STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455467	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Care Center of Alamo	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 residents (Resident #1) reviewed for care plans, in that: The facility failed to develop and implement a care plan related to monitoring for side effects of Resident #1's use of Aspirin (antiplatelet/blood thinner) and Ticagrelor (anti-platelet/blood thinner). This failure could place the residents at risk for delayed interventions and decline in health. Findings included: Record review of Resident #1's Admission Record, dated 9/26/24, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Nontraumatic Acute Subdural Hemorrhage, Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Atherosclerotic Heart Disease (damage in the heart's major blood vessels), Myocardial Infarction (heart attack), Hypertension (high blood pressure), Cognitive Communication Deficit (difficulty with thinking and language), Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone), Dementia (group of thinking and social symptoms that interferes with daily functioning), And Alzheimer's Disease (disease affecting memory and other important mental functions). Record review of Resident #1's optional MDS assessment, dated 9/6/24, revealed the Resident #1 had a BIMS score of 5, suggesting severely impaired cognition. Further review of this document revealed it did not include antiplatelet medication. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan, dated 8/29/24, revealed: The resident has altered cardiovascular status r/t NSTEMI, angina pectoris, CAD, hypertension, hyperlipidemia She is prescribed aspirin for hearth [sic] health . She is prescribed Ticagrelor for hematological agent . Assess for shortness of breath and cyanosis . Diet consult as necessary . Encourage low fat, low salt intake . Further review of the document revealed it did not include monitoring for side/adverse effects of Aspirin and Ticagrelor. Record review of Resident #1's Order Summary, dated 9/26/24, revealed orders for Aspirin 81 MG chewable tablet for heart health, and Ticagrelor 90 MG oral tablet for hematological agent. Further review revealed it did not include orders for monitoring. Record review of Resident #1's Black Box Warning, dated 9/27/24, revealed: .Warning: Bleeding risk Ticagrelor, like other antiplatelet agents, can cause significant, sometimes fatal, bleeding . During an observation and interview on 9/27/24 at 9:08 a.m., Resident #1 was lying in the ICU hospital bed, alert, with purple discoloration noted to her left mandible, left side of neck, left shoulder and left side of chest. (Translated from Spanish) Resident #1 said she was doing very bad. Resident #1 said she did not fall but the refrigerator fell on top of her with the door open. During an interview on 9/27/24 at 4:10 p.m., LVN A said Resident #1 did not receive blood thinners and was not monitored for side/adverse effects of blood thinners. During an interview on 9/30/24 at 1:40 p.m., LVN B said Resident #1 received Aspirin, an antiplatelet, and Ticagrelor, it's a hematological and antiplatelet as well. LVN B further stated these medications were not considered blood thinners because they were antiplatelets. LVN B said the anti-platelet helped the blood not clot and not stick together. LVN B further stated there was a risk for bleeding with these medications, adding, she thought it had more of a risk for bruising than bleeding. LVN B said she completed the resident care plans for nursing. LVN B said she included medications in the care plans, but as far as monitoring it depended on whether the physician ordered it. LVN B further stated the facility did not necessarily need an order for monitoring; however, they usually did not monitor residents who received antiplatelet medication. LVN B said she included aspirin under cardiovascular in the care plans. LVN B further stated the care plans included a template and she chose whichever interventions she felt was good for the resident. LVN B said Resident #1 was at higher risk for bruising due to age and risk for falls. LVN B further stated she would not include monitoring in every care plan as long as it was being done, adding Resident #1 had weekly skin assessments. LVN B said if a medication had a high risk for bleeding, she would add that to the care plan. LVN b said Resident #1's care plan did not include monitoring for bleeding. LVN B said she guessed including monitoring for bleeding in the care plan was important to alert the staff if Resident #1 had bruising or, black poop, it was possibly due to the medications. LVN B further stated black stool would be considered a change in condition because it meant there could be a bleed in the gastrointestinal tract. LVN B said she did not believe omitting monitoring for side/adverse effects from Resident #1's care plan would not result in negative outcomes because the facility completed skin assessments. LVN B said she guessed she did not include monitoring in Resident #1's care plane because there were a lot if interventions and not all of them were always done. LVN B further stated if the care plan said, monitor, there should be documentation that it was being done; otherwise, there would not be evidence that the intervention was in place. LVN B said she did not know what staff would document or how they would document that monitoring was being done. LVN B said she did not know how the facility would follow up on that intervention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/30/24 at 2:34 p.m., LVN C said auditing care plans was a group effort and was completed, mostly, every day by LVN B, the ADON, and the DON. LVN C said they reviewed weight on weekly basis, but the other portions of the care plan were reviewed sporadically. LVN C further stated LVN B, and the DON oversaw the care plans. During interview on 10/1/24 at 11:48 p.m., the DON said Resident #1 was on two blood thinner, Aspirin and Brilinta (Ticagrelor). The DON further stated that Resident #1 was being monitored for side/adverse effects of Aspirin and Ticagrelor. The DON said she was not sure if Resident #1's care plan included monitoring for side/adverse effects of Aspirin and Ticagrelor and would have to check. The DON said anticoagulants were care planned but all medications had potential side effects and expected medications to be in the care plan depending on the severity of the side effects. The DON further stated she expected the nurses to be familiar with medications, their side effects, and research medications they were unfamiliar with. The DON said LVN B was responsible for the nursing care plans. The DON further stated she audited care plans about once a week, but the lack of monitoring for aspirin and Ticagrelor in Resident #1's care plan did not stand out to her. The DON said it was important that monitoring for the side/adverse effects of Aspirin and Ticagrelor had been included in Resident #1's care plan so that nurses knew what to do and what to monitor for. The DON further stated this to staff not having noticed if a resident was experiencing side effects of medications and may result in a delay in response. During an interview on 10/1/24 at 1:18 p.m., the Administrator said the IDT was responsible for the resident care plans, but LVN B was responsible for the nursing portion of it. The Administrator further stated it was important that resident care plans were accurate for person-centered care and informed staff the care each resident required. Record review of the facility's policy titled Care Planning - Interdisciplinary Team, revised July 2024, revealed: .The interdisciplinary team is responsible for the development of resident care plans .2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT) . Record review of website Drugs.com at https://www.drugs.com/aspirin.html, last updated on March 1, 2024, revealed: .Aspirin may cause serious side effects .ringing in your ears, confusion, hallucinations, rapid breathing, seizure (convulsions); severe nausea, vomiting, or stomach pain; bloody or tarry stools, coughing up blood or vomit that looks like coffee grounds; fever lasting longer than 3 days; or swelling, or pain lasting longer than 10 days . Record review of website Drugs.com at https://www.drugs.com/mtm/ticagrelor.html, last reviewed on January 12, 2024, revealed: Ticagrelor may cause serious side effects .slow heartbeats; nosebleeds, or any bleeding that will not stop; shortness of breath even with mild exertion or while lying down; easy bruising, unusual bleeding, purple or red spots under your skin; red, pink, or brown urine; black, bloody, or tarry stools; or coughing up blood or vomit that looks like coffee grounds .

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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 - Some	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** 39251 Based on interviews and record review, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 4 residents (Resident #4) reviewed for administration. 1. The facility failed to ensure Resident #4's EMR reflected unwitnessed falls on (2) occasions. 2. The facility failed to ensure Resident #4's EMR reflected behaviors requiring PRN medication on (2) occasions. These failures could place residents at risk for improper care due to inaccurate records. Findings included: 1. Record review of Resident #4's Admission Record, dated 9/27/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dementia (group of thinking and social symptoms that interferes with daily functioning), Muscle Weakness, Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Insomnia (sleep disorder that makes it difficult to fall asleep or stay asleep), Alzheimer's Disease (disease affecting memory and other important mental functions), COPD (lung diseases that block airflow and make it difficult to breathe), Cognitive Communication Deficit (difficulty with thinking and language), Hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone), Hyperlipidemia (high levels of fat in the blood) and Hypertension (high blood pressure). Record review of Resident #4's quarterly MDS assessment, dated 7/14/24, revealed the resident's cognitive skills for daily decision making was severely impaired. The MDS revealed behavioral symptoms not directed toward others (such as, hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smashing food, screaming, disruptive sounds) occurred 1 to 3 days. The MDS further revealed Resident #4 had 1 fall since admission, re-entry, or prior assessment. Record review of Resident #4's Care Plan, revised 3/4/24, revealed: The resident is at risk for falls . Follow facility fall protocol . Record review of the facility's incident description, dated 8/3/24, revealed: RESIDENT NOTED LYING ON FLOOR BESIDE BED . Resident Unable to give description .NOT PART OF THE MEDICAL RECORD . Record review of the facility's incident description, dated 8/5/24, revealed: Resident was laying [sic] in bed when hospice CNA arrived to provide resident with shower she got resident up but resident was to [sic] drowsy to walk so she sat her down into stationary chair at the bedside then went to look for wheelchair. When she got back into the room resident was laying [sic] on the floor on her left side Resident Unable to give Description .NOT PART OF THE MEDICAL RECORD . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Change in Condition Evaluation, dated 8/5/24 and signed by LVN on 9/27/24, revealed the resident had a fall on 8/5/24 in the afternoon. Further review of this document revealed no further details related to the fall. Record review of Resident#4's Neurological Evaluation Flow Sheet, dated 8/5/24 - 8/8/24, revealed unwitnessed fall in room [ROOM NUMBER]/5/24. Record review of the facility's incidents, dated 9/25/24, revealed Resident #4 had an unwitnessed fall on 8/3/24 in the resident's room and an unwitnessed fall on 8/5/24 in the dayroom. Record review of Resident #4's Progress Notes revealed there was no documentation regarding Resident #4's unwitnessed falls on 8/3/24 and 8/5/24. During an interview on 9/27/24 at 4:18 pm, LVN D said on 8/5/24 Resident #4 was drowsy because she had received her PRN Ativan. LVN further stated the Hospice CNA put Resident #4 in a chair in her room at the bedside, the aide said she forgot something, so she walked out of the room and when she went back into the room Resident #4 was on the floor. LVN D said the Hospice CNA told her that Resident #4 was on the floor and said she had put her in the chair and when she returned, she was on the floor. LVN B said she did a full assessment, and Resident #4 didn't have any injuries, no c/o pain, and the neurological assessment were WNL. LVN D said she was required to enter a progress note following falls. LVN D further stated the ADON and DON were responsible for ensuring documentation was completed. LVN D said the fall should have been documented immediately after it happened because they did not want to forget details, but at minimum by the end of the shift. LVN D further stated that was important so that everyone saw the details of the fall and were aware of the incident, to reference the incident or determine patterns and could determine the interventions, if any, required. During a telephone interview on 9/30/24 at 1:16 pm, LVN E said he did not remember Resident #4 falling on 8/3/24. LVN E further stated he was required to document in the progress notes if a resident had a fall but did not remember if Resident #4 had a fall on 8/3/24. 2. Record review of Resident #4's Order Summary, dated 9/27/24, revealed: AB Ativan/Benadryl topical Gel Apply to wrist topically every 6 hours as needed for agitation for 2 Weeks .Order Date 08/21/2024 . LORazepam Concentrate 2 MG/ML Give 0.5 ml by mouth every 6 hours as needed for Agitation; Anxiety for 2 Weeks . Order Date 08/02/2024 . Record review of Resident #4's EMAR progress note, dated 8/5/24 at 8:14 pm, revealed the resident was administered PRN lorazepam concentrate by LVN D at 9:52 am. Progress note did not include observed behaviors. Record review of Resident #4's August MAR revealed, on 8/5/24, for the evening shift LVN A documented NO for behaviors observed and 00 for number of episodes the targeted behavior occurred. Record review of Resident #4's August MAR revealed, on 8/5/24, for the day shift LVN D documented 0 for number of episodes the targeted behavior occurred. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's EMAR progress note, dated 8/28/24 at 5:00 pm, revealed the resident was administered PRN AB (Ativan/Benadryl) topical gel by LVN A. Progress note did not include observed behaviors. Record review of Resident #4's August MAR revealed, on 8/28/24, for the evening shift LVN A documented NO for behaviors observed and 00 for number of episodes the targeted behavior occurred. Attempted telephone interview on 9/30/24 at 1:15 pm with LVN A was unsuccessful. During an interview on 9/30/24 at 2:20 pm, LVN D said there was no documentation regarding behaviors requiring the administration of lorazepam on 8/5/24. LVN D further stated most of the time, when a PRN medication was administered, the behaviors observed were documented in the EMAR. LVN D said she did not remember what behaviors Resident #4 exhibited on 8/5/24 that required the administration of lorazepam. LVN D said No on the EMAR meant the behavior was not observed and 0 represented the number of times the behavior was observed. LVN D said staff were required to document behaviors in the EMAR or enter a progress note. LVN D further stated this was the expectation so that everyone knew what behaviors were exhibited and the physician and the psychiatrist could monitor the behaviors. LVN D said the lack of documentation could result in a negative outcome for the resident because the physician would not have all the information needed and therefore would not be able to give the appropriate care. LVN D said it was facility policy to document the behaviors observed and the efficacy of the medication. LVN D further stated if staff said the resident was combative and PRN medication was administered, then the documentation should reflect that, so the physician knew whether it was effective or not. During an interview on 9/30/24 at 2:34 pm, LVN C said falls, progress notes, and PRN medications administered were reviewed in the morning meeting Monday - Friday by the IDT. LVN C further stated the expectation was to document the behaviors observed, the reason the lorazepam was being administered. LVN C said the progress notes were reviewed for the behaviors and the reason why the PRN medication was administered; cause and effect. LVN C said when PRN medications were administered there was a place to enter a progress note detailing why the medication was administered and hoped this was what the staff were doing. LVN C further stated the nurses knew that they should be entering a progress note when a PRN medication was administered. LVN C said he did not know what the policy said but it was the facility's expectation that behaviors be documented when PRN medications were administered. LVN C said he was not aware Resident #4's behaviors were not documented, otherwise, it would have been addressed. LVN C said it was important to document behaviors observed because there was a reason for the medication. LVN C stated especially for an anti- anxiety medication, for follow-up and to see if it was effective or not, because if it was not, the resident should not be administered the medication. LVN C said it was also important for the safety of the resident. LVN C said there was a risk for a negative outcome with any medication and that's why documentation was required. LVN C said without the documentation, the facility did not know the possible cause as to why the medication was given, why were they agitated, were there other interventions that could have been provided instead of the PRN medication, what were the behaviors observed, and what other interventions were attempted prior to the administration. LVN C said the documentation was also important for trends and patterns such as sundowning and trying to limit those behaviors was what the facility was trying to achieve. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/1/24 at 11:48 pm, the DON said she did not see any progress notes regarding Resident #4's falls on 8/3/24 and 8/5/24. The DON said she expected the nurses to document the details of the incident in a progress note. The DON further stated the IDT and herself were responsible for ensuring documentation was complete and accurate. The DON said she reviewed documentation every day and on Mondays for the weekends. The DON said she must have missed the lack of documentation because the facility reviewed and discussed both falls and interventions. The DON said it was important to document falls for follow-up and to let everyone know what was going on. The DON further stated lack of documentation could cause a delay in resident care. The DON said her expectation was that a progress note be entered every time a PRN medication was administered, the reason it was administered, and the efficacy of the medication. The DON further stated for behaviors, the nurse should have documented the behaviors observed, what other interventions were tried prior to administering the medication, such as redirection, toileting, snack, and pain assessment. The DON said the charge nurse was responsible for ensuring the staff document why they administered the PRN medication. The DON further stated documenting the rationale for PRN medications was important so that they knew why the resident was administered the medication and whether it was effective or not. The DON said the documentation also allowed them to evaluate the root cause and go back to the drawing board if necessary. The DON further stated, how would you know if it was effective if you're not documenting why it was given. During an interview on 10/1/24 at 1:18 pm, the Administrator said the charge nurse was responsible for documentation and the DON oversaw the documentation of incidents. The Administrator further stated the accuracy of documentation was important to show an accurate picture of what was going on with the resident. The Administrator said when PRN medications were administered the expectation was that the behaviors were documented as well. Record review of the facility's policy titled Charting and Documentation, revised July 2017, revealed: .All services provided to the resident .or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .2. The following information is to be documented in the resident medical record: a. Objective observations .d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident .3. Documentation in the medical record will be objective .complete, and accurate . Record review of the facility's Clinical Protocol titled Falls, revised March 2018, revealed: .the nurse shall assess and document/report the following .details on how fall occurred .