

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455467	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/23/2024
NAME OF PROVIDER OR SUPPLIER  Asbury Care Center of Alamo		STREET ADDRESS, CITY, STATE, ZIP CODE  8223 Broadway San Antonio, TX 78209	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47611</b></p> <p>Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs for 2 of 6 residents reviewed for call light (Residents #13 and #19) reviewed for reasonable accommodations, in that:</p> <ol style="list-style-type: none"> <li>1. Resident #16's call light was behind the headboard of the resident's bed and not within the resident's reach on 02/21/2024.</li> <li>2. Resident #17's call light was on the floor on the resident's room and not within the resident's reach on 02/21/2024.</li> </ol> <p>This failure could place residents who used call lights for assistance in maintaining and/or achieving independent functioning, dignity, and well-being.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Record review of Resident #16's face sheet, dated 02/21/2024, revealed an [AGE] year-old female admitted on [DATE] with diagnoses that included: chronic kidney disease, muscle weakness, cognitive communication deficit and muscle wasting and atrophy.</li> </ol> <p>Record review of Resident #16's Admission MDS, dated [DATE], revealed a BIMS score of 03, which indicated the resident was severely cognitively impaired. Further review revealed that under section G, showed the resident required 2-person, extensive assist with activities of daily living.</p> <p>Record review of Resident #16's care plan, dated 12/01/2023, revealed ADL self-care deficit: Be sure the resident's call light is within reach .</p> <p>Observation on 02/21/2024 at 2:50 pm revealed the call light was hanging over the headboard of resident #16's bed out of her reach.</p> <p>During an interview with CMA D on 2/21/2024 @ 2:52 pm, she stated the call light should not be over the headboard and she stated the resident could not reach the call light.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #17's face sheet, dated 02/23/2024, revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included: senile degeneration of the brain (a decrease in the ability to think, concentrate, or remember), cognitive communication deficit, and cerebral infarction (disrupted blood flow to the brain).</p> <p>Record review of Resident #17's Quarterly MDS, dated [DATE], revealed a BIMS score 11, which indicated the resident was moderately cognitively intact.</p> <p>Record review of Resident #17's care plan, dated 02/12/24, revealed The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t impaired memory, impaired mobility.</p> <p>Observation on 2/21/2024 at 2:54 pm revealed the call light was under resident #17's bed, out of her reach.</p> <p>During an interview on 2/21/2024 at 2:55 pm with resident # 17, she was asked if she could reach the call light and she shook her head, no.</p> <p>During an interview on 2/21/2024 at 2:56 pm with CMA D, she observed the call light was under the bed and that the resident could not reach it.</p> <p>During an interview on 2/23/2024 at 9:40 am with LVN B, she stated the call lights should be within reach. She stated not having the call light within reach could place the residents at risk for lack of care.</p> <p>During an interview on 2/23/2024 at 9:58 am with the DON - She stated call lights should be in reach so resident has access to request assistance. Residents could have a delay in care due to call lights not being within reach.</p> <p>Record review of the facility's policy, Answering the Call Light, dated 09/2022, revealed, Ensure the call light is accessible to the resident when in bed .</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>45307</p> <p>Based on record review and interview, the facility failed to implement written policies and procedures to prohibit and prevent abuse, neglect, and exploitation for 2 of 6 staff (LVN A and CNA B) reviewed for employee misconduct screenings, in that:</p> <p>The facility had failed to complete an annual Employee Misconduct Registry search for LVN A and CNA B.</p> <p>This failure could place residents at risk for abuse, neglect, exploitation, and misappropriation of property.</p> <p>The findings included:</p> <p>Record review of the Abuse and Neglect policy, dated Revised April 2021, reflected Conduct employee background checks and not knowingly employ or otherwise engage any individual who has . had a finding entered into the state nurse aide registry concerning abuse, neglect, or exploitation, mistreatment of residents or misappropriation of their property . No further information related to completed recurring searched of the EMR were not located within facility policy.</p> <p>Record review of the facility staff roster, undated, revealed LVN A's hire date to be 06/11/2015, and CNA B's hire date to be 11/04/2021.</p> <p>Record review of LVN A's personnel file reflected the last EMR search completed was on 02/11/2022.</p> <p>Record review of CNA B's personnel file reflected the last EMR search completed was on 01/21/2022.</p> <p>Interview on 02/23/2024 at 9:22 AM, the HRD stated she began in her role as the HRD last month (January 2024) and had discovered many personnel records to be missing or misplaced. The HRD stated the previous HRD informed the current ADM and HRD that EMR searches were completed in 2023 but could not identify where the evidence of said searches were located. The HRD stated it was within her role responsibility to ensure staff were searched for employee misconduct but could not correct a past mistake by the previous HRD. The HRD stated she could not locate any further evidence to support an annual search of the EMR for LVN A or CNA B.</p> <p>Interview on 02/23/2024 at 9:40 AM, the ADM stated she was not familiar with the annual EMRs for LVN A and CNA B as that role responsibility resided with the HRD. The ADM stated she began in her role last month (January 2024). The ADM stated it was her expectation that all staff be searched annually in the EMR, including existing staff prior to her assuming her role as the ADM and stated the risk to the residents remained the same, regardless of who was staffing the building. The ADM stated she intended to reach out to the previous HRD to assist in locating evidence of the annual EMR searches for LVN A and CNA B but stated she was uncertain if they were searched annually. The ADM stated the potential risk to residents could be being cared for by staff who had committed misconduct towards residents in long term care.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45307</p> <p>Based on record review, interview, and observation, the facility failed to assure that menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines.</p> <p>The facility had no existing method to inform residents of substitutions to the menu.</p> <p>This failure could place residents at risk for dissatisfaction, poor intake, and diminished quality of life.</p> <p>The findings included:</p> <p>Record review of the menu/alternate, always available menu reflected various items like sandwiches, salad, burgers, fries, soup that residents can get at any time and can be able to request, in addition to being posted outside of the dining room.</p> <p>Record review of Resident #14's face sheet, dated 02/23/2024, reflected a [AGE] year-old with an original admitted [DATE] and a primary diagnosis of Type-2 Diabetes (A long-term condition in which the body has trouble controlling blood sugar and using it for energy.)</p> <p>Record review of Resident #14's Quarterly MDS, dated [DATE], reflected Resident #14 was evaluated to be a 15, indicating cognitively intact.</p> <p>Interview on 02/21/2024 at 4:15 PM, Resident #14 stated she has been at the facility for several years originally due to her husband being a former resident and has elected to remain the facility after his expiration. Resident #14 stated her concerns related to her care were that the food options made to her and other residents were poor food options and that alternates are not available to them apart from a hamburger that she did not feel was a sufficient nutritional equivalent. Resident #14 stated she had made reports about the food and being notified of alternates or substitutions to the ADM but no changes have been made.</p> <p>Interview on 02/22/2024 at 11:42 AM, the DM stated the always available menu includes various items like sandwiches, salad, burgers, fries, soup that residents can get at anytime and can be able to request, in addition to being posted outside of the dining room. The DM stated food options have become more diverse since the new menu has been reviewed with the RD/LD effective in the last few weeks. The DM stated the substitutions are completed on a [substitution] log that is completed near the front office of the kitchen where the changed item is on there and the new item is listed, along with the date and notification by the RD/LD. The DM stated staff are not expected to notify residents and she herself does not tell residents of a substitution and the mechanism in place to tell residents is when their plate is different.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation on 02/22/2024 at 11:58 AM, the ADM stated it is her expectation that the DM inform the residents of a potential change and believed it to be on a white board outside of the kitchen/dining room. Observation immediately following this conversation revealed no white board outside of the kitchen and the ADM stated she was not aware the DM was not informing residents of the substitutions.</p> <p>Interview on 02/22/2024 at 3:12 PM, the SW stated she had not received any further complaints regarding food or substitutions apart from the written grievances in the grievances' binder. The SW stated she had begun at the facility in the last month (January 2024) and was not familiar with previous changes to the food or the menus.</p> <p>Record review of Resident #13's face sheet, dated 02/23/2024, reflected an [AGE] year-old with an original admitted [DATE] and a primary diagnosis of Other Lack of Coordination (problems with movement).</p> <p>Record review of Resident #13's Quarterly MDS, dated [DATE], reflected Resident #13 was evaluated to be a 14, indicating cognitively intact.</p> <p>Interview on 02/22/2024 at 4:45 PM, Resident #13 stated the food served was poor, included too many carbs, and gets changed without notification. Resident #13 stated he has submitted grievances about the food and has not noticed any positive changes to the food even in the last several weeks. Resident #13 stated as he has diabetes, he watched his carb intake and had noticed he received too many carbs on his tray. Resident #13 stated his nurse assured him the trays were appropriate for his diet.</p> <p>Record review of Resident #12's face sheet, dated 02/23/2024, reflected a [AGE] year-old with an original admitted [DATE] and a primary diagnosis of muscle wasting and atrophy (decrease in size and wasting of muscle tissue).</p> <p>Record review of Resident #12's Quarterly MDS, dated [DATE], reflected Resident #12 was evaluated to be a 15, indicating cognitively intact.</p> <p>Interview on 02/23/2024 at 10:15 AM, Resident #12 stated the food varies in quality from meal to meal however a change to the food of the day did not get communicated to the residents, including herself. Resident #12 stated she would sometimes eat in the dining room but regardless of where she ate, there was never a notification of a change in the menu.</p> <p>Record review of Resident #15's face sheet, dated 02/23/2024, reflected a [AGE] year-old with an original admitted [DATE] and a primary diagnosis of hemiplegia and hemiparesis (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles).</p> <p>Record review of Resident #15's Quarterly MDS, dated [DATE], reflected Resident #15 was evaluated to be a 15, indicating cognitively intact.</p> <p>Interview on 02/23/2024 at 10:32 AM, Resident #15 stated she did not enjoy the food and is sometimes served cold. Resident #15 stated she had submitted grievances related to the food quality, but no change had been made since. Resident #15 stated changes to the menu are occasionally reported to the residents but most often she only finds out the food had been changed based on what she got on her tray.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of grievances binder, undated, reflected:</p> <p>A grievance on 01/22/2024 by Resident #14 that she wanted more variety of options in snacks apart from sandwich.</p> <p>A grievance on 02/01/2024 by Resident #15 that the food is not diverse enough and SW responded by telling DM and they said the new menu is more diverse than before.</p> <p>A grievance on 02/14/2024 by Resident #13 about getting too many carbs while being a diabetic.</p> <p>Record review of facility policy, titled Nutritional Policies and Procedures dated Completed Revision 8/1/2020, reflected Make appropriate substitutions when items on the menu are not available. Record these substitutions and keep the records on file with the menus . No additional information related to informing residents about substitutions made was reflected within the policy.</p>		