

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2024
NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	
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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651</p> <p>42031</p> <p>Based on interview and record review the facility failed to immediately consult with the resident's physician when there was a change in condition and a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for 4 of 11 residents (Residents #1, #2, #3, #4), reviewed for physician notification, in that:</p> <p>Residents #1-#4 were administered blood pressure medications when their blood pressures were low and outside of the physician ordered parameters without physician notification prior to or after medication administration.</p> <p>This failure could result in decreased continuity of care, and a delay in needed treatment and services.</p> <p>An immediate jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 7:23 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm at a scope of pattern due to the facility's need to monitor the effectiveness of their plan of removal.</p> <p>The findings were:</p> <p>Closed record review of Resident #1's face sheet dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (diffuse disease of the brain that alters brain function or structure caused by metabolic changes due to underlying health conditions), essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and hypotension, unspecified (abnormally low blood pressure that can result in inadequate blood flow to the brain and other vital organs). Resident #1 was discharged to the hospital on [DATE].</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 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Closed record review of Resident #1's care plan revealed a focus for the diagnosis of hypertension initiated on [DATE] with the resident at risk for hypertension and hypotension episodes and a goal for Resident #1 to have no side effects of medications. Interventions included to assess reports of hypotension and hypertension episodes, check B/P as ordered and notify the doctor of abnormal results, observe for signs and symptoms and to provide medications as ordered.</p> <p>Closed record review of Resident #1's physician orders revealed an order with a start date of [DATE] for Losartan potassium 100mg tablet (medication used to lower blood pressure) to be given once daily for hypertension at 8:00 p.m. with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of 60 beats per minute or less.</p> <p>Closed record review of Resident #1's EMAR for [DATE] revealed on [DATE] at 8:00 p.m. Losartan potassium 100mg tab was administered by LVN A with a B/P of ,d+[DATE], P-78.</p> <p>Closed record review of Resident #1's EHR progress notes revealed no documentation regarding the physician being notified of the low blood pressure reading and or the administration of the Losartan potassium medication outside of the ordered parameters on [DATE].</p> <p>Record review of Resident #2's face sheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses including: cellulitis of right lower limb, essential primary hypertension, and legal blindness.</p> <p>Record review of Resident #2's care plan, revised [DATE], revealed a focus, [Resident #2] has [diagnosis] of Hypertension. Is at risk for Hypo-/hypertensive episodes, and interventions, Check B/P as ordered and notify MD of abnormal results and Provide medications as ordered.</p> <p>Record review of Resident #2's physician orders revealed an order with a start date of [DATE] for Metoprolol Tartrate Oral Tablet 25mg tablet to be given once daily for hypertension with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of 60 beats per minute or less.</p> <p>Record review of Resident #2's EMAR for February 2024 revealed on [DATE] at 8:00 p.m., Metoprolol Tartrate Oral Tablet 25mg tablet was administered by LVN B with a B/P of ,d+[DATE], P-79.</p> <p>Record review of Resident #2's EHR progress notes revealed no documentation regarding the physician being notified of the low blood pressure reading and or the administration of the Metoprolol Tartrate medication outside of the ordered parameters on [DATE].</p> <p>Record review of Resident #3's face sheet, dated [DATE], revealed the resident was admitted on [DATE] with diagnoses including: unspecified dementia, essential primary hypertension, and heart failure.</p> <p>Record review of Resident #3's care plan, revised [DATE], revealed a focus, [Resident #3] has a [diagnosis] of Hyperlipidemia. Is at risk for complications related to [diagnosis] and adverse reaction to medications, and interventions, Provide medications as ordered. Further review revealed a focus, [Resident #3] is at risk for chest pains, irregular pulse and adverse reaction to medications due to [diagnosis] of Heart Failure, and interventions, Hold medications within parameters from MD and indicated (example: hold digoxin if pulse is below 60).</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Closed record review of Resident #4's EMAR for February 2024 revealed Carvedilol 25mg tab was administered on [DATE] at 8:00 a.m. by LVN A with a B/P of ,d+[DATE] P-86 and at 8:00 p.m. by LVN B with a B/P of ,d+[DATE] P-86. On [DATE] at 8:00 p.m. by LVN B with a B/P of ,d+[DATE] P-68, on [DATE] at 8:00 p.m. by LVN B with a B/P of ,d+[DATE] P-70. On [DATE] at 8:00 a.m. by LVN B with a B/P of ,d+[DATE] P-113.</p> <p>Closed record review of Resident #4's EMAR for [DATE] revealed Carvedilol 25mg tab was administered on [DATE] at 8:00 p.m. by LVN B with a B/P of ,d+[DATE] P-78</p> <p>Closed record review of Resident #4's EHR progress notes revealed no documentation regarding the physician being notified of the low blood pressure readings and or the administration of the Losartan potassium or Carvedilol medications outside of the ordered parameters.</p> <p>In an interview on [DATE] at 12:05 p.m., LVN A stated she takes her own vital signs and if she administered any medications outside of the ordered parameters then she had contacted the physician and documented in the resident progress notes or through the EMAR documentation. LVN A further stated she does not know what happened and does not copy vital signs. LVN A was unable to state where else the documentation of the physician being notified would be.</p> <p>In an interview on [DATE] at 5:17 p.m., LVN B stated that he personally measures and accurately records vital signs including blood pressure and pulse each time the physician orders call for vital signs and stated that he does not administer medications outside of the parameters noted in the physician orders. LVN B stated he always follows physician orders, including notifying the physician if and when a resident's vital signs were outside of parameters noted in the orders. When asked why he had not notified the physician on [DATE] when Resident #2 received medication outside of parameters, and on [DATE] when Resident #3 received medication outside of parameters, LVN B stated that he always notifies the physician when needed and stated he did not know why there was no documentation of his notification.</p> <p>In an interview with the DON [DATE] at 5:15 p.m., the DON confirmed that accurately measuring and recording vital signs as per physician order and notifying the physician of a change in the resident's condition and/or a need to alter the resident's treatment were integral to assisting the residents to maintain good health.</p> <p>In a telephone interview on [DATE] at 1:02 p.m. the MD stated he was not aware and could not recall being notified specifically with vital sign issues but was driving and did not have his patient records in front of him. The MD further stated patient safety was a priority for him and his group of physicians.</p> <p>In a telephone interview on [DATE] at 2:40 p.m. the MD stated the vital sign issues brought to his attention by surveyor were concerning. The MD stated he and other physicians in his group were in the facility often, and at times even 2 to 3 times a week and he had not recalled seeing blood pressure or vital sign issues on what was displayed to the physician. The MD further stated the vital sign issues could make clinical decision making more difficult.</p> <p>The facility's Plan of Removal was accepted on [DATE] at 5:10 p.m. and included:</p> <p>Date: [DATE]</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>F 726</p> <p>Immediate action:</p> <p>The Medical Director was notified of the Immediate Jeopardy status on [DATE] at 7:35 pm.</p> <p>Resident Vital Signs were taken when the issue was identified on [DATE]. An audit was done to ensure parameters were ordered for all residents on cardiac medication and vitals were being recorded on the computer correctly. The cardiac medication and vitals were found to be within normal limits. No adverse reactions observed with any resident. VS are currently in progress for all residents to ensure they are within normal/ safe limits. The primary physician will be notified for any residents found with abnormal vital signs to determine if additional treatment is warranted. This task will be completed by 10 pm on [DATE].</p> <p>The Director of Nurses completed an audit on administration parameters for all residents receiving cardiac medications on [DATE] once the issue was identified. An audit will be completed again to ensure that all parameters are in place and being followed for residents on cardiac medications.</p> <p>On [DATE], a complete audit was done which included checking the data on the computer, taking new vital signs for residents, ensuring the vitals were recorded correctly and calling the doctors to ensure parameters were correct. This task was completed before 11:59 pm on [DATE]. Parameters will be verified with the primary care physician and updated if appropriate by 11:59 pm [DATE].</p> <p>All nursing staff involved in administration of medication were in serviced to ensure they were taking vital signs prior to administering cardiac medications to ensure parameters were correct and medication was either held or administered accordingly. The staff had to do return demonstration following the in-service. Agency staff will be in-serviced on this issue prior to their starting their shift.</p> <p>Education will be provided to all nurses and certified medication aides on the need to take a new set of vital signs with each medication pass, and the importance of following parameters to hold or give medications based on vital sign values obtained and to notify the physician if medication was given outside of the parameters provided. The EMR system (PCC) copy feature that allowed the utilization of the last set of vital signs taken for medication administration has been turned off as of [DATE] @ 12:45pm.</p> <p>Facilities Plan to ensure compliance quickly</p> <p>Education provided by the DON will include all nurses and certified medication aides on the need to take a new set of vital signs with each medication pass, and the importance of following parameters to hold or give medications based on vital sign values obtained and to notify the physician if medication was given outside of the parameters provided. Education was initiated on [DATE] by the Director of Nurses and will continue until all nurses and med aides have completed the education and skill check for Vital Sign competency.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview with the DON on [DATE] at 5:15 p.m., the DON stated that only nurses and medication aides measured vital signs and administered at the facility and there were 2 medication aides and 12 nurses employed by the facility. The DON stated that 11 of the 14 staff members who administered medications had both of two in-service trainings and completed both of two skills checks. Skills checks required staff to demonstrate how to assess blood pressure using two techniques. The DON stated that the three staff members who did not yet receive training will be required to do so before their next shift.</p> <p>During an interview with LVN B on [DATE] at 5:17 p.m., LVN B stated his work schedule was Saturday and Sunday from 6:00 a.m. to 10:00 p.m., confirmed that he received two in-service trainings, and verbalized understanding of the trainings. LVN B further stated he had completed two demonstrative skills checks with the DON.</p> <p>During an interview with Medication Aide E on [DATE] at 5:22 p.m., Medication Aide E stated her work schedule was Monday through Friday from 6:00 a.m. to 10:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. Medication Aide E further stated she had completed two demonstrative skills checks with the DON.</p> <p>During an interview with LVN A on [DATE] at 5:26 p.m., LVN A stated her work schedule was Monday through Friday from 8:00 a.m. to 5:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LVN A further stated she had completed two demonstrative skills checks with the DON.</p> <p>During an interview with RN F on [DATE] at 5:32 p.m., RN F stated her work schedule was Saturday and Sunday from 6:00 a.m. to 10:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. RN F further stated she had completed two demonstrative skills checks with the DON.</p> <p>During an interview with LVN G on [DATE] at 5:43 p.m., LVN G stated his work schedule was Saturday and Sunday from 6:00 a.m. to 10:00 p.m., confirmed that he received two in-service trainings, and verbalized understanding of the trainings. LVN G further stated he had completed two demonstrative skills checks with the DON.</p> <p>During an interview with LVN H on [DATE] at 5:50 p.m., LVN H stated her work schedule was Monday through Friday from 2:00 p.m. to 10:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LVN H further stated she had completed two demonstrative skills checks with the DON.</p> <p>During a telephone interview with LVN I on [DATE] at 5:55 p.m., LVN I stated his work schedule was Monday through Friday from 2:00 p.m. to 10:00 p.m., confirmed that he received two in-service trainings, and verbalized understanding of the trainings. LVN I further stated he had completed two demonstrative skills checks with the DON.</p> <p>During a telephone interview with LVN J on [DATE] at 6:04 p.m., LVN J stated her work schedule was Monday through Friday from 8:00 a.m. to 5:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LVN J further stated she had completed two demonstrative skills checks with the DON.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	
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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a telephone interview with LVN K on [DATE] at 6:16 p.m., LVN K stated her work schedule was Monday through Friday from 6:00 a.m. to 2:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LVN K further stated she had completed two demonstrative skills checks with the DON.</p> <p>During a telephone interview with LVN L on [DATE] at 6:24 p.m., LVN L stated her work schedule was Monday through Friday from 10:00 a.m. to 6:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LN L further stated she had completed two demonstrative skills checks with the DON.</p> <p>During a telephone interview with LVN M on [DATE] at 6:16 p.m., LVN M stated his work schedule was Monday through Friday from 10:00 p.m. to 6:00 a.m., confirmed that he received two in-service trainings, and verbalized understanding of the trainings. LVN M further stated he had completed two demonstrative skills checks with the DON.</p> <p>Record review of the facility in-service training, Checklist Vital Signs: Assessing Blood Pressure, dated [DATE], revealed it had been signed as completed by eleven staff members.</p> <p>Record review of the facility in-service training, Blood Pressure Measurement (Digital) Skills Checklist, dated [DATE], revealed it had been signed as completed by eleven staff members.</p> <p>Record review of the facility skills check, Vital Signs Parameters/Blood Pressure/Pulse, dated [DATE], revealed it had been signed as completed by eleven staff members.</p> <p>Record review of the facility skills check, Vital Signs Parameters, dated [DATE], revealed it had been signed as completed by eleven staff members.</p> <p>The Administrator was informed the Immediate Jeopardy was lifted on [DATE] at 8:12 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility needed to monitor their corrective actions.</p> <p>No facility policy regarding physician notification was received prior to exit.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive resident centered care plan for 1 (Resident #9) of 11 residents reviewed for comprehensive resident centered care plans, in that:</p> <p>Resident #9's care plan was incomplete and did not accurately describe his care needs.</p> <p>This deficient practice could result in insufficient resident care.</p> <p>The findings were:</p> <p>Record review of Resident #9's facesheet, dated 03/12/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Depression, Generalized Anxiety Disorder, Frontal Lobe and Executive Function Disorder, Personality Disorder, Schizophrenia, Bipolar Disorder, Acquired Absence of Right Leg Below Knee, and Acquired Absence of Left Leg Below Knee.</p> <p>Record review of Resident #9's Comprehensive MDS, dated [DATE], revealed a BIMS score of 15. Further review revealed the resident was dependent upon staff for toileting and required partial assistance with transfers into and out of a bath or shower.</p> <p>Record review of resident #9's care plan, revised 02/08/2024, revealed a focus [Resident #9] has an ADL self-care performance deficit and a single intervention, Staff assistance to the extent needed to accomplish task. Further review revealed a focus, [Resident #9] is an elopement risk/wanderer and a single intervention, Assess for fall risk. Further review revealed, [Resident #9] has impaired cognitive function/dementia or impaired thought processes and a single intervention, Administer medications as ordered. Monitor/document for side effects and effectiveness. Further review revealed a focus, The resident is at risk for falls and a single intervention, Anticipate and meet the resident's needs. Further review revealed a focus, [Resident #9] is on sedative/hypnotic therapy r/t [sentence ends], and interventions, Adjustment of Medication/Treatment Administration Times, Pain Management Program. Further review revealed the care plan address Resident #9's diagnoses of Depression and Anxiety, and failed to address his diagnoses of: Frontal Lobe and Executive Function Disorder, Personality Disorder, Schizophrenia, Bipolar Disorder, Acquired Absence of Right Leg Below Knee, or Acquired Absence of Left Leg Below Knee.</p> <p>During an interview with the MDS Coordinator on 03/15/2024 at TIME, the MDS Coordinator confirmed that information vital to the resident's care was missing from the care plan which could lead to improper care.</p> <p>During an interview with the DON on 03/15/2024, at TIME, the DON confirmed that care plans should include all information needed for a caregiver to provide informed and adequate resident care.</p> <p>Record review of the facility policy, Care Plans, revised March 2022, revealed, A comprehensive care plan .a summary of the resident's medications and dietary instructions, any [NAME] e and treatment to be administered by the facility personnel .</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651</p> <p>42031</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 4 of 11 residents (Residents #1, #2, #3, #4), reviewed for significant medication errors, in that:</p> <p>Residents #1, #2, #3, and #4 were administered medications to lower blood pressures when their blood pressures or Pulse was already low and outside the physician ordered parameters.</p> <p>An immediate jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 7:23 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm at a scope of pattern due to the facility's need to monitor the effectiveness of their plan of removal.</p> <p>This failure could result in critically low blood pressures, inadequate blood flow, and could result in dizziness, fainting, hospitalization, and death.</p> <p>The findings were:</p> <p>Closed record review of Resident #1's face sheet dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (diffuse disease of the brain that alters brain function or structure caused by metabolic changes due to underlying health conditions), essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and hypotension, unspecified (abnormally low blood pressure that can result in inadequate blood flow to the brain and other vital organs). Resident #1 was discharged to the hospital on [DATE].</p> <p>Closed record review of Resident #1's care plan revealed a focus for the diagnosis of hypertension initiated on [DATE] with the resident at risk for hypertension and hypotension episodes and a goal for Resident #1 to have no side effects of medications. Interventions included to assess reports of hypotension and hypertension episodes, check B/P as ordered and notify the doctor of abnormal results, observe for signs and symptoms and to provide medications as ordered.</p> <p>Closed record review of Resident #1's physician orders revealed an order with a start date of [DATE] for Losartan potassium 100mg tablet medication used to lower blood pressure) to be given once daily for hypertension at 8:00 p.m. with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of less than 60 beats per minute.</p> <p>Closed record review of Resident #1's EMAR for [DATE] revealed on [DATE] at 8:00 p.m. Losartan potassium 100mg tab was administered by LVN A with a B/P of ,d+[DATE], P-78.</p> <p>Closed record review of Resident #1's EHR progress notes revealed no documentation regarding the physician being notified of the low blood pressure reading and or the administration of the Losartan potassium medication outside of the ordered parameters on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #2's face sheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses including: cellulitis of right lower limb, essential primary hypertension, and legal blindness.</p> <p>Record review of Resident #2's care plan, revised [DATE], revealed a focus, [Resident #2] has [diagnosis] of Hypertension. Is at risk for Hypo-/hypertensive episodes, and interventions, Check B/P as ordered and notify MD of abnormal results and Provide medications as ordered.</p> <p>Record review of Resident #2's physician orders revealed an order with a start date of [DATE] for Metoprolol Tartrate Oral Tablet 25mg tablet to be given once daily for hypertension with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of 60 beats per minute or less.</p> <p>Record review of Resident #2's EMAR for February 2024 revealed on [DATE] at 8:00 p.m., Metoprolol Tartrate Oral Tablet 25mg tablet was administered by LVN B with a B/P of ,d+[DATE], P-79.</p> <p>Record review of Resident #2's EHR progress notes revealed no documentation regarding the physician being notified of the low blood pressure reading and or the administration of the Metoprolol Tartrate medication outside of the ordered parameters on [DATE].</p> <p>Record review of Resident #3's face sheet, dated [DATE], revealed the resident was admitted on [DATE] with diagnoses including: unspecified dementia, essential primary hypertension, and heart failure.</p> <p>Record review of Resident #3's care plan, revised [DATE], revealed a focus, [Resident #3] has a [diagnosis] of Hyperlipidemia. Is at risk for complications related to [diagnosis] and adverse reaction to medications, and interventions, Provide medications as ordered. Further review revealed a focus, [Resident #3] is at risk for chest pains, irregular pulse and adverse reaction to medications due to [diagnosis] of Heart Failure, and interventions, Hold medications within parameters from MD and indicated (example: hold digoxin if pulse is below 60).</p> <p>Record review of Resident #3's physician orders revealed an order with a start date of [DATE] for Hydrochlorothiazide Tablet 25 mg. Give 1 tablet by mouth one time a day for hypertension with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of 60 beats per minute or less.</p> <p>Record review of Resident #3's EMAR for February 2024 revealed on [DATE] Hydrochlorothiazide was administered by LVN B with a B/P of ,d+[DATE], P-56.</p> <p>Record review of Resident #3's EHR progress notes revealed no documentation regarding the physician being notified of the low blood pressure reading and or the administration of the Hydrochlorothiazide medication outside of the ordered parameters on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Closed record review of Resident #4's face sheet dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included ESRD (End Stage Renal Disease- medical condition in which the kidneys cease functioning on a permanent basis leading to the need for long-term dialysis or a kidney transplant to maintain life), hypertensive heart disease with heart failure (constellation of changes in the left ventricle, left atrium, and coronary arteries as a result of chronic blood pressure elevation with the heart unable to pump enough blood to meet the body's needs for blood and oxygen), essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and hypotension, unspecified (abnormally low blood pressure that can result in inadequate blood flow to the brain and other vital organs). Resident #4 was discharged as expired on [DATE].</p> <p>Closed record review of Resident #4's physician orders revealed an order with a start date of [DATE] and a DC date of [DATE] for Losartan potassium 25mg tablet to be given once daily for hypertension with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of 60 beats per minute or less.</p> <p>Closed record review of Resident #4's EMAR for [DATE] revealed losartan potassium 25mg was administered on [DATE] at 8:00 a.m. by LVN A with a B/P of ,d+[DATE] P-77, and on [DATE] at 8:00 a.m. with a B/P of ,d+[DATE] P- 77.</p> <p>Closed record review of Resident #4's EMAR for February 2024 revealed losartan potassium 25mg was administered on [DATE] at 8:00 a.m. by LVN A with a B/P of ,d+[DATE] P-86, and on [DATE] at 8:00 a.m. by LVN B with a B/P of ,d+[DATE] P-113.</p> <p>Closed record review of Resident #4's physician orders revealed an order with a start date of [DATE] for carvedilol 25mg tablet by mouth twice daily for hypertension with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of 60 beats per minute or less.</p> <p>Closed record review of Resident #4's EMAR for [DATE] revealed Carvedilol 25mg tab was administered on [DATE] at 8:00 a.m. by LVN A with a B/P of ,d+[DATE] P-77 and at 8:00 p.m. by LVN B with a B/P of , d+[DATE] P-77. On [DATE] at 8:00 a.m. it was administered by LVN A with a B/P of ,d+[DATE] P- 77.</p> <p>Closed record review of Resident #4's EMAR for February 2024 revealed Carvedilol 25mg tab was administered on [DATE] at 8:00 a.m. by LVN A with a B/P of ,d+[DATE] P-86 and at 8:00 p.m. by LVN B with a B/P of ,d+[DATE] P-86. On [DATE] at 8:00 p.m. by LVN B with a B/P of ,d+[DATE] P-68, on [DATE] at 8:00 p.m. by LVN B with a B/P of ,d+[DATE] P-70. On [DATE] at 8:00 a.m. by LVN B with a B/P of ,d+[DATE] P-113.</p> <p>Closed record review of Resident #4's EMAR for [DATE] revealed Carvedilol 25mg tab was administered on [DATE] at 8:00 p.m. by LVN B with a B/P of ,d+[DATE] P-78.</p> <p>Closed record review of Resident #4's EHR progress notes revealed no documentation regarding the physician being notified of the low blood pressure readings and or the administration of the Losartan potassium or Carvedilol medications outside of the ordered parameters.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an observation and interview on [DATE] at 11:45 a.m. the DON stated she was unaware of a way to copy and paste vital signs and showed surveyor a resident's vital sign list that did not have repeat vital signs for the resident listed. And after reviewing the EMAR the repeat vital signs could be seen on the EMAR documentation only and not on the residents' vital sign list in the EHR. The DON stated she would investigate the repeat vital signs.</p> <p>In an interview on [DATE] at 10:30 a.m. the DON stated she contacted her corporate entity, and they removed the use last documented vital sign option from their computer system.</p> <p>In an observation and interview on [DATE] at 4:00 p.m. CMA D was passing medications and had just taken a resident's blood pressure and was entering it in the computer system. CMA D stated he did not copy vital signs and takes his own manually each time. CMA D stated there was not a way to copy and paste vital signs but there used to be a button that had used last documented but he never used it. CMA D showed surveyor the vital signs entry screen and where the button used to be but stated it was not an available option now. CMA D was unsure when it was no longer an option.</p> <p>In an interview on [DATE] at 12:05 p.m. LVN A stated she takes her own vital signs and if she administered any medications outside of the ordered parameters then she had contacted the physician and documented in the resident progress notes or through the EMAR documentation. LVN A further stated she does not know what happened and does not copy vital signs. LVN A stated there was a use last documented vital signs button, but she did not use it. LVN A was unable to state where else the documentation of the physician being notified would be.</p> <p>In an interview on [DATE] at 5:17 p.m., LVN B stated that he personally measures and accurately recorded vital signs including blood pressure and pulse each time the physician orders call for vital signs and stated that he does not administer medications outside of the parameters noted in the physician orders. LVN B stated he always follows physician orders, including notifying the physician if and when a resident's vital signs are outside of parameters noted in the orders. When asked why he had not notified the physician on [DATE] when Resident #2 received medication outside of parameters, and on [DATE] when Resident #3 received medication outside of parameters, LVN B stated that he always notifies the physician when needed and stated he did not know why there was no documentation of his notification.</p> <p>In an interview with the DON [DATE] at 5:15 p.m., the DON confirmed that accurately measuring and recording vital signs as per physician order and notifying the physician of a change in the resident's condition and/or a need to alter the resident's treatment were integral to assisting the residents to maintain good health.</p> <p>In a telephone interview on [DATE] at 1:02 p.m. the MD stated he was not aware and could not recall being notified specifically with vital sign issues but was driving and did not have his patient records in front of him. The MD further stated patient safety was a priority for him and his group of physicians.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In a telephone interview on [DATE] at 2:40 p.m. the MD stated the vital sign issues (administration of medications outside of parameters and same vital signs documented) brought to his attention by surveyor were concerning. The MD stated he and other physicians in his group were in the facility often, and at times even 2 to 3 times a week and he had not recalled seeing blood pressure or vital sign issues on what was displayed to the physician. The MD further stated the vital sign issues could make clinical decision making more difficult.</p> <p>Review of https://www.ncbi.nlm.nih.gov/books/NBK526065/ last updated [DATE], for Losartan indicated . Losartan is FDA approved for the treatment of several medical conditions, which include the following: Hypertension . acute coronary syndrome, stable coronary artery disease . and treatment of heart failure . The onset of action of losartan is 6 hours, lasting for 24 hours . Reevaluate blood pressure (including orthostatic blood pressure), renal function, and serum potassium . Any clinician (MD, DO, NP, PA) can prescribe losartan for the treatment of hypertension and diabetic nephropathy. However, clinicians should follow the patients and regularly monitor their renal function and blood pressure. The drug is effective for hypertension and can be part of long-term therapy. However, it still requires the participation of an interprofessional team to optimize treatment. When initially prescribed, a pharmacist should verify appropriate dosing, perform medication reconciliation, and can counsel the patient about the drug. Nursing can also provide valuable patient counseling, as well as answer questions and assess therapeutic effectiveness on subsequent visits. If the pharmacist or nursing staff encounter any concerns, they should report these to the prescriber promptly so that therapeutic adjustments can take place. This interprofessional team approach to losartan therapy can optimize patient outcomes while minimizing potential adverse effects.</p> <p>Review of https://www.ncbi.nlm.nih.gov/books/NBK532923/ last updated [DATE], indicated . Metoprolol is FDA-approved to treat angina, heart failure, myocardial infarction, atrial fibrillation/flutter, and hypertension. Off-label uses include supraventricular tachycardia and thyroid storm . The primary adverse effects of metoprolol include heart failure exacerbation, fatigue, depression, bradycardia or heart block, hypotension, bronchospasm, cold extremities, dizziness, decreased libido, diarrhea, tinnitus, decreased exercise tolerance, glucose intolerance, and may mask hypoglycemia . Metoprolol is contraindicated in patients with sick sinus syndrome, second or third-degree heart block (in the absence of a pacemaker), decompensated heart failure, hypotension . Monitoring . Oral administration, heart rate rhythm, and blood pressure require monitoring.</p> <p>Review of https://www.ncbi.nlm.nih.gov/books/NBK430766/ last updated [DATE] indicated . Hydrochlorothiazide is a medication approved by the U.S. Food and Drug Administration (FDA) to treat hypertension and peripheral edema Patients undergoing hydrochlorothiazide treatment should be regularly monitored for electrolyte imbalances, including sodium, potassium, calcium, and magnesium levels . Blood pressure should be closely monitored to ensure patients on hydrochlorothiazide treatment achieve and maintain their target blood pressure, minimizing the risk of adverse effects associated with high or low blood pressure.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of https://www.ncbi.nlm.nih.gov/books/NBK534868/ last updated [DATE], for carvedilol indicated . Screen patients for potential contraindications, such as severe hypotension, second or third-degree AV block, and other conditions that may necessitate caution or alternative therapies . The most prevalent adverse effect of carvedilol is undesired, excessive hypotension resulting from its vasodilating properties, leading to symptoms such as dizziness, lightheadedness, fatigue, and headaches . Vital signs, such as blood pressure and heart rate, should be monitored before initiation and at each dose titration. Individuals undergoing heart failure treatment necessitate vigilant monitoring for any indications of decompensation.</p> <p>The facility's Plan of Removal was accepted on [DATE] at 5:10 p.m. and included:</p> <p>Date: [DATE]</p> <p>F 726</p> <p>Immediate action:</p> <p>The Medical Director was notified of the Immediate Jeopardy status on [DATE] at 7:35 pm.</p> <p>Resident Vital Signs were taken when the issue was identified on [DATE]. An audit was done to ensure parameters were ordered for all residents on cardiac medication and vitals were being recorded on the computer correctly. The cardiac medication and vitals were found to be within normal limits. No adverse reactions observed with any resident. VS are currently in progress for all residents to ensure they are within normal/ safe limits. The primary physician will be notified for any residents found with abnormal vital signs to determine if additional treatment is warranted. This task will be completed by 10 pm on [DATE].</p> <p>The Director of Nurses completed an audit on administration parameters for all residents receiving cardiac medications on [DATE] once the issue was identified. An audit will be completed again to ensure that all parameters are in place and being followed for residents on cardiac medications.</p> <p>On [DATE], a complete audit was done which included checking the data on the computer, taking new vital signs for residents, ensuring the vitals were recorded correctly and calling the doctors to ensure parameters were correct. This task was completed before 11:59 pm on [DATE]. Parameters will be verified with the primary care physician and updated if appropriate by 11:59 pm [DATE].</p> <p>All nursing staff involved in administration of medication were in serviced to ensure they were taking vital signs prior to administering cardiac medications to ensure parameters were correct and medication was either held or administered accordingly. The staff had to do return demonstration following the in-service. Agency staff will be in-serviced on this issue prior to their starting their shift.</p> <p>Education will be provided to all nurses and certified medication aides on the need to take a new set of vital signs with each medication pass, and the importance of following parameters to hold or give medications based on vital sign values obtained and to notify the physician if medication was given outside of the parameters provided. The EMR system (PCC) copy feature that allowed the utilization of the last set of vital signs taken for medication administration has been turned off as of [DATE] @ 12:45pm.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2024
NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Facilities Plan to ensure compliance quickly</p> <p>Education provided by the DON will include all nurses and certified medication aides on the need to take a new set of vital signs with each medication pass, and the importance of following parameters to hold or give medications based on vital sign values obtained and to notify the physician if medication was given outside of the parameters provided. Education was initiated on [DATE] by the Director of Nurses and will continue until all nurses and med aides have completed the education and skill check for Vital Sign competency.</p> <p>The DON or designee will educate all newly hired licensed nurses and medication aides on medication administration and reconciliation guidelines as well as the importance of following parameters, taking a new set of vital signs with each med pass, and alerting the physician if a medication is given outside of the parameters.</p> <p>The DON or designee will audit all new admission, readmission, and new/ changed orders to ensure accuracy and that appropriate parameters, based on the medication, are in place if warranted.</p> <p>Nurses and medication aides will have a skills check completed by the Director of Nurses for medication pass to ensure they are taking a new set of vital signs and following parameters as appropriate by [DATE] 11:59 pm.</p> <p>Nursing and medication aide staff members will not be allowed to work their oncoming shift until this education and skill check is completed. The Director of Nurses or designee will audit vital signs and bp parameters daily x 14 days, then weekly x 4 weeks to ensure compliance. Ongoing audits will be completed randomly thereafter to verify continued compliance and ensure standards are met.</p> <p>Re-education will be completed with the nurse(s) or medication aide(s) if any evidence of non-compliance is determined.</p> <p>The Director of Nurses will present audit findings to the QAPI committee each month until compliance achieved.</p> <p>POR Verification</p> <p>The Medical Director was notified of the Immediate Jeopardy status on [DATE] at 7:35 pm.</p> <p>- Confirmed via interview with the Medical Director [DATE] at 5:37 pm</p> <p>Resident Vital Signs were taken when the issue was identified on [DATE]. An audit was done to ensure parameters were ordered for all residents on cardiac medication and vitals were being recorded on the computer correctly. The cardiac medication and vitals were found to be within normal limits. No adverse reactions observed with any resident. VS are currently in progress for all residents to ensure they are within normal/ safe limits. The primary physician will be notified for any residents found with abnormal vital signs to determine if additional treatment is warranted. This task will be completed by 10 pm on [DATE].</p> <p>- Confirmed via interview with Medical Director [DATE] at 5:37 pm</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- Confirmed via record review of 15 resident clinical records</p> <p>The Director of Nurses completed an audit on administration parameters for all residents receiving cardiac medications on [DATE] once the issue was identified. An audit will be completed again to ensure that all parameters are in place and being followed for residents on cardiac medications.</p> <p>- Confirmed via interview with the DON [DATE] at 5:15 pm</p> <p>On [DATE], a complete audit was done which included checking the data on the computer, taking new vital signs for residents, ensuring the vitals were recorded correctly and calling the doctors to ensure parameters were correct. This task was completed before 11:59 pm on [DATE]. Parameters will be verified with the primary care physician and updated if appropriate by 11:59 pm [DATE].</p> <p>- Confirmed via interview with the DON [DATE] at 5:15 pm</p> <p>- Confirmed via interview with the Medical Director [DATE] at 5:37 pm</p> <p>- Confirmed via record review of 15 resident clinical records</p> <p>All nursing staff involved in administration of medication were in serviced to ensure they were taking vital signs prior to administering cardiac medications to ensure parameters were correct and medication was either held or administered accordingly. The staff had to do return demonstration following the in-service. Agency staff will be in-serviced on this issue prior to their starting their shift.</p> <p>- Confirmed via interviews with 11 of 14 nursing staff members who administer medication</p> <p>- Confirmed via record review of two in-service trainings</p> <p>- Confirmed via record review of two skills check off lists for each 11 of 14 staff</p> <p>Education will be provided to all nurses and certified medication aides on the need to take a new set of vital signs with each medication pass, and the importance of following parameters to hold or give medications based on vital sign values obtained and to notify the physician if medication was given outside of the parameters provided. The EMR system (PCC) copy feature that allowed the utilization of the last set of vital signs taken for medication administration has been turned off as of [DATE] at@ 12:45pm.</p> <p>- Confirmed via interviews with 11 of 14 nursing staff members who administer medication</p> <p>- Confirmed via record review of two in-service trainings</p> <p>- Confirmed via record review of two skills check off lists for each 11 of 14 staff</p> <p>Facilities Plan to ensure compliance quickly</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Education provided by the DON will include all nurses and certified medication aides on the need to take a new set of vital signs with each medication pass, and the importance of following parameters to hold or give medications based on vital sign values obtained and to notify the physician if medication was given outside of the parameters provided. Education was initiated on [DATE] by the Director of Nurses and will continue until all nurses and med aides have completed the education and skill check for Vital Sign competency.</p> <ul style="list-style-type: none"> - Confirmed via interviews with 11 of 14 nursing staff members who administer medication - Confirmed via record review of two in-service trainings - Confirmed via record review of two skills check off lists for each 11 of 14 staff <p>The DON or designee will educate all newly hired licensed nurses and medication aides on medication administration and reconciliation guidelines as well as the importance of following parameters, taking a new set of vital signs with each med pass, and alerting the physician if a medication is given outside of the parameters.</p> <ul style="list-style-type: none"> - Confirmed via interviews with 11 of 14 nursing staff members who administer medication - Confirmed via record review of two in-service trainings - Confirmed via record review of two skills check off lists for each 11 of 14 staff <p>The DON or designee will audit all new admission, readmission, and new/ changed orders to ensure accuracy and that appropriate parameters, based on the medication, are in place if warranted.</p> <ul style="list-style-type: none"> - Confirmed via interview with DON [DATE] at 7:12 pm <p>Nurses and medication aides will have a skills check completed by the Director of Nurses for medication pass to ensure they are taking a new set of vital signs and following parameters as appropriate by [DATE] 11:59 pm.</p> <ul style="list-style-type: none"> - Confirmed via interviews with 11 of 14 nursing staff members who administer medication - Confirmed via record review of two in-service trainings - Confirmed via record review of two skills check off lists for each 11 of 14 staff <p>Nursing and medication aide staff members will not be allowed to work their oncoming shift until this education and skill check is completed. The Director of Nurses or designee will audit vital signs and bp parameters daily x 14 days, then weekly x 4 weeks to ensure compliance. Ongoing audits will be completed randomly thereafter to verify continued compliance and ensure standards are met.</p> <ul style="list-style-type: none"> - Confirmed via interview with DON [DATE] at 7:12 pm <p>Re-education will be completed with the nurse(s) or medication aide(s) if any evidence of non-compliance is determined.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- Confirmed via interview with DON [DATE] at 7:12 pm</p> <p>The Director of Nurses will present audit findings to the QAPI committee each month until compliance achieved.</p> <p>- Confirmed via interview with DON [DATE] at 7:12 pm</p> <p>During an interview with the DON on [DATE] at 5:15 p.m., the DON stated that only nurses and medication aides measured vital signs and administered at the facility and there were 2 medication aides and 12 nurses employed by the facility. The DON stated that 11 of the 14 staff members who administered medications had both of two in-service trainings and completed both of two skills checks. Skills checks required staff to demonstrate how to assess blood pressure using two techniques. The DON stated that the three staff members who did not yet receive training will be required to do so before their next shift.</p> <p>During an interview with LVN B on [DATE] at 5:17 p.m., LVN B stated his work schedule was Saturday and Sunday from 6:00 a.m. to 10:00 p.m., confirmed that he received two in-service trainings, and verbalized understanding of the trainings. LVN B further stated he had completed two demonstrative skills checks with the DON.</p> <p>During an interview with Medication Aide E on [DATE] at 5:22 p.m., Medication Aide E stated her work schedule was Monday through Friday from 6:00 a.m. to 10:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. Medication Aide E further stated she had completed two demonstrative skills checks with the DON.</p> <p>During an interview with LVN A on [DATE] at 5:26 p.m., LVN A stated her work schedule was Monday through Friday from 8:00 a.m. to 5:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LVN A further stated she had completed two demonstrative skills checks with the DON.</p> <p>During an interview with RN F on [DATE] at 5:32 p.m., RN F stated her work schedule was Saturday and Sunday from 6:00 a.m. to 10:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. RN F further stated she had completed two demonstrative skills checks with the DON.</p> <p>During an interview with LVN G on [DATE] at 5:43 p.m., LVN G stated his work schedule was Saturday and Sunday from 6:00 a.m. to 10:00 p.m., confirmed that he received two in-service trainings, and verbalized understanding of the trainings. LVN G further stated he had completed two demonstrative skills checks with the DON.</p> <p>During an interview with LVN H on [DATE] at 5:50 p.m., LVN H stated her work schedule was Monday through Friday from 2:00 p.m. to 10:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LVN H further stated she had completed two demonstrative skills checks with the DON.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a telephone interview with LVN I on [DATE] at 5:55 p.m., LVN I stated his work schedule was Monday through Friday from 2:00 p.m. to 10:00 p.m., confirmed that he received two in-service trainings, and verbalized understanding of the trainings. LVN I further stated he had completed two demonstrative skills checks with the DON.</p> <p>During a telephone interview with LVN J on [DATE] at 6:04 p.m., LVN J stated her work schedule was Monday through Friday from 8:00 a.m. to 5:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LVN J further stated she had completed two demonstrative skills checks with the DON.</p> <p>During a telephone interview with LVN K on [DATE] at 6:16 p.m., LVN K stated her work schedule was Monday through Friday from 6:00 a.m. to 2:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LVN K further stated she had completed two demonstrative skills checks with the DON.</p> <p>During a telephone interview with LVN L on [DATE] at 6:24 p.m., LVN L stated her work schedule was Monday through Friday from 10:00 a.m. to 6:00 p.m., confirmed that she received two in-service trainings, and verbalized understanding of the trainings. LN L further stated she had completed two demonstrative skills checks with the DON.</p> <p>During a telephone interview with LVN M on [DATE] at 6:16 p.m., LVN M stated his work schedule was Monday through Friday from 10:00 p.m. to 6:00 a.m., confirmed that he received two in-service trainings, and verbalized understanding of the trainings. LVN M further stated he had completed two demonstrative skills checks with the DON.</p> <p>Record review of the facility in-service training, Checklist Vital Signs: Assessing Blood Pressure, dated [DATE], revealed it had been signed as completed by eleven staff members.</p> <p>Record review of the facility in-service training, Blood Pressure Measurement (Digital) Skills Checklist, dated [DATE], revealed it had been signed as completed by eleven staff members.</p> <p>Record review of the facility skills check, Vital Signs Parameters/Blood Pressure/Pulse, dated [DATE], revealed it had been signed as completed by eleven staff members.</p> <p>Record review of the facility skills check, Vital Signs Parameters,</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651</p> <p>42031</p> <p>Based on observation, interview, and record review, the facility failed to in accordance with accepted professional standards and practices, maintain medical records on each resident that are complete and accurately documented for 7 of 11 residents (Residents #1, #2, #3, #4, #5, #7, #8) reviewed for medical records, in that:</p> <p>Residents #1-#5's, and #7, #8's blood pressures and or vital signs were documented as the same on different shifts on the same day and on subsequent days.</p> <p>This failure could place residents at risk for inaccurate health assessments, medication administration errors, and could result in missed signs and symptoms of illness.</p> <p>The findings were:</p> <p>Closed record review of Resident #1's face sheet dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and hypotension, unspecified (abnormally low blood pressure that can result in inadequate blood flow to the brain and other vital organs).</p> <p>Resident #1 was discharged to the hospital on [DATE].</p> <p>Closed record review of Resident #1's EMAR for [DATE] revealed vital signs recorded on days and evenings for COVID quarantine isolation were on [DATE] evening by LVN A B/P- ,d+[DATE], T- 97.6, P- 92, R- 18, O2 Sat- 96%, on [DATE] LVN A documented the same vital signs for both day and evening entries.</p> <p>Closed record review of Resident #1's EMAR for [DATE] revealed on [DATE] at 7:00 a.m. Amlodipine (medication to treat hypertension) 10mg once daily was not administered due to being outside the ordered parameters by a staff member with a B/P of ,d+[DATE], P-78. At 8:00 p.m. Losartan potassium 100mg tab was administered by LVN A with the same B/P of ,d+[DATE], P-78.</p> <p>Closed record review of Resident #1's EMAR for [DATE] revealed vital signs recorded on days and evenings for COVID quarantine isolation were documented by LVN A on [DATE] for day as B/P-,d+[DATE], T- 97.9, P- 110, R- 18, O2 Sat- 97%. LVN A documented the same vital signs for evenings on [DATE] and [DATE].</p> <p>Record review of Resident #2's face sheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses including: cellulitis of right lower limb, essential primary hypertension, and legal blindness.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's care plan, revised [DATE], revealed a focus, [Resident #2] has [diagnosis] of Hypertension. Is at risk for Hypo-/hypertensive episodes, and interventions, Check B/P as ordered and notify MD of abnormal results and Provide medications as ordered.</p> <p>Record review of Resident #2's physician orders revealed an order with a start date of [DATE] for Metoprolol Tartrate Oral Tablet 25mg tablet to be given once daily for hypertension with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of 60 beats per minute or less.</p> <p>Record review of Resident #2's EMAR for February 2024 revealed blood pressure of ,d+[DATE] and pulse of 69 document by LVN A on [DATE] at 8:00 a.m. and again on [DATE] at 8:00 a.m. by LVN B. Additionally, Resident #2's blood pressure was documented as ,d+[DATE] and pulse as 93 on [DATE] at 8:00 p.m. and again on [DATE] at 8:00 a.m. Further review revealed Resident #2's blood pressure was documented as , d+[DATE] and 79 pulse on [DATE] at 8:00 p.m., no recorded again until [DATE] at 8:00 p.m. where it was also documented as blood pressure ,d+[DATE] and pulse 79. Lastly, Resident #2's blood pressure and pulse were documented on [DATE] at 8:00 p.m. and on [DATE] at 8:00 p.m. as ,d+[DATE] and 66 for both days.</p> <p>Record review of Resident #3's face sheet, dated [DATE], revealed the resident was admitted on [DATE] with diagnoses including: unspecified dementia, essential primary hypertension, and heart failure.</p> <p>Record review of Resident #3's care plan, revised [DATE], revealed a focus, [Resident #3] has a [diagnosis] of Hyperlipidemia. Is at risk for complications related to [diagnosis] and adverse reaction to medications, and interventions, Provide medications as ordered. Further review revealed a focus, [Resident #3] is at risk for chest pains, irregular pulse and adverse reaction to medications due to [diagnosis] of Heart Failure, and interventions, Hold medications within parameters from MD and indicated (example: hold digoxin if pulse is below 60).</p> <p>Record review of Resident #3's physician orders revealed an order with a start date of [DATE] for Hydrochlorothiazide Tablet 25 mg. Give 1 tablet by mouth one time a day for hypertension with parameters to hold the medication for a SBP (first/top number) of 110 or less or a pulse of 60 beats per minute or less.</p> <p>Record review of Resident #3's EMAR for [DATE] revealed blood pressure reading of ,d+[DATE] and pulse of 55 were documented on [DATE] at 8:00 p.m., [DATE] at 8:00 a.m. and at 8:00 p.m., not recorded on [DATE] at 8:00 a.m., and documented again on [DATE] at 8:00 p.m. as blood pressure reading of ,d+[DATE] and pulse of 55.</p> <p>Closed record review of Resident #4's face sheet dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and hypotension, unspecified (abnormally low blood pressure that can result in inadequate blood flow to the brain and other vital organs). Resident #4 was discharged as expired on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Closed record review of Resident #4's EMAR for [DATE] revealed Carvedilol 25mg tab was documented as given by LVN B on [DATE] at 8:00 a.m. with a B/P- ,d+[DATE], P- 70 and at 8:00 p.m . by LVN B with the same blood pressure and pulse. On [DATE] at 8:00 p.m. another staff member documented it was not given with a B/P- ,d+[DATE], P-77. On [DATE] at 8:00 a.m. LVN A documented the same blood pressure and pulse of B/P- ,d+[DATE], P77 at the 8:00 a.m. dose and LVN B documented the same blood pressure and pulse for the 8:00 p.m. dose. On [DATE] and [DATE], LVN B documented B/P- ,d+[DATE], P- 65 for both the 8:00 a.m. and the 8:00 p.m. doses on both days.</p> <p>Closed record review of Resident #4's EMAR for February 2024 revealed Carvedilol 25mg tab was documented as given by LVN A on [DATE] at 8:00 a.m. with a B/P- ,d+[DATE], P-86. LVN B documented the same blood pressure and pulse for the 8:00 p.m. dose. On [DATE] at 8:00 a.m. LVN A documented the B/P- ,d+[DATE], P-65, and at 8:00 p.m. LVN B documented the same blood pressure and pulse. On [DATE] at 8:00 p.m. another staff member documented B/P- ,d+[DATE], P-68, and on [DATE] and [DATE] LVN B documented the same blood pressure and pulse for the 8:00 p.m. doses. On [DATE] at 8:00 p.m. a staff member documented B/P- ,d+[DATE], P-113 and LVN B documented the same blood pressure and pulse the following morning on [DATE] at 8:00 a.m. On [DATE] at 8:00 p.m. LVN C documented B/P- ,d+[DATE], P- 106 and LVN B documented the same blood pressure and pulse the following morning on [DATE] at 8:00 a.m. On [DATE] and [DATE] at 8:00 a.m. LVN B documented the same B/P- ,d+[DATE], P-106 for both.</p> <p>Closed record review of Resident #4's EMAR for [DATE] revealed Carvedilol 25mg tab was documented as not given by another staff on [DATE] at 8:00 p.m. with a of B/P- ,d+[DATE], P-73. On [DATE] LVN B documented at 8:00 p.m. with the same blood pressure and pulse.</p> <p>Record review of Resident #5's face sheet dated [DATE] revealed he was a [AGE] year-old male admitted to the facility on [DATE] with readmission on [DATE]. His diagnoses included essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition), and sepsis unspecified (the body's extreme reaction to an infection that can lead to organ failure, tissue damage and death).</p> <p>Record review of Resident #5's EMAR for [DATE] revealed vital signs (B/P, T, P, R, O2 Sats) every shift weekly on Sundays was documented on [DATE] day by LVN A B/P- ,d+[DATE], P-76, the same blood pressure and pulse was documented for eve by another staff and for day the following Sunday on [DATE] by LVN B. On [DATE] LVN C documented B/P- ,d+[DATE], P-70 for both day and evening shifts. On [DATE] LVN C documented B/P- ,d+[DATE], P-76 for both day and evening shifts. On [DATE] LVN C documented B/P- ,d+[DATE], P-81 for both day and evening shifts. The same blood pressure and pulse was documented by another staff member for the night shift. (10 of 12 blood pressures documented for December were identical to another entry).</p> <p>Record review of Resident #5's EMAR for [DATE] revealed vital signs every shift weekly on Sundays was documented on [DATE] by LVN A B/P- ,d+[DATE], 81 for both day and evening shifts (which was identical to the last blood pressure and pulse documented on night shift for December). On [DATE] LVN C documented B/P- ,d+[DATE], P-82 for both day and evening shifts. On [DATE] for 10pm shift another staff documented B/P- ,d+[DATE], P-78 and LVN C documented that same blood pressure on [DATE] for both day and evening shifts. On [DATE] LVN C documented B/P- ,d+[DATE] for both the day and evening shifts. (10 of 11 blood pressures documented for January were identical to another entry in the resident's EMAR's).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/16/2024
NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's EMAR for February 2024 revealed vital signs every shift weekly on Sundays was documented on [DATE] by LVN C B/P-,d+[DATE], P-85 for both day and evening shifts. On [DATE] LVN B documented B/P-,d+[DATE], P-74 and LVN A documented the same blood pressure and pulse for the evening shift. B/P-,d+[DATE], P-74 was documented by LVN C for the rest of the month on [DATE] and [DATE] for both day and evening shifts. (8 of 9 blood pressures documented for February were identical to another entry). On [DATE] for 10 p.m. entry another staff documented B/P-,d+[DATE], P-68.</p> <p>Record review of Resident #5's EMAR for [DATE] revealed vital signs every shift weekly on Sundays was documented on [DATE] LVN B documented B/P-,d+[DATE], P-68 (which is identical to the last blood pressure and pulse documented on the last entry for February)</p> <p>Record review of Resident #7's facesheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses including: essential primary hypertension, sepsis, and cellulitis of left upper limb.</p> <p>Record review of Resident #7's care plan, revised [DATE], revealed a focus, [Resident #7] has DX of Hypertension. Is at risk for Hypo-/hypertensive episodes and interventions, Check B/P as ordered and notify MD of abnormal results and Provide medications as ordered.</p> <p>Record review of Resident #7's EMAR for [DATE] revealed, his blood pressure was documented as , d+[DATE] and pulse 96 on [DATE] at 8:00 p.m., [DATE] at 8:00 p.m., and [DATE] at 8:00 a.m. and 8:00 p.m. Additionally, Resident #7's blood pressure and pulse were documented as ,d+[DATE] and 90 on [DATE] at 8:00 p.m., [DATE] at 8:00 a.m. and at 8:00 p.m., and again on [DATE] at 8:00 p.m.</p> <p>Record review of Resident #8's facesheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses including: schizoaffective disorder bipolar type, unspecified asthma, and anxiety disorder.</p> <p>Record review of Resident #8's care plan, revised [DATE], revealed, [Resident #8] has an ADL selfcare performance deficit and an intervention, Staff assistance to the extent needed to accomplish task.</p> <p>Record review of Resident #8's physician orders, dated [DATE], revealed, Vital Signs LTC Patient Q shift x 72 hours then monthly one time a day every 1 month(s) starting on the 15th for 28 day(s).</p> <p>Record review of Resident #8's EMAR for February 2024, revealed blood pressure was documented as , d+[DATE], temperature as 96.5, pulse as 70, and respiration as 18 on [DATE] at 8:00 a.m., [DATE] at 8:00 a. m., and on [DATE] at 8:00 a.m.</p> <p>In an observation and interview on [DATE] at 11:45 a.m. the DON stated she was unaware of a way to copy and paste vital signs and showed surveyor a resident's vital sign list that did not have repeat vital signs for the resident listed. And after reviewing the EMAR the repeat vital signs could be seen on the EMAR documentation only and not on the residents vital sign list in the EHR. The DON stated she would investigate the repeat vital signs.</p> <p>In an interview on [DATE] at 10:30 a.m. the DON stated she contacted her corporate entity, and they removed the use last documented vital sign option from the computer system.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on [DATE] at 4:00 p.m. CMA D was passing medications and had just taken a resident's blood pressure and was entering it in the computer system. CMA D stated he did not copy vital signs and takes his own manually each time. CMA D stated there was not a way to copy and paste vital signs but there used to be a button that had used last documented but he never used it. CMA D showed surveyor the vital signs entry screen and where the button used to be but stated it was not an available option now. CMA D was unsure when it was no longer an option.</p> <p>In an interview on [DATE] at 12:05 p.m., LVN A stated she takes her own vital signs, and she does not know what happened and why the vital signs were identical to other entries. LVN A stated she does not copy vital signs. LVN A further stated there was not a way to copy vital signs in the computer system. LVN A stated there was a use last documented vital signs button but she did not use it.</p> <p>Review of facility policy, Charting and Documentation, revised [DATE], revealed, Documentation in the medical record will be .complete and accurate.</p>		