STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455484	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Juan Nursing Home Inc	300 N Nebraska San Juan, TX 78589

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** 49301 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 7 residents (Resident #71) reviewed for care plans: The facility failed to ensure Resident #71's care plan reflected her diagnosis of Dementia. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and not having personalized plans developed to address their specific needs. The findings included: Record review of Resident #71's face sheet, dated 9/6/2024, reflected a [AGE] year-old female with an initial admitted [DATE]. Resident #71 had diagnoses which included the following: Unspecified Dementia (a neurological condition affecting the brain that worsens over time which causes the loss of the ability to think, remember, and reason to levels that affect daily life and activities), and depression (a mood disorder that involves a persistent low mood or loss of interest in activities that affects how a person feels, thins, and functions). Record review of Resident #71's quarterly MDS, dated [DATE], reflected the resident was rarely/never understood and rarely/never understood and cognitive skills for daily decision making were severely impaired. Resident #71 was dependent on staff for ADLs and mobility. Resident #71 had Non-Alzheimer's Dementia. Record review of Resident #71's most recent care plan, dated 8/21/24, did not reflect Resident #71 had a diagnosis of Dementia and did not have a focus, goals, or interventions/tasks care planned for her diagnosis of Dementia. Observation on 09/03/24 at 11:58 AM revealed Resident #71 is not interviewable. The resident's eyes were open, but she did not respond to any questions. (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	In an interview on 9/6/24 at 1:40 PM with MDS A, he said he focused on updating information on the MDS, but it was a collaborative effort among staff to ensure care planning was completed. The State Surveyor asked who was responsible for updating Resident # 71's care plan for Dementia diagnosis, MDS B said that she was responsible. In an interview on 9/6/24 at 3:04 PM with MDS B. She said she was responsible for ensuring the care planning for Resident #71 was completed. She said they usually printed out the order summary, then addressed each diagnosis on the MDS. She said Dementia was mentioned in the ADLs portion of Resident #71's care plan. The care plan reflected Resident #71 had an ADL self-care performance related to dementia, fatigue, impaired balance, limited mobility, limited range of motion, muscle spasms, and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination. She also said when there was a treatment or medication for the condition, that would trigger them to care plan, but the resident did not have any. She said it just got overlooked. She said if Resident #71's dementia was not care planned, staff would be unable to anticipate the resident needs due to Resident #71 could not communicate. In an interview on 9/6/24 at 3:12 PM with the DON. He said Resident #71's dementia diagnosis should have been care planned. He said it was a collaborative effort for care planning. He said the initial care plan was done by the nurse doing admission. He said the more comprehensive care plans, such as dementia were completed by the MDS staff. He said if Resident #71's Dementia was not care planned, all the resident's needs would not be met appropriately. Record review of the facility's Care Plans - Comprehensive Policy, dated October 2010, reflected: Policy Statement An individualized comprehensive care plan that includes measurable objectives and timetable to meet the resident's medical, nursing, mental and psychological needs is developed for each resident . Purpose of Care Plan 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; . e. Reflet treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aide in preventing or reducing declines in the resident's functional status and/or functional levels; . i. Reflect currently recognized standards of practice for problem areas and conditions . Care Plan Interventions (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying sources(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49301 Based on observation, interview and record review the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 3 residents (Resident #12) reviewed for respiratory care. The facility failed to ensure Resident #12 received oxygen at the prescribed rate. This failure could place residents at risk for respiratory distress. The findings include: Record review of Resident #12's face sheet, dated 9/5/24 reflected the resident was a 90 -year-old female originally admitted to the facility on [DATE]. Resident #12 had diagnoses which included the following: Alzheimer's Disease (a type of dementia that affects memory, thinking and behavior which eventually grow severe enough to interfere with daily tasks), Parkinsonism (a neurodegenerative disease which causes slowed movements, stiffness, tremors, and unstable posture, leading to profound gait impairment), hypertensive heart disease with heart failure (a long-term condition that develops over many years in people who have high blood pressure that can cause heart failure when high blood pressure is unmanaged), and vascular dementia (brain damage caused by multiples strokes which causes memory loss in older adults). Record review of Resident #12's Comprehensive MDS assessment, dated 7/20/24, reflected the resident rarely/never understood and rarely/never understood and cognitive skills for daily decision making were severely impaired. Resident #12 was dependent on staff for ADLs and mobility. Record review of the most recent Care Plan for Resident #12, dated 8/1/24, reflected the resident had oxygen therapy as needed for Hypoxemia (low blood oxygen), to maintain O2 above 92 percent. Date Initiated: 06/17/2024. Revision on: 07/02/2024. Interventions/tasks reveal OXYGEN SETTINGS: O2 via nasal cannula at 2 lpm as needed for Hypoxemia to maintain o2 above 92 percent. Date Initiated: 06/17/2024. Revision on: 07/02/2024. Record review of the Doctor's Order Summary reflected Resident #12 was prescribed O2 via nasal cannula at 2 lpm as needed for Hypoxemia to maintain O2 above 92 percent. Active 06/17/2024. Record review of the MAR/TAR for September 2023 reflected the resident prescribed was O2 via nasal cannula at 2 lpm as needed for Hypoxemia to maintain O2 above 92 percent. -Order Date- 06/17/2024. Record reflected the resident was administered O2 on 9/4/24 O2 sat at 89 %, and on 9/5/24 O2 sats at 96%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/03/24 at 04:45 PM, revealed Resident #12 lying in bed with her eyes closed and the head of the bed was elevated. Resident #12 did not respond to the State Surveyor when knocked on door or asked questions. Resident was not interviewable. Resident was groomed and dressed appropriately. Resident receiving O2 at 3L via NC. Suctioning supplies located next bedside. Resident did not have symptoms of respiratory distress, such as shortness of breath/difficulty breathing, rapid breathing, bluish tint around mouth or fingertip, or cough. Interview on 9/6/24 at 1:40 PM, MDS A said since the oxygen was prescribed as needed and it was not used the whole month of July, it was not captured on the MDS for 7/20/24. He said they only did a 7-day look back. He said if the resident was using the oxygen anytime during the 7-day look back of the next quarterly MDS, it would trigger and be captured that month. Interview and observation on 9/4/24 at 4:34 PM, revealed LVN C checked the O2 flow rate. LVN C stated the flow rate was set at 3LPM. LVN C adjusted the flow rate to 2L, and she stated that's what was on the order. She said the floor nurse was responsible to ensure their residents received the correct oxygen rate. LVN C said she usually checked O2 rates every time they went into the resident's room to ensure the flow rate was accurate. LVN C said she checked Resident #12's flow rate and O2 saturation that morning and her saturation was at 96 %. Said she might have bumped the oxygen concentrator machine and it caused the flow rate to change, but she was not sure. She said if residents received more oxygen than prescribed by the doctor, dependency on the oxygen could occur and the residents could get nasal irritation. Interview on 9/4/24 at 4:43 PM with LVN D, she said to read the oxygen flow rate on an oxygen concentrator machine, the line next to the numbered liters should be located at the center of the ball. She said the floor nurses were responsible for ensuring the flow rates for their assigned residents were accurate. She said she checked oxygen flow rates first thing in the morning when she arrived on shift and throughout the day. She said if a resident received more oxygen than prescribed by the doctor, it could affect their saturation and could cause respiratory alkalosis (a condition that occurs when the body's blood becomes too alkaline which can be caused by hyperventilation, too high a supplemental oxygen setting, or give too large a volume in each breath) or respiratory distress for receiving too much oxygen. Interview on 9/4/24 at 4:57 PM with the DON, he said the floor nurses assigned to the residents on that floor were responsible for ensuring the oxygen flow rates on the oxygen concentrator were accurate. The DON said it should be checked twice a day on shift change at a minimum. The DON said the nurses were trained during their onboarding/initial training process. The DON said they also did spot checks especially withing the first 90 days of onboarding to ensure the staff were comfortable using all the equipment. The DON said the negative effect of a resident receiving more oxygen than prescribed by the doctor depended on a resident's diagnosis. He said if the resident had a diagnosis of Congestive Heart Failure (the heart's capacity to pump blood cannot keep up with the body's need, causing blood to back up, causing fluid to build up in the lungs) it could be problematic, but he said, at the end of the day following a doctor's order should be what we are doing. Record review of Licensed Nurse Competencies Checklist reflected the nursing staff trained were checked off on Respiratory: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxygen Mask/Nasal Cannula, Oxygen Equipment Set Up, Oxygen Equipment Maintenance/Cleaning, Oxygen Equipment Storage, and Respiratory Training: Nebulizer treatment, respiratory exercised, and required documentation). Record review of the Oxygen Administration policy, dated October 2010, reflected: The purpose of this procedure is to provide guidelines for safe oxygen administration . Steps in the Procedure . 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute . 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered . 11. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50532 Based on observation, interview and record review the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable in 7 of 12 boxes of medical supplies (200 hallway) reviewed for medication storage and labeling. The facility failed to ensure7 boxes of medical supplies in the medication storage room, on the 200 hallway, had current usage dates and expired supplies were stored along with current medications/supplies. This failure could place residents at risk of receiving expired medical supplies, wound dressings that past expiration date would not have the intended therapeutic level or effect on a resident's wound. The findings include: Observation on 09/05/24 at 10:16 AM of the medication storage room, on the 200 hallway, revealed 2 boxes of 10 count [NAME] Collagen Dressings 1 x 1 with an expiration date of 11/2023; 3 boxes of 10 count [NAME] Silicone super-absorbent Dressings 3.5 x 4 with an expiration date of 10/19/2023; 1 box 10 count Allevyn Adhesive 3 x 3 dressing; 1 box 10 count Allevyn Adhesive 4 x 4 with an expiration date of 01/01/24. Interview with LVN E, the floor nurse, on 09/05/24 11:15 AM, he stated there was a box in the medication room where they put and then discarded expired medications. Then the ADON, the DON and the pharmacist disposed of expired medications, but not sure how often. Everyone as a group was responsible for reviewing expiration dates in the medication room and carts and kept things organized and dated, the ADON and DON did random checks of medication rooms and carts, but sure how often. Interview with the ADON on 09/05/24 at 11:50 AM, she that she was the ADON for both wings, and everyone was responsible for checking expiration dates in the medication room. She stated she did random checks but there was no set time to check, just random checks every 2-3 months. She looked and signaled to wound dressing boxes and stated yeah, probably overlooked those and she set them aside from current medications and supplies. Interview with the DON on 09/05/24 at 03:15 PM, the DON stated dressings and supplies, as long as they were not pharmaceutical, could be tossed. The DON stated that everyone who had access to the medication room is responsible for ensuring expired medications and supplies are discarded and should keep the medication room tidy, and medication carts as well. Dressings should be discarded if expired and replaced if needed. Expired dressings would not be effective as manufacturer intended. Interview with the DON on 09/06/24 at 05:12 PM, the DON stated the facility did not have any policy specifically on expired medication/supplies. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy, titled Record review of the facility's Discarding and Destroying Medication policy, revised April 2007, reflected Medications that cannot be returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by the resident, and /or medication left by residents upon discharge) shall be destroyed.