed he was at risk for malnutrition and to monitor and document meal intake and resident weights. There were no care areas for dialysis. During an interview on 8/28/25 at 11:39 a.m. the DON stated dialysis should be care planned for continuity of care and to ensure staff was monitoring the resident and dialysis site. During an interview on 8/28/25 at 11:51 a.m. the MDS Coordinator stated the resident was started on dialysis about 2 weeks prior. The MDS Coordinator stated she was responsible for updating the care plans and should have updated the residents care plan to include he was on dialysis. The MDS Coordinator stated the care plan needed to be updated for nursing staff and CNAs to see necessary interventions on their point of care system. 3. Record review of Resident #7's admission sheet dated 10/16/2023 with an original date of 4/08/2020 documented a [AGE] year-old female resident with diagnoses including dementia, schizophrenia, diabetes mellitus, anxiety, hypertension (high blood pressure), bipolar disorder, depression, and hyperlipidemia (high cholesterol). Record review of Resident #7's MDS dated [DATE] documented a BIMS score of 6 indicating severe cognitive impairment and documented the use of antipsychotic, antianxiety, antidepressant, antiplatelet, and hypoglycemic medications. Record review of Resident #7's order summary documented active orders for the psychotropic medications Lamotrigine (an anticonvulsant indicated for the treatment of epilepsy and bipolar disorder), Sertraline (an antidepressant indicated for the treatment of depression, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, premenstrual dysphoric disorder, and social anxiety disorder), Zyprexa (an atypical antipsychotic indicated for the treatment of schizophrenia and bipolar disorder), and Depakote (an anticonvulsant indicated for the treatment of manic episodes associated with bipolar disorder, seizures, and migraine prophylaxis). Record review of Resident #7's July 2025 MAR documented the resident had been receiving Lamotrigine, Sertraline, Zyprexa, and Depakote as prescribed. Further review of the July MAR documented that Lamotrigine was ordered as Lamotrigine 100mg, give 1 tablet by mouth one time a day for anxiety. Sertraline was ordered as Sertraline 100mg give 1 tablet by mouth one time a day.give with 25mg tab to equal 125mg daily. Zyprexa was ordered as Zyprexa 20mg give 1 tablet by mouth one time a day. Depakote was ordered as Depakote 500mg give 1 tablet by mouth two times a day. Record review of Resident #7's care plan, revision dated on 04/07/2025, documented ANTIPSYCHOTIC MEDICATIONS: The resident requires the use of antipsychotic medications r/t long-standing mental illness, dx Schizophrenia -Depakote -lamotrigine. The care plan listed Depakote and Lamotrigine in the antipsychotic medication section, however both medications are in the anticonvulsant medication class. The care plan did not include the use of Zyprexa in the antipsychotic medication class. 4. Record review of Resident #10's admission sheet dated 8/13/2024 with an original date of 7/30/2024 documented a [AGE] year-old female resident with diagnoses including schizophrenia, diabetes mellitus, hyperlipidemia, depression, hypertension, and chronic obstructive pulmonary disease (a lung condition caused by damaged to the airways that limits air flow). Record review of Resident #10's MDS dated [DATE] documented a BIMS score of 13 indicating intact cognition and documented the use of antipsychotic, antidepressant, hypnotic, anticoagulant, diuretic, opioid, and hypoglycemic medications. Record review of Resident #10's August 2025 MAR documented the resident had been receiving Aspirin (an antiplatelet medication) as prescribed. Further review of the August MAR documented Aspirin was ordered as Aspirin 81mg, give 1 tablet by mouth one time a day for heart health. Record review of Resident #10's care plan, dated 08/03/2024, documented The resident is on anticoagulant therapy. Resident #10's active orders did not include any anticoagulant medications. Further review of the care plan showed the assessment did not include monitoring for antiplatelet therapy. 5. Record review of Resident #35's admission sheet dated 7/01/2025 documented a [AGE] year-old male resident with diagnoses including dementia with behavioral disturbance, benign prostatic hyperplasia (enlarged prostate leading to difficulty urinating), and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Record (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #35's MDS dated [DATE] documented a BIMS score of 14 indicating intact cognition and documented the use of antipsychotic, antidepressant, and opioid medications. Record review of Resident #35's order summary documented active orders for the psychotropic medication Risperdal (an atypical antipsychotic indicated for the treatment of schizophrenia, bipolar I disorder with acute manic or mixed episodes, and autism-associated irritability). Record review of Resident #35's July 2025 MAR documented the resident had been receiving Risperdal as prescribed. Further review of the July 2025 MAR documented Risperdal was ordered as Risperdal 1mg, give 0.5 tablet by mouth one time a day for bipolar and Risperdal 1mg, give 1 tablet by mouth at bedtime for bipolar, with a start date of 07/01/2025. Record review of Resident #35's care plan, revised dated on 07/18/2025, documented Adverse medication effect and behavior monitoring but did not specify the type of medication class to monitor. Further review of the care plan revealed the diagnosis of bipolar disorder was not included on the diagnosis list. During an interview with the DON on 8/29/25 at 1:23 PM, the DON stated it was important for the care plan to be accurate, because the care plan is the communication between staff regarding a resident's care and includes information necessary for the Kardex (a patient care summary tool often found in digital format). The DON stated her expectation is for care plans to be part of the morning meetings so they can be done quickly, and important things needed on the plan can be covered in the meetings. Review of the facility's policy titled Comprehensive Care Planning, undated, noted 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 and 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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 3 of 5 carts (2300/2400 hall nurse cart, 2300/2400 hall medication aide cart, and the 2200/2500 hall medication aide cart) reviewed for pharmacy services. The facility failed to ensure the controlled substance reconciliation logs were signed for accuracy of medication quantities during shift change. This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain and anxiety, and a decreased quality of life. The findings included: During an observation of the 2200/2500 hall medication aide cart on 8/28/2025 at 8:14 AM, a sample of controlled medications was inventoried for accuracy with Medication Aide B. The sample inventory showed no discrepancies between medication quantities documented on the individual controlled substance logs and the number of pills remaining in the blister packs, however record review of the comprehensive controlled medication reconciliation log used for cart audit during shift change revealed the log was missing a signature. During an interview with Medication Aide B on 8/28/2025 at 8:14 AM, Medication Aide B stated it was important to perform the card audit and to sign the reconciliation log in the presence of the staff member who was receiving or relinquishing the cart. Medication Aide B further stated she should always sign the reconciliation log, because if the log was not signed the next person responsible for the cart will not know if the count of controlled medications was correct. During an observation of the 2300/2400 hall medication aide cart on 8/28/2025 at 8:24 AM, a sample of controlled medications was inventoried for accuracy with Medication Aide C. The sample inventory showed no discrepancies between medication quantities documented on the individual controlled substance logs and the number of pills remaining in the blister packs, however record review of the comprehensive controlled medication reconciliation log used for cart audit during shift change revealed the log was missing a signature. During an interview with Medication Aide C on 8/28/2025 at 8:24 AM, Medication Aide C stated it was important to sign the reconciliation log to make sure the medication count was right. Medication Aide C further stated if the reconciliation log was not signed at shift change, it would not be known if the log was accurate, and the count of medication could be off. During an observation of the 2300/2400 hall nurse cart on 8/28/2025 at 8:40 AM a sample of controlled medications was inventoried for accuracy with LVN D. The sample inventory showed no discrepancies between medication quantities documented on the individual controlled substance logs and the number of pills remaining in the blister packs, however record review of the comprehensive controlled medication reconciliation log used for cart audit during shift change revealed the log was missing a signature. During an interview with LVN D on 8/28/2025 at 8:40 AM, LVN D stated if the reconciliation log was missing a signature, the medication count might be wrong, and the log should be verified during shift change. LVN D stated if she found the count of a controlled substance to be incorrect, she would bring it to the attention of the DON. During an interview with the DON on 8/29/25 at 1:23 PM, the DON stated her expectation for medication carts was that anytime a staff member hands off a cart to another employee, there needed to be two people to perform the controlled medication audit, and both parties should be looking at both the log and the blister packs while counting. The DON further stated it was important to never accept someone else's cart without inventorying the controlled medications together, because it cannot be known if there was a discrepancy without counting. Record review of the facility policy titled Controlled Medications-Administration dated 2025 noted At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and is documented on an audit record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 8 residents (Resident #3 and Resident #34) reviewed for infection control: 1. The facility failed to ensure staff wore proper PPE while performing wound care for Resident #3. 2. The facility failed to ensure CNA F and CNA G performed hand hygiene between glove changes while performing incontinent care for Resident #34. These failures could place residents at-risk for infection due to improper care practices.The findings included: 1. Record review of Resident #3's admission record, dated 8/29/25, revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included liver cell carcinoma (liver cancer), mid protein calorie malnutrition, malignant neoplasm (cancerous tumors) of bone and articular cartilage, and alcoholic cirrhosis of liver without ascites (condition resulting from long term heavy alcohol use, characterized by the scarring of liver tissue. Unlike other forms is does not usually cause fluid retention in the abdomen). Record review of Resident #3's quarterly MDS assessment, dated 8/4/25, revealed the resident cognition was severely impaired for daily decision-making skills, and section M revealed he had 1 stage 1 pressure injury, 1 stage 4 pressure injury, 4 unstageable pressure ulcers, and 2 deep tissue injuries. Record review of Resident #3's care plan, initiated 2/7/25 revealed the resident was on enhanced barrier precautions, with interventions to gloves and gown should be donned if any of the following activities occur . wound care. Record review of Resident #3's Physician Order, dated 8/29/25, revealed the following:- Stage IV (L) Ischium Cleanse with normal saline wound cleanser, pat dry w/ 4X4 gauze. Apply medihoney and calcium alginate to wound bed, dress with gauze island with border dressing daily or as needed one time a day for 30 Days, with a start date of 8/11/25 and an end date of 9/11/25. -Stage IV Sacrum Cleanse with normal saline wound cleanser, pat dry w/ 4X4 gauze. Apply medihoney and calcium alginate to wound bed, dress with gauze island with border dressing daily or as needed one time a day for 30 Days, with a start date of 8/11/25 and an end date of 9/11/25. -Unstageable R Ischium Cleanse with normal saline wound cleanser, pat dry w/ 4X4 gauze. Apply medihoney and calcium alginate to wound bed, dress with gauze island with border dressing daily or as needed one time a day for 30 Days, with a start date of 8/11/25 and an end date of 9/11/25.-Unstageable DTI left heel, Cleanse with wound cleanser/Normal saline pat dry WITH 4X4 gauze. Apply skin prep/betadine to area left open to air as, one time a day for Skin fragility or hair/nail weakness for 30 Days with a start date of 8/11/25 and end date of 9/10/25. -Unstageable DTI left lateral foot, cleanse with wound cleanser/normal saline, pat dry with 4X4 gauze apply skin prep/betadine daily/as needed to area leave open to air. One time a day for 30 Days, with a start date of 8/11/25, and an end date of 9/11/25. -Unstageable DTI to right ankle cleanse with wound cleanser/normal saline, pat dry with 4x4 gauze apply skin prep/betadine daily or as needed to area leave open to air. One time a day for 30 Days, with a start date of 8/11/25, and an end date of 9/11/25. - Unstageable left hip Cleanse with normal saline wound cleanser, pat dry w/ 4X4 gauze. Apply medihoney and calcium alginate to wound bed, dress with gauze island with border dressing daily or as needed one time a day for 30 Days, with a start date of 8/11/25 and an end date of 9/11/25. During an observation on 8/29/25 at 11:19 a.m. the ADON prepare to provide wound care to Resident #3's wounds. The ADON cleansed the residents right foot wound with skin prep, removed her gloves, and stated she forgot a PPE gown and went outside the room to put one on. During an interview on 8/29/25 at 12:34 p.m. the ADON stated she needed a gown to provide wound care to resident #3 because he was on EBP and also to prevent her from getting any wound drainage on her. During an interview on 8/29/25 at 1:15 p.m., the DON stated staff should be wearing a gown while providing wound care to Resident #3 because he was on EBP. The DON stated the gown helped (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protect staff and resident from infection. 2. Record Review of Resident #34's admission record, dated 8/26/25, revealed a [AGE] year-old female initially admitted [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes(high blood sugar levels, insulin resistance, and a relative last of insulin), bacteremia (infection or bacteria in the blood), schizoaffective disorder (a mental health condition with a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania), generalized anxiety disorder, epilepsy (a brain condition that causes recurring seizures), insomnia, and disorganized schizophrenia (a subtype of schizophrenia characterized by disorganized thought process, speech, and behavior). Record Review of Resident #34's quarterly MDS assessment, dated 8/2/25, reflected Resident #34 had intact cognition for daily decision making and was frequently incontinent of bladder and always incontinent of bowel. Record review of Resident #34's care plan, initiated 6/11/25, revealed a care area for Resident #34 had bowel incontinence with an intervention to check resident every 2 hours and assist with toileting as needed. During an observation on 8/29/25 at 10:54 a.m. CNA F and CNA G provided incontinent care to Resident #34. Both aides removed their gloves during the care and put on new gloves. They did not perform hand hygiene after removing soiled/used gloves, and putting on new gloves. During a joint interview on 8/29/25 at 11:11 a.m. CNA F and CNA G stated they did not have any hand sanitizer on them when they started. They stated the resident was in pain so they wanted to be quick with the incontinent care. They stated they should have preformed hand hygiene between glove changes to prevent infection to the resident. During an interview on 8/29/25 at 1:07 p.m. the DON stated staff was expected to perform hand hygiene between glove changes to provide infection control. Record review of the facility policy titled Fundamentals of Infection Control Precautions, dated 3/2024, stated A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions.1. Hand Hygiene, Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene. Before and after assisting a resident with personal care.After removing gloves or aprons. Record review of the facility policy titled Enhanced Barrier Precautions, dated 4/1/24, stated Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following. Wounds.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 3 (dry #1, #3, and #4) of 4 dryers reviewed for environment. The facility failed to properly dispose and maintain the lint accumulation in the facility dryers in a timely manner. This failure could put residents at risk for an unsafe and unsanitary environment.Findings included: Observation on 8/28/25 at 4:19 p.m. of facility's laundry room revealed there were four (4) dryers that were in use at that time. Observation of the lint collector area beneath three (3) dryers revealed a layer of thick lint about 0.5 inch thick accumulated on the top of lint trap and on the bottom of the dryer. Record review of a document titled Dryer Cleaning, no date, showed a log that was filled out on 8/26/25 at 11:00 a.m., 1:00 p.m., and 3:00 p.m. Interview on 8/28/25 at 3:07 p.m. Laundry Aide H stated they should clean out the lint trap every 2 hours and document it in a log after she cleans it. Laundry Aide H stated she forgot to document on the log when she last cleaned the lint traps, and she thought she cleaned them about 4 times that day already. Laundry Aide H stated if she had not cleaned the lint traps regularly and documented when she had it could be a fire hazard. During an interview on 8/28/25 at 3:15 p.m. the Laundry Supervisor (LS) stated staff should be every 2 hours or after every cycle. The LS stated they vacuum the lint trap with a shop vac. The LS stated not cleaning the lint traps on the dryers could cause a fire. During an interview on 8/29/25 at 3:02 p.m. the Administrator stated staff should be completing the log but was unsure of how often they needed to clean the dryer lint traps. The Administrator stated the purpose of the log was to ensure staff was being accountable and cleaning the lint. The Administrator stated there was a risk of fire if they had not filled out the log or cleaned the lint traps as needed. Record review of a facility document titled Sign off sheet for Laundry Dryer, stated Dryer filters will be inspected and cleaned free of any lint every two hours; any damage must be reported to maintenance supervisor immediately. Laundry Employee to confirm and sign off that this has been completed every two hours.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents have the right to be informed of and participate in their treatment, including the right to be informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options, and to choose the alternative or option they prefer for 1 of 6 residents (Resident #35) whose records were reviewed for informed consent. The facility failed to obtain signed consent prior to administering the psychotropic medication Risperdal (an atypical antipsychotic indicated for the treatment of schizophrenia, bipolar I disorder with acute manic or mixed episodes, and autism-associated irritability) for Resident #35. This failure could place residents at risk of receiving medications without consent and without the option choose alternative treatment or decline treatment based on awareness of the risks and benefits of the medications.The findings included: Record review of Resident #35's admission sheet dated 7/01/2025 documented a [AGE] year-old male resident with diagnoses including dementia with behavioral disturbance, benign prostatic hyperplasia (enlarged prostate leading to difficulty urinating), and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Record review of Resident #35's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognition and documented the use of antipsychotic, antidepressant, and opioid medications. Record review of Resident #35's order summary included active orders for Risperdal 1mg, give 0.5 tablet by mouth one time a day for bipolar and Risperdal 1mg, give 1 tablet by mouth at bedtime for bipolar. Record review of Resident #35's July 2025 MAR documented the resident had been receiving Risperdal as ordered. Record review of Resident #35's medication consents included a Texas Health and Human Services Form 3713 Nursing Facility Consent for Antipsychotic or Neuroleptic Medication Treatment for the medication Risperdal with no resident or resident representative signature in Section II of the form. During an interview with the DON on 8/29/25 at 1:23 PM, the DON stated for new psychotropic medication orders, her expectation is for consents to be complete with doctor and resident signatures on the appropriate forms and be obtained within 24 to 48 hours for inclusion in the resident's medical record. The DON stated all consents should be signed by either the resident if they are their own responsible party, or by their designated representative if they are unable to sign themselves. The DON stated Resident #35's consent for Risperdal should have been signed by the resident or the responsible party so they would be informed of the medication's potential side effects, understand why they have been prescribed the medication, and decide if they want to take the medication. Record review of the facility policy titled Unnecessary Medications, with a revision date of 2/12/2025, documented Residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a mediation. To demonstrate compliance, the resident's medical record must include documentation that the resident or resident representative was informed in advance.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations, interview and record review, the facility failed to respect the residents' right to confidentiality in his or her personal and medical records for one (Laptop) of three medication cart computers reviewed for confidential medical records. The facility failed to ensure a laptop A was not left open with patient information on the screen. This failure could place residents at risk of resident-identifiable information being accessed by unauthorized persons. Findings included: Observation on 08/26/25 at 11:21 a.m. revealed laptop A was on top of a medication cart was left open in hallway displaying Resident #25's appointment information for a medical appointment with the date, time, and location for the appointment for anyone passing by to see. No staff was at the cart with laptop A and no staff returned to Laptop A before it timed out and turned off on its own. Interview on 8/29/25 at 1:05 p.m. the DON stated the laptop was used by all staff. The DON stated the computer should not be left on displaying patient information because it was a HIPPA violation and anyone could access patient health records. Record review of the facility's policy titled Resident Rights, revised 11/28/16, stated .Privacy and confidentiality- the resident has a right to personal privacy and confidentiality of his or her personal and medical records .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort for 1 of 8 residents reviewed for PASRR (Resident #34). The facility failed to ensure Resident #34 had an accurate PASRR Level 1 Screening indicating diagnoses of mental illness and refer the residents to the state designated authority. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs.Findings included: Record Review of Resident #34's admission record, dated 8/26/25, revealed a [AGE] year-old female initially admitted [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental health condition with a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania), generalized anxiety disorder, epilepsy (a brain condition that causes recurring seizures), insomnia, and disorganized schizophrenia (a subtype of schizophrenia characterized by disorganized thought process, speech, and behavior). Record Review of Resident #34's quarterly MDS assessment, dated 8/2/25, reflected Resident #34 had intact cognition for daily decision making and had anxiety, seizure disorder, and schizophrenia. Record review of Resident #34's care plan, initiated 6/11/25, revealed a care area for Resident #34 required anti-psychotic medications, to administer as ordered, and monitor/document for side effects and effectiveness. Record review of Resident #34's physician's order, dated 8/26/25, indicated Resident #34 took Risperdal for schizophrenia daily. Record review of Resident #34's PASRR Level 1 Screening completed on 5/19/25 indicated in section C0100 there was no evidence of this individual having mental illness or dementia. During an interview on 8/28/25 at 11:48 a.m. the MDS Coordinator stated Resident #34 did not have a qualifying mental disorder for PASRR services. The MDS Coordinator stated the resident came with the PASRR already completed prior to her admission and she did not think there were any errors on Resident #34's PASRR Level 1 Screening. During a follow up interview on 8/28/25 at 5:00 p.m. the MDS Coordinator stated they had corrected the PASRR for Resident #34 to answer yes to the mental illness question so the resident could be evaluated by the local authority to see if the resident could qualify for services. Record review of the facility's policy titled PASRR Nursing Facility Specialized Policy and Procedure, dated 3/6/19, stated Policy: It is the policy of [corporate name] facilities to ensure NFSS Forms are submitted timely and accurately. Procedure: 1. PL1 is completed. 2. If PL1 is coded as suspicion of MI, ID or DD, then a PE is required. 3. The LA completes the PE and if Positive, a PCSP Initial Meeting is scheduled. 4. NF PCSP meetings scheduled within 14days of admission and annually.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 4 hallways (hallway 2300) observed for accidents and hazards: The facility failed to ensure hallway 2300 did not have a capped lancet lying in the middle of the floor. This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: During an observation on 8/28/2025 at 11:07 AM, a capped lancet was observed lying on the floor of hallway 2300. Twenty minutes later at 11:27 AM, the capped lancet was still observed lying on the floor of hallway 2300. Between 11:07 AM and 11:27 AM, Housekeeper A was observed walking up and down hallway 2300 past the capped lancet cleaning restrooms and resupplying rooms with soap and paper towels. Housekeeper A did not pick up the capped lancet or bring it to the attention of staff nurses during the observation period. During an interview with Housekeeper A on 8/28/2025 at 11:30 AM, Housekeeper A stated she did not know what the capped lancet was, and that it should be cleaned up. Housekeeper A further stated she did not know where the item should be disposed. Housekeeper A stated when something is on the floor and she does not know what it is or how to dispose of it, she should ask the nurse. Housekeeper A stated if a capped lancet was left on the ground a resident could slip and fall on it.During an interview with the DON on 8/29/25 at 1:23 PM the DON stated her expectation is for staff to keep a clean house, and if a staff member walks down a hall and sees trash, the staff member should pick it up, especially if it is something that can injure a resident. The DON further stated if a staff member did not know how to dispose of an item, she expects them to ask for guidance from a nurse.Record review of the facility policy titled Fall Policy, undated, documented Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident and family, Appropriate education will be provided to all staff members as needed on fall prevention, and Remove clutter from floors/hallways.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 1 of 4 residents (Resident #34) reviewed for incontinent care: The facility failed to ensure CNA F did not wipe between Resident #34's gluteal folds from back to front in the wrong direction during incontinent care. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices. The findings included: Record Review of Resident #34's admission record, dated 8/26/25, revealed a [AGE] year-old female initially admitted [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes (high blood sugar levels, insulin resistance, and a relative loss of insulin), bacteremia (infection or bacteria in the blood), schizoaffective disorder (a mental health condition with a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania), generalized anxiety disorder, epilepsy (a brain condition that causes recurring seizures), insomnia, and disorganized schizophrenia (a subtype of schizophrenia characterized by disorganized thought process, speech, and behavior). Record Review of Resident #34's quarterly MDS assessment, dated 8/2/25, reflected Resident #34 had intact cognition for daily decision making and was frequently incontinent of bladder and always incontinent of bowel. Record review of Resident #34's care plan, initiated 6/11/25, revealed a care area for Resident #34 had bowel incontinence with an intervention to check resident every 2 hours and assist with toileting as needed. During an observation on 8/29/25 at 10:54 a.m. CNA F provided incontinent care to Resident #34. After cleansing the resident's urethral area, CNA F moved to her rectal area and wiped between the gluteal folds and towards to urethra and vaginal area. During an interview on 8/29/25 at 11:11 a.m. CNA F stated she should wipe from front to back or away from the front area of the resident to prevent from getting bacteria from her rectal area in her urethral or vaginal area. CNA F stated the resident was at risk of a UTI. CNA F stated she did not realize she was wiping the wrong direction while cleaning between the gluteal folds. During an interview on 8/29/25 at 1:07 p.m. the DON stated staff needed to wipe the resident from front to back direction while providing incontinent care to prevent infection. Record review of the facility's policy titled Perineal Care, effective date 5/11/22, stated Purpose, This procedure aims to maintain the resident dignity and self-worth and reduce embarrassment by providing cleanliness and comfort to the resident, preventing infections and skin irritation, and observing the resident's skin condition.Front. 17) Gently perform perineal care, wiping from clean, urethral area, to dirty, rectal area, to avoid contaminating the urethral area - CLEAN to DIRTY. Female resident: Working from front to back, wipe one side of the labia majora, the outside folds of perineal skin that protect the urinary meatus and the vaginal opening. Continue perineal care to the inner thigh.Use a clean area of the washcloth or pre-moistened cleansing wipes for each stroke.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 1 resident (Resident #4) reviewed for dialysis: The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #4. This failure could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs. The findings included:Record review of Resident #4's admission record, dated 8/29/25 with an initial admission date of 12/13/2017 and readmission of 7/31/25 revealed a resident [AGE] year-old male resident with diagnoses that included end stage renal disease (the final stage of and type 2 diabetes mellitus (high blood sugar levels, insulin resistance, and a relative last of insulin) without complications. Record Review of Resident #4's quarterly MDS assessment, dated 7/31/25, reflected Resident #4 had severely impaired cognition for daily decision making and section O revealed he received dialysis while a resident. Record review of Resident #4's care plan, dated 8/28/25, revealed he was at risk for malnutrition and to monitor and document meal intake and resident weights. There were no care areas for dialysis. Record review of Resident #4's physician's order, dated 8/29/25, revealed Resident #4 received dialysis every Monday, Wednesday, and Friday, with a start date of 8/1/25, and no end date. Record review of Resident #4's dialysis communication forms revealed: -8/1/25 the dialysis communication form was complete. -8/4/25 the dialysis communication form had the prior to dialysis assessment completed but was missing the dialysis center assessment, and the facility post assessment portion of the form.-8/6/25 the form was not in the resident's dialysis binder. -8/8/25 the form was not in the resident's dialysis binder.-8/11/25 the form was not in the resident's dialysis binder.-8/13/25 the dialysis communication form had the prior to dialysis assessment completed and the dialysis center assessment completed but was missing the facility post assessment portion of the form.-8/15/25 the dialysis communication form had the prior to dialysis assessment completed but was missing the dialysis center assessment, and the facility post assessment portion of the form.-8/18/25 the dialysis communication form had the prior to dialysis assessment completed but was missing the dialysis center assessment, and the facility post assessment portion of the form.-8/20/25 the dialysis communication form had the prior to dialysis assessment completed but was missing the dialysis center assessment, and the facility post assessment portion of the form.-8/22/25 the dialysis communication form had the prior to dialysis assessment completed but was missing the dialysis center assessment, and the facility post assessment portion of the form. During an interview on 8/26/25 at 3:18 p.m. Resident #4 stated he went to dialysis a few days a week. He stated staff assessed his port and he had no concerns or issues. During an interview on 8/28/25 at 11:39 a.m. the DON stated the dialysis communication forms should be completed in entirety for continuity of care, to ensure the resident was stable pre and post dialysis, and to monitor the resident's port site. Record review of the facility's policy titled Dialysis, no date, stated Dialysis is a process used to remove fluid and waste products from the body when the kidneys are unable to do so because of impaired function or when toxins or poisons must be removed immediately to prevent permanent or life-threatening damage. The purposes of dialysis are to maintain the life and wellbeing of the patient until kidney function is restored and to remove unwanted substances from the blood if renal function does not return .Procedure. 7. The site will be assessed for bleeding, bruising, lack of pulsations, and aneurysm, as ordered by the physician. The nurse will palpate the access from the from the distal anastomosis to the proximal anastomosis.the procedure should be conducted once a shift.record the results of the examination.18. The resident's clinical record will be documented with this information. The date and time that the resident leaves the facility will be recorded by the nurse. The facility will monitor departures and returns from the dialysis center. The facility will document the resident's vital signs, general appearance, orientation, (continued on next page)

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	08/29/2025

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

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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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and additional baseline data as needed. The resident's clinical record will be documented with this information. The date and time of the resident's return to the facility will be recorded by the nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles for 2 of 5 medication carts (the 2200/2500 hall medication aide cart and the 2300/2400 hall medication aide cart) assessed for medication storage and labeling. The facility failed to ensure all medications located inside the 2200/2500 hall medication aide cart and the 2300/2400 hall medication aide cart were stored in labeled containers. This failure could place residents at risk of receiving inadequate treatments or ingesting medications for which they were not prescribed. The findings included: During an observation of the 2200/2500 hall medication aide cart on 8/28/2025 at 8:14 AM, two dosing cups with pills were discovered sitting in the top drawer of the cart. During an interview with Medication Aide B on 8/28/2025 at 8:14 AM, Medication Aide B stated if pills are left in dosing cups in the medication cart, they could be mistaken for someone else's pills and be given to the incorrect resident. Medication Aide B further stated when she sees pills in dosing cups left in the cart, she should let the nurse know and dispose of the unlabeled medications. During an observation of the 2300/2400 hall medication aide cart on 8/28/2025 at 8:24 AM, two loose pills were discovered lying in the bottom of the second drawer of the cart. During an interview with Medication Aide C on 8/28/2025 at 8:24 AM, Medication Aide C stated if there were loose pills in the cart it would not be known what the pills were. Medication Aide C further stated she did not know what could happen to a resident if they received a pill found loose in the cart. During an interview with the DON on 8/29/25 at 1:23 PM, the DON stated her expectation for medication carts was that they should be kept locked, clean, and organized with no spills or loose medications. The DON further stated pills should be labeled appropriately and should match orders in the chart. The DON stated her expectation for staff was that if they cannot administer a medication, they were supposed to dispose of it. Record review of the facility policy titled Medication Labels dated 2025 noted Medications are labeled in accordance with facility requirements, state, and federal laws and Medication labels are not altered, modified, or marked in any way by nursing personnel. Contents are not transferred from one container to another. Record review of facility policy titled Medication Storage in the Facility dated 2025 noted Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier and the pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. Transfer of medications from one container to another is done only by a pharmacist. Review of the facility policy titled Medication Administration and General Guidelines dated 2025 noted Medications are administered at the time they are prepared. Medications are not pre-poured.

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	455390	A. Building B. Wing	08/29/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 1 of 6 residents (Resident #35) reviewed for accuracy of records. The facility failed to ensure Resident #35's diagnosis of bipolar disorder was documented on the resident's active diagnosis list, the MDS assessment, and the care plan. This failure could place residents at risk for improper care due to inaccurate records. The findings included: Record review of Resident #35's admission sheet dated 7/01/2025 documented a [AGE] year-old male resident with diagnoses including dementia with behavioral disturbance, benign prostatic hyperplasia (enlarged prostate leading to difficulty urinating), and hypothyroidism (when the thyroid gland does not produce enough thyroid hormone). Record review of Resident #35's MDS dated [DATE] documented a BIMS score of 14 indicating intact cognition and recorded the use of antipsychotic, antidepressant, and opioid medications. Further review of the MDS revealed the assessment did not include a diagnosis of bipolar disorder. Record review of Resident #35's order summary included active orders for Risperdal 1mg, give 0.5 tablet by mouth one time a day for bipolar and Risperdal 1mg, give 1 tablet by mouth at bedtime for bipolar. Record review of Resident #35's care plan documented the resident had behaviors but did not include a diagnosis of bipolar disorder in the diagnosis list. Record review of Resident #35's diagnosis report did not include a diagnosis of bipolar disorder. Record review of Resident #35's hospital Discharge summary dated [DATE] documented the resident had a diagnosis of bipolar disorder. Record review of Resident #35's psychiatric progress note dated 7/5/2025 documented under Assessment and Plan: Bipolar/Behavioral Symptoms: Continue Risperidone, Olanzapine, Paroxetine and Trazodone. Monitor for sedation, effectiveness, and adverse effects. During an interview with the DON on 8/29/25 at 1:23 PM the DON stated her expectation for clinical records was for notes to be reviewed and all diagnoses be added to the medical record. The DON further stated she expected hospital discharge paperwork to be reviewed for new diagnoses and care plan updates. The DON stated if diagnoses were missing from the medical record, the facility could not provide care, because they would not have the full picture of the resident. In an interview with the Regional Compliance Nurse on 8/29/25 at 2:32 PM the Regional Compliance Nurse stated there was no specific facility policy for clinical records.