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	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Nursing & Rehabilitation	8223 Broadway San Antonio, TX 78209

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 7 residents (Resident #1) whose records were reviewed. LVN A failed to notify Resident 1, Resident 1's physician or NP and Resident 1's emergency contact when LVN A received a critical CO2 lab result (A CO2 blood test measures the amount of carbon dioxide in your blood, primarily in the form of bicarbonate (HCO3). This test is often part of a broader electrolyte panel or comprehensive metabolic panel (CMP), which helps evaluate your body's acid-base balance and overall metabolic function). This deficient practice could place residents at risk of not having the opportunity to make informed decisions about their health status. The findings were: Review of Resident #1's face sheet, dated 3/25/26, revealed she was admitted into the facility on 3/1/26 with diagnoses including heart failure, obstructive sleep apnea (is a common sleep disorder characterized by repeated interruptions in breathing during sleep due to airway blockage), chronic pulmonary edema (long-term condition where fluid gradually accumulates in the lungs, often due to heart or lung problems, leading to persistent breathing difficulties) and acute and chronic respiratory failure with hypoxia (occurs when the lungs cannot supply enough oxygen to the blood, leading to low tissue oxygen levels, and can be life-threatening if untreated). Review of Resident #1's admission MDS assessment, dated 3/3/26, revealed her BIMS score was 15 of 15 reflecting no cognitive impairment and she was receiving oxygen therapy. Review of Resident #1's Care Plan, dated 3/1/26, revealed Resident #1 had a pacemaker and one of the interventions included to monitor vital signs as ordered/per facility protocol and record, she had altered respiratory status and one of the interventions included Monitor for s/sx of respiratory distress and report to MD PRN: Increased Respirations; Decreased Pulse oximetry; Increased heart rate (Tachycardia); Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis; Cough; Pleuritic pain; Accessory muscle usage; Skin color changes to blue/grey. Review of Resident #1's lab results dated 3/2/26 revealed a critical lab value for CO2 of 42 which was labeled at HH in red. Further review revealed LVN A was notified of the critical lab on 3/2/26 at 8:34 PM pacific time (10:34 PM central time). Review of Resident #1 progress note dated 3/3/26 at 1:14 AM written by LVN A read Resident (#1) has critical lab results for CO2 at 42 (reference range 21-31) informed NP and DON. Resident stable at this time. Review of progress note for Resident #1 dated 3/3/26 at 06:52 AM written by LVN B read Night nurse (LVN A) stated he sent results to NP pending response. Review further of Resident #1's progress notes revealed there was no other documentation entered by LVN A in response to the critical lab. Review of Resident #1's assessments for March 2026 revealed there was not a change of condition assessment completed in response to Resident #1 critical lab value of CO2, dated 3/2/26. Review of NP progress note, dated 3/3/26, read Orders:1. Utilize [NAME] Inpatient Care Protocol Orders, please notify NP accordingly.2. SLUMS X 1 BY REHAB SERVICES, please upload document in (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MISC/Documents tab.3. LABS: CBC, BMP, BNP, MAG, PHOS every MONDAY starting next week. Summary: Call from (LVN B, no date), CO2 reported by (LVN B), however, pt on O2 and needs to be off due to retention of CO2. Pt has CHONIC HYPERCARBIC RESP FAILURE with elevated CO2 levels (R79.81). Discussed and verbal understanding with (LVN B). Pt breathing 16-21, unlabored and sat > 96%. Pt denies dyspnea (shortness of breath). Monitor for acute needs. Interview on 3/25/26 at 4:25 PM with the DON revealed on 3/3/26 nurse (LVN A) received a critical lab, CO2 at 42. LVN A noted he informed the NP and himself. He stated LVN A notified the NP and himself via phone text. He stated he received it when he woke up on 3/3/26 and the NP never responded to LVN A's text. The DON stated (LVN A) should have called the NP and himself for a critical lab which was considered a change of condition. LVN A should have called the on-call nurse if he was unable to make contact with the NP and himself. He stated according to LVN B's skilled nursing note dated 3/3/26 at 6:14 AM Resident #1's O2 level was documented at 95%. The DON stated he did not recall talking with the NP about Resident #1's critical lab on Wednesday 3/4/26 when the NP was on-site. He stated the NP rounded on residents every Monday, Wednesday and Friday. The DON stated the importance of following protocols for a change of condition was to avoid worsening of Resident #1's condition. Nursing staff would continue to monitor more frequently and start interventions in a timely manner once orders were received. Interview on 3/26/25 at 10:55 AM with LVN B revealed she had worked at the facility for about 5 years. She stated facility protocols for change of condition required she notify the NP or MD and nursing management via phone call. Upon receipt of a critical lab she would call immediately and would keep calling until she got an answer. She stated it was important to make contact because a change of condition could be life threatening. LVN B stated on 3/3/26 LVN A reported he had notified the NP and was pending a response. She stated LVN A did not share when he received the critical lab or when he notified the NP. LVN B stated she called the NP on 3/3/26 around breakfast time to inform her of the critical lab value for CO2 and of Resident #1's daily assessment. She stated the NP said she planned to ween Resident #1 off oxygen and would address it with Resident #1 during rounding. LVN A stated she did not enter a progress note after contacting the NP. She stated she must have forgotten to enter the note. LVN B stated she let the DON know that she had called the NP about the critical lab for Resident #1. Telephone interview on 3/26/26 at 4:58 PM with LVN A revealed he had worked at the facility for 6 years on the night shift. He stated he did not remember the details about receiving a critical lab for Resident #1. He stated facility protocols when receiving a critical lab included immediately calling the NP and the DON and to follow orders. He stated a critical lab would be considered a change of condition and would be required to assess the resident and obtain vitals prior to calling the NP and the DON, to complete a change of condition, notify the RP which he would document in the assessment and on a progress note. LVN A stated sending a text was not sufficient when responding to a change of condition/critical lab. He stated he would monitor the resident until he received a call back from the NP and the DON. In the event they did not call within 10 minutes he would send the resident out to the hospital. LVN A stated a resident who had a critical lab value of 42 for CO2 could go into cardiac arrest and for a resident like Resident #1 who had a history of heart problems could lead to death if the change of condition was not addressed right away. LVN A stated sometimes the NP took a long time to respond when he reached out to her during the night shift. He stated the DON would respond but sometimes it takes time to get a response. He stated his option was to call the ADON when having difficulties getting a response from the NP and the DON. He stated he had reached out to ADON before but not every time. LVN A stated he did not remember what he did in response to receiving a critical lab for Resident #1. Observation and interview on 3/26/25 at 4:17 PM with Resident #1, her emergency contact and a close personal friend revealed they were visiting. Surveyor asked Resident #1 if anyone talked with her about an abnormal lab result received earlier in the month (March). Resident #1 stated and her emergency contact stated facility staff did not notify them of any abnormal lab results. The emergency contact stated hospital staff told him Resident #1 had retained a lot of carbon dioxide (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because of her breathing patterns. The emergency contact stated if they called him, he did not answer numbers he did not recognize but stated he had talked with nursing staff before on the phone. Resident #1 stated it was upsetting that no one talked to her about it because she would want the opportunity to decide whether or not to go to the hospital as needed. Interview on 3/27/26 at 9:30 AM with the DON revealed he talked with LVN A about what he did in response to receiving the critical lab for Resident #1. The DON stated LVN A reported he assessed the resident and she was in stable condition. He agreed to call and not text when communicating with the NP and himself regarding a critical lab. The DON stated he acknowledged he did not complete documentation reflecting what he did to ensure the residents safety. Interview on 3/27/26 at 11:57 AM with the NP revealed LVN A often did not follow protocols. She stated he texted her about Resident #1's critical lab for CO2 via his personal email which was not allowed because it was not secure and it violated HIPAA. The NP stated she would not have done anything differently had LVN A called her because she understood Resident #1's health status and stated Resident #1 had complicated comorbidities. She stated Resident #1 had a tendency to open her mouth when receiving oxygen which would make her CO2 level go up. The NP stated Resident #1 was not in any distress when LVN B assessed her on the morning of 3/3/26 and when she rounded on Resident #1 on 3/4/26. Review of facility policy dated 01/2025 read Change of Condition Notification Nursing Manual - Nursing AdministrationPolicy No. - NP - 104CONFIDENTIAL AND PROPRIETARY INFORMATION Page 1 of 2PurposeTo ensure residents, family, legal representatives, and physicians are informed of changes in theresident's condition in a timely manner.PolicyDefinition: An acute change of condition (ACOC) is a sudden, clinically important deviation from apatient's baseline in physical, cognitive, behavioral, or functional domains. Clinically importantmeans a deviation that, without intervention, may result in complications or death. (AMDA 2003)I. Members of the Interdisciplinary Team (IDT) are expected to report and document signs andsymptoms that might represent an ACOC.II. The Facility will promptly inform the resident, consult with the resident's Attending Physician, andnotify the resident's legal representative when the resident endures a significant change in theircondition caused by, but not limited to:A. An injury/accident;B. A significant change in the resident's physical, cognitive, behavioral or functional status;C. A significant change in treatment; and/orD. A decision to transfer or discharge the resident from the Facility.ProcedureI. The Licensed Nurse will notify the resident's Attending Physician when there is an:A. Incident/accident involving the resident;B. An accident involving the resident which results injury and has the potential for requiringphysician intervention;C. A significant change in the resident's physical, mental or psychosocial status, e.g.,deterioration in health, mental or psychosocial status, life-threatening conditions orclinical complications;D. A need to alter treatment significantly;E. A decision to transfer or discharge the resident from the Facility.II. The Licensed Nurse will assess the resident's change of condition and document the observationsand symptoms.III. Notifying the Attending Physician:A. The Attending Physician will be notified timely with a resident's change in condition.B. Notification to the Attending Physician will include a summary of the condition changeand an assessment of the resident's vital signs and system review focusing on thecondition and/or signs and symptoms for which the notification is required.C. The Licensed Nurse will review the resident's advanced directives and ensure that theAttending Physician is aware of the resident's wishes. Interventions should be inaccordance with the resident's instructions.IV. Reporting Information to the Attending PhysicianA. Emergency Situationsi. In emergency situations, (e.g., a resident is experiencing unexpected shortness ofbreath, intense pain, unexpected bleeding, serious abnormal labs or x-ray) theLicensed Nurse will:a. Immediately call the Attending Physician.Change of Condition NotificationNursing Manual - Nursing AdministrationPolicy No. - NP - 104CONFIDENTIAL AND PROPRIETARY INFORMATION Page 2 of 2(i) NOTE: If the Licensed Nurse is unable to reach the AttendingPhysician or the Physician on call during emergency situations,he/she will notify the Facility's Medical Director.(ii) If the resident deteriorates, the symptoms are serious, and themost rapid intervention available by a physician would place theresident in great jeopardy, call 911 for (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transport to hospital;b. Notify the Nursing Supervisor of emergency situation; andV. Family NotificationA. The Licensed Nurse will notify the resident, the resident's responsible party, or thefamily/surrogate decision-makers of any changes in the resident's condition as soon aspossible.VI. DocumentationA. A Licensed Nurse will document the following:i. Date, time, and pertinent details of the incident and the subsequent assessmentin the Nursing Notes.ii. The time the Attending Physician was contacted, the method by which he wascontacted, the response time, and whether or not orders were received.iii. The time the family/responsible person was contacted.iv. Update the Care Plan to reflect the resident's current status.v. The incident and brief details in the 24-Hour Report.vi. If the resident is transferred to an acute care hospital, complete an inter-facilitytransfer form.vii. Complete an incident report per Facility policy.B. A Licensed Nurse will communicate any changes in required interventions to the IDTmembers involved in the resident's care.C. A Licensed Nurse will document each shift for at least seventy-two (72) hours.D. Documentation pertaining to a change in the resident's condition will be maintained inthe resident's medical record and on the 24-Hour Report.ReferencesSources:42 C.F.R. S 483.10(g)(14). American Medical Directors Association (AMDA)Forms:NoneEmployees:Nursing StaffVersion No. 1.0 Date Revised: 01/2025.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse or mistreatment were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse for 1 of 7 Residents (Resident #2) whose records were reviewed for abuse. The ADM failed to report an allegation of abuse when Resident #2 threw a plastic cup at Resident #3 causing a skin tear over his left eyebrow within two hours after the allegation was made. This deficient practice could place residents at risk of further abuse. The findings were:Review of Resident #2's face sheet, dated 3/27/26, revealed he was admitted to the facility on [DATE] with diagnoses including Dementia in other diseases classified elsewhere mild, with agitation (indicating dementia as a symptom of an underlying condition) and other stimulant abuse with stimulant induced anxiety disorder (misuse of stimulants leads to the development of anxiety disorders). Review of Resident #2's quarterly MDS assessment, dated 3/16/26, revealed his BIMS was 8 of 15 reflecting moderate cognitive impairment and had a diagnosis of anxiety. Review of Resident #2's Care Plan, dated 2/20/26, revealed he had cognitive impairment/Dementia, one of the interventions reflected Discuss concerns about confusion, disease process, NH placement with the resident/family/caregivers, he has a behavior problem r/t throwing items at other people, one of the interventions reflected Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes). Review of the Provider Investigation Report, dated 1/13/26 revealed on 1/6/26 at 5:45 PM Resident #2 threw an empty cup towards Resident #3 because he tried to open privacy curtain during care. The cup hit Resident #3 and caused a small skin tear. The injury was treated in-house. Resident #3 was moved to another room. Both residents were referred for psychiatric services. Further review revealed the ADM reported the resident-to-resident altercation on 1/7/26 at 11:04 AM. Observation and interview on 3/24/26 at 2:06 PM revealed Resident #2 was lying in bed. He stated he had a roommate who would talk a lot of shit and stated the other resident wasn't all there. Resident #2 said his roommate would talk about his Mom and one day, staff was changing his clothes and the roommate opened the privacy curtain. He stated his roommate opened it a couple times before and talked shit about his Mom. Resident #2 stated he lost his temper and threw a cup at his roommate and hit him over the left eye. He stated the roommate had a small skin tear. Resident #2 stated he felt bad and had tried to help his roommate, but he got tired of his roommate's mouth. Resident #2 stated staff intervened and then his roommate was moved. Resident #2 stated he had not had any other problems with other residents. Further observation revealed Resident #2 did not have a roommate. Observation on 3/24/26 at 2:25 PM with Resident #3 revealed he was lying in bed. Attempted interview with Resident #3 revealed he presented as being alert to self (he responded to his name) with confusion. Resident #3 did engage in conversation. Further observation revealed Resident #3 did not have any skin tears or discoloration on his face. Interview on 3/27/25 at 3:30 PM with the ADM revealed Resident #2 threw a cup at Resident #3 because Resident #3 opened the privacy while care was provided to Resident #2. She stated Resident #2 admitted he threw the cup at Resident #3. The ADM stated she reported the resident-to-resident incident between Resident #2 and Resident #3 within 24 hours. Upon reviewing the regulation, the ADM stated she understood she should report an allegation of abuse within 2 hours when the resident sustained serious bodily injury which was not the case. The ADM stated she did not have a problem with reporting allegations of abuse and stated having to report it within 2 hours was a technicality. The ADM stated Resident #3 was moved to a different room and did not have any lasting emotional affects but stated based on Survey's interpretation she would report allegations of abuse within 2 hours. Review of facility policy Abuse Prevention and Prohibition Program, dated October 24, 2022, read in relevant part To ensure (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.IX. Reporting/ResponseD. The Facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime. See AN - 01 - Form E - Initial Report - Facility Reported Incidents.i. Immediately, but no later than 2 hours after forming the suspicion - if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation). See AN - 01 - Form G - Crosswalk of Abuse Reporting Requirements.ii. No later than 24 hours after forming the suspicion - if the alleged violation (e.g., misappropriation of property, neglect) does not involve abuse and does not result in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman (if applicable per state regulation). See AN - 01 - Form G - Crosswalk of Abuse Reporting Requirements.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter for 4 of 7 Residents (Resident #2, Resident #3, Resident #4, Resident #5) reviewed for physician visits. The facility failed to ensure Resident #2's, Resident #3's, Resident #4's and Resident #5's were visited by their physician at least every 60 days after their 90-day admission period. This deficient practice could place residents at risk for not having an MD assessing their health status. The findings were:1.Review of Resident #2's face sheet, dated 3/27/26, revealed he was admitted to the facility on [DATE] with diagnoses including Dementia (decline in cognitive function severe enough to interfere with daily life) in other diseases classified elsewhere mild, with agitation (indicating dementia as a symptom of an underlying condition) and other stimulant abuse with stimulant induced anxiety disorder (misuse of stimulants leads to the development of anxiety disorders). Review of Resident #2's quarterly MDS assessment, dated 3/16/26, revealed his BIMS was 8 of 15 reflecting moderate cognitive impairment and had a diagnosis of anxiety. Review of Care Plan, dated 2/20/26, revealed he had cognitive impairment/Dementia, one of the interventions reflected Discuss concerns about confusion, disease process, NH placement with the resident/family/caregivers, he has a behavior problem r/t throwing items at other people, one of the interventions reflected Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes). 2. Review of Resident #3's face sheet, dated 3/27/26, revealed he was admitted to the facility on [DATE] with diagnosis including unspecified Dementia (decline in cognitive function severe enough to interfere with daily life), unspecified severity, with other behavioral disturbance. Review of Resident #3's Care Plan, dated 12/10/25, read The resident has impaired cognitive function/dementia or impaired thoughtprocesses. One of the interventions included Ask yes/no questions in order to determine the resident's needs). Review of Resident #3's History and Physical, dated 3/20/26, revealed the NP had completed the History and Physical. Further review Resident #3's physician signed it but did not date it. 3. Review of Resident #4's face sheet, dated 3/27/26, revealed he was admitted to the facility on [DATE] with diagnosis including Dementia (decline in cognitive function severe enough to interfere with daily life), in other diseases classified elsewhere, mild, with anxiety. Review of Resident #4's quarterly MDS, dated [DATE], revealed his BIMS score was 15 of 15 reflecting no cognitive impairment. Review of Resident #4's Care Plan, dated 11/26/25, read The resident has impaired cognitive function/dementia or impaired thoughtprocesses. One of the interventions included (Identify yourself at each interaction. Face the resident when speaking and make eye contact). 4. Review of Resident #5's face sheet, dated 3/27/26, revealed she was admitted to the facility on [DATE] with diagnosis including Schizoaffective Disorder, Bipolar type (form of mental illness that has the features of both schizophrenia and a mood disorder. It has two variations: bipolar type and depressive type. A hallmark feature of bipolar type schizoaffective disorder is the presence of manic episodes). Review of Resident #5's quarterly MDS, dated [DATE], revealed her BIMS score was 15 of 15 reflecting no cognitive impairment. Review of Resident #5's Care Plan, dated 12/13/25, read Resident #5 has mood problem related to Bipolar disorder, Insomnia, depression,anxiety. She is at risk for changes in mood related to pain/discomfort. She is prescribed anticonvulsant medications for bipolar disorder. Review of Resident #2's, Resident #3's, Resident #4's and Resident #5's EHR revealed there were no physician progress notes/assessments or History and Physical's completed by their physician from 3/27/25 to 3/27/26. Interview on 3/27/26 at 4:00 PM with the DON and ADM revealed #2's, Resident #3's, Resident #4's and Resident #5's rounded on his residents on Wednesday's. The ADM and DON stated the Resident's physician would sign off on the NP's notes and stated they did not have any of the physician's notes written by the physician himself. The ADM provided a copy of Resident #3's (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	History and Physical completed by the NP on 3/20/26. It was signed by Resident #3's physician but not dated. The ADM stated Resident #2's, Resident #4's and Resident #5's NP's progress notes for all of them would all be signed by the Resident's physician. The ADM and DON stated they were unable to provide any written physician progress notes or an H&P for any of the residents. Review of facility policy Physician Services & Visits, dated 8/20/20, 08/2020, read in relevant part Physician Services & Visits:I. Physician services include, but are not limited toA. The resident's Attending Physician participation in the resident's assessment and careplanning, monitoring changes in resident's medical status, and providing consultation ortreatment when called by the FacilityB. The Attending Physician must:i. Evaluate the resident as needed and at least every 30 days for the first 90 daysafter admissions, and at least once every 60 days thereafter unless there is analternate schedule or state specific requirement. The Attending Physician willdocument the visits in the resident's health record. II. Patient diagnosesA. Provide advice, treatment and determination of appropriate level of care needed for eachpatient.B. Providing written and signed orders for diet, care, diagnostic tests and treatment ofpatients by others with the exception of influenza and pneumococcal vaccines, which maybe administered after an assessment for contraindications.C. Health record progress notes and other appropriate entries in the patient's healthrecords.i. Physician orders and progress notes shall be maintained in accordance withcurrent OBRA regulations and Facility policy.

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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 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. Based on interview and record review the facility failed to ensure 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 7 Residents (Resident #1) whose records were reviewed. LVN A and LVN B failed to document what they did in response to Resident #1's critical lab, CO2 for value of 42, This deficient practice could place residents at risk of not having their medical records reflecting the care and services the residents received. The findings were:Review of Resident #1 progress note dated 3/3/26 at 1:14 AM read Resident (1) has critical lab results for C02 at 42 (reference range 21-31) informed NP and DON. Resident stable at this time. Review of progress note for Resident #1 dated 3/3/26 at 06:52 AM read Night nurse (LVN A) stated he sent results to NP pending response. Review of Resident #1's progress notes revealed no other documentation related to Resident #1's critical lab was entered by LVN A. Review of Resident #1's assessments for March 2026 revealed there was not a change of condition assessment in response to Resident #1's critical lab value of C02, dated 3/2/26. Interview on 3/26/25 at 10:55 AM with LVN B revealed she called the NP on 3/3/26 around breakfast time and the NP did not provide any new orders. LVN B stated she did not enter a progress note after contacting the NP. She stated she must have forgotten to enter the note. She stated it was important to document so that other nursing staff knew the NP had been contacted and there were no new orders. She stated other nursing staff would not know the exact status in response to the critical lab. Telephone interview on 3/26/26 at 4:58 PM with LVN A revealed he did not remember the details about receiving a critical lab for Resident #1 if he wrote any notes. Interview on 3/27/26 at 9:30 AM with the DON revealed he talked with LVN A about what he did in response to receiving the critical lab for Resident #1. The DON stated LVN A reported he assessed the resident and she was in stable condition and he texted the NP and himself. The DON stated LVN A acknowledged he did not complete documentation reflecting what he did to ensure the residents safety. He stated communication was a form of coordination of care which was important to ensure Resident #1 received the care and services she needed. Review of facility policy Change of Condition Notification, dated 01/2025, read in relevant part VI. DocumentationA. A Licensed Nurse will document the following:i. Date, time, and pertinent details of the incident and the subsequent assessmentin the Nursing Notes.ii. The time the Attending Physician was contacted, the method by which he wascontacted, the response time, and whether or not orders were received.iii. The time the family/responsible person was contacted.iv. Update the Care Plan to reflect the resident's current status.v. The incident and brief details in the 24-Hour Report.