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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455523 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/30/2024 |
| NAME OF PROVIDER OR SUPPLIER Morningside Manor | | STREET ADDRESS, CITY, STATE, ZIP CODE 602 Babcock Rd San Antonio, TX 78201 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs and preferences for 1 of 8 residents (Resident #54) reviewed for call lights.</p> <p>Resident #54 was placed in her room without access to her call light. On 06/05/2024 CNA P assisted Resident #54 in her wheelchair to her room and placed her out of reach of her call light.</p> <p>This failure could place residents at risk for harm by not having the ability to call for assistance.</p> <p>The findings included:</p> <p>A record review of Resident #54's admission record dated 06/06/2024 revealed an admitted [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), glaucoma (a condition where the eye's optic nerve, which provides information to the brain, is damaged and will cause gradual vision loss), atherosclerosis of the aorta (a condition characterized by the gradual buildup of plaque in the largest artery in your body).</p> <p>A record review of Resident #54's annual MDS assessment dated [DATE], revealed Resident #54 was a [AGE] year-old female assessed with an ability to hear as, Moderate difficulty - speaker has to increase volume and speak distinctly, with impaired vision, Impaired - sees large print, but not regular print in newspapers/books, and had clear speech, was attentive, and did not have disorganized thinking. Further review of the assessment revealed Resident #54 had not refused any care provided. Resident #54 was assessed as always incontinent of bowel and bladder. Resident #54 was assessed as, Dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity, Or the assistance of 2 or more helpers is required for the resident to complete the activity for the following abilities:</p> <p>Eating, oral hygiene, toileting hygiene, personal hygiene, shower / bathing dressing, and transferring.</p> <p>Manual wheelchair - Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Manual wheelchair, Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.</p> <p>A record review of Resident #54's care plan dated 06/06/2024 revealed, The resident has a potential for communication problem Hearing deficit .The resident will be able to make basic needs known on a daily basis through the review date .Be conscious of resident position when in groups, activities, dining room to promote proper communication with others . Ensure/provide a safe environment: Call light in reach</p> <p>During an observation and interview on 06/05/2024 at 11:05 AM revealed Resident #54 loudly calling out for attention. Resident #54 was observed seated in her wheelchair in her room positioned mid room equidistant from her bed and the entry door. Resident #54's call light rested upon her bed and out of her reach by an approximate 3 feet. Resident #54 stated she was brought into her room by a CNA and left there without an ability to call for assistance. Resident #54 stated she did not have a call light within her reach. Resident #54 stated she was angry that staff do not take time with their care, (they) rush with care and run off.</p> <p>During an observation and interview on 06/05/2024 at 11:16 AM revealed CNA P entered Resident #54's room responding to Resident #54's loud vocalizations calling out for assistance. Upon CNA P's entrance Resident #54 began with a complaint alleging you left me here .you said you would be right back .I had to yell to get you here . Resident #54 continued in an irritable manner and would often over speak CNA P, .you all are always in a rush and leave CNA P stated she had assisted Resident #54 in her wheelchair to her room and placed Resident #54 where she sat in her wheelchair as observed. CNA P stated Resident #54's call light was on Resident #54's bed and out of reach from Resident #54. CNA P stated she positioned Resident #54 away from her bedside due to Resident #54's preference. CNA P stated she had not attempted to place Resident #54's call light at her side. CNA P then attempted to reposition Resident #54's call light and succeeded to place Resident #54's call light at Resident #54's side, secured to her wheelchair. Resident #54 continued to verbalize irritably, don't tell your stories .you left me here .without lunch .with the button over there</p> <p>During an interview on 06/07/2024 at 09:04 AM the DON stated call lights were to be placed within a residents reach. The DON added there maybe times when residents may not be able to be placed next to their call lights, e.g., during activities, when residents have their ability to self-ambulate within their room, and according to their preferences, residents in their room should have their call lights within reach.</p> <p>During an interview on 06/09/2024 at 12:20 PM the DON stated the facility's policy for call lights was to adhere to the CMS regulations regarding call lights .</p> <p>A record review of the CMS's State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities dated 02/03/2023, revealed, GUIDANCE .Reasonable accommodation(s) of resident needs and preferences includes, but is not limited to, individualizing the physical environment of the resident's bedroom and bathroom, as well as individualizing common living areas as much as feasible .PROCEDURES .Observe residents in their rooms and common areas and interview residents, if possible, to determine if their environment accommodates their needs and preferences .Determine if the resident has the call system within reach and is able to use it if desired.</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>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** 48366</p> <p>Based on interviews and record reviews the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly for 1 of 8 residents (Resident #6) reviewed for notification.</p> <p>On 03/23/24, LVN A and LVN C failed to notify the Medical Doctor 3 out of 7 neuro checks were not being done for 12 hours. Resident #6 was hospitalized on [DATE] and returned 03/27/24 with new diagnoses to include: cerebral infarction (a type of stroke caused by impaired blood flow to the brain), hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of one side of the body) following cerebral infarction affecting right dominant side , ataxia (a loss of muscle coordination), and slurred speech .</p> <p>An IJ was identified on 06/07/2024. The IJ template was provided to the facility on [DATE] at 09:00 PM. While the IJ was removed on 06/09/2024, the facility remained out of compliance at a scope of pattern and a severity level of potential harm because all staff not been trained on.</p> <p>The findings were:</p> <p>Record review of Resident #6's admission record, accessed 06/07/24, reflected the resident was admitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing food or liquid) following cerebral infarction (a type of stroke caused by impaired blood flow to the brain) and dementia (neurodegenerative disease that affects memory, thinking and interferes with daily life). It further reflected Resident #6 returned to the facility on [DATE] with new diagnoses to include: cerebral infarction (a type of stroke caused by impaired blood flow to the brain), hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of one side of the body) following cerebral infarction affecting right dominant side , ataxia (a loss of muscle coordination), and slurred speech .</p> <p>Record review of Resident #6's significant change in status MDS, dated [DATE], reflected a BIMS score of 99, indicating resident was unable to complete the interview. Further review of this MDS reflected Resident #6's cognitive skills for daily decision making was severely impaired with short term and long term memory problems.</p> <p>Record Review of nursing progress note, authored by LVN A on 03/22/24 at 01:20 PM, reflected Resident #6's RP reported Resident #6 could not hold her beverage. This progress note further revealed NP B ordered neuro checks Q 4 hrs x 3days, notify NP of any deficit.</p> <p>Record review of Orders- Administration Note , authored by LVN C, reflected:</p> <p>03/23/24 at 02:02 AM Neuro check was not done due to [Resident #6] being asleep</p> <p>03/23/24 at 04:55 AM Neuro check was not done due to refusal</p> <p>Record review of Orders- Administration Note , authored by LVN A, reflected:</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>03/23/24 at 09:06 AM Neuro check was not done due to family member refused since [Resident #6] was sleeping</p> <p>Record review of Resident #6's Medication Administration Record for March, undated, revealed neuro checks that were done were: 03/22/24 at 04:00 PM and 08:00PM, 03/23/24 at 12:00 PM and 04:00 PM.</p> <p>Record review of nursing notes from 03/23/24 revealed no documentation of NP or MD being notified of neuro checks not being done per order.</p> <p>During an interview on 06/07/24 at 10:20 AM, Resident #6's RP 2 revealed on Friday [03/22/24] Resident #6 had weakness in her hands because she was not able to hold a cup of V8 in order to drink it. They revealed they reported this to LVN A. She further revealed the facility said she was fine so Resident #6's RP 2 let it go. Residents #6's RP 2 continued to reveal the next day on Saturday [03/23/24], Resident #6 speech got worse and Resident #6's balance was off. Resident #6's RP 2 revealed she asked resident to be sent out to the hospital because Resident #6 was not at baseline and got worse. She further revealed the facility called regular transport to send out resident.</p> <p>Record Review of Resident #6's hospital record with admitted [DATE] revealed history of CVA and dysphagia s/p cerebral infarction. [Resident #6] present with slurring in speech that started yesterday at 1 PM, as well as clumsiness and weakness in her left upper extremity that was noted when she attempts to hold objects like a cup. Hospital records further reflected a new diagnosis and chief complaint of cerebrovascular accident (CVA).</p> <p>During an interview on 06/07/24 at 12:41 PM, the DON revealed LVN A reported to her that the family declined having Resident #6's vital signs checked overnight and wanted to wait and see if Resident #6 would get better.</p> <p>During an interview on 06/07/24 at 01:17 PM, LVN A revealed Resident #6 had stroke like symptoms on 03/22/24, but family declined having Resident #6 sent out to the hospital. LVN A further revealed the family wanted LVN A to contact Resident #6's NP to see what she recommended. LVN A revealed NP ordered neuro checks every 4 hours for 3 days. LVN A revealed Resident #6's family declined having neuro checks done when Resident #6 was asleep. LVN A further revealed she did not contact NP B that neuro checks were not done. LVN A also revealed she did not explain what could happen if Resident #6 had a stroke because Resident #6 had a history of having a stroke, so the family knew information about strokes.</p> <p>Left voicemail for LVN C on 06/07/24 at 05:21 PM.</p> <p>During an interview on 06/07/24 at 05:02 PM the DON revealed NP B was not contacted because there were no deficits in neuro checks, which was how the doctor order read. The DON revealed the NP B would not have been contacted if the family refused neuro checks.</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>During an interview on 06/07/2024 at 05:29 PM NP B stated LVN A reported on 03/22/2024 Resident #6 had a change of condition, with weakness in arms and NP B issued an order for Neurological assessments every 4 hours for 3 days. NP B stated she was not aware the orders for Resident #6 Neurological assessments were not performed for 12 hours and would have wanted to be notified when her orders were not followed. NP B stated neurological assessment deficits would indicate a potential for a stroke. NP B stated if the neurological assessment deficit were revealed it would have warranted an immediate hospitalization .</p> <p>During an interview on 06/09/24 at 03:16 PM, the Medical Director stated he was given a report for Resident #6's missed neurological assessments from 03/23/2024 on 06/08/2024. The Medical Director confirmed he did not know about these missed neurological assessments before 06/08/24. He stated the ideal would be for the prescriber to be given a report when the orders given were not able to be completed.</p> <p>Record Review of facility's policy, revised April 2009, Change in a Resident's Condition or Status, reflected 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: f. refusal of treatment or medications.</p> <p>An Immediate Jeopardy (IJ) was identified on 06/07/2024 at 09:00 PM and presented to the Administrator, a plan of removal was requested.</p> <p>The following Plan of Removal submitted by the facility was accepted on 06/08/2024 01:46 PM.</p> <p>Immediate Jeopardy Plan of Removal Verification</p> <p>6/8/2024</p> <p>All residents with orders for neuro checks are at risk of the orders not being followed or prescriber not being notified of the refusals.</p> <p>During an interview on 06/08/24 at 02:30 PM, the Administrator revealed the census was 79 and there were 0 residents currently being assessed for neurological assessments.</p> <p>Action to correct and remove IJ:</p> <p>1.) Verify that current orders are being followed as prescribed by physician/NP. The DON and/or designee will complete this by noon 6/8/2024.</p> <p>During an interview on 06/09/24 at 12:22 PM, the DON stated she and her staff reviewed all the current residents' physicians' orders for compliance and all evidenced compliant.</p> <p>During an interview on 06/08/24 at 02:30 PM, the Administrator revealed there were no residents on neuro checks and 2 residents had received neurological assessments in the recent past, Resident #44 and Resident #48.</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>During an interview on 06/09/24 at 12:22 PM, the DON stated 2 residents (Resident #44 and Resident #48) had received neurological assessments per post fall protocols. The DON stated there were no residents ordered to receive neurological assessments since 03/23/2024 when Resident #6 was ordered neurological assessments due to her stroke-like symptoms.</p> <p>A record review of the facility's census revealed 2 of 79 residents (Resident #44 and Resident #48) had completed worksheets for neurological assessments:</p> <ul style="list-style-type: none"> o A record review of Resident #44's neurological assessment worksheet dated 05/21/2024, revealed Resident #44 was assessed every 15 minutes 5 times, assessed every 30 minutes 4 times, assessed every hour three times, and every 4 hours 4 times. o A record review of Resident #48's neurological assessment worksheet dated 05/21/2024, revealed Resident #44 was assessed every 15 minutes 7 times, assessed every hour eight times. <p>2.) All licensed nurses will be in-serviced regarding the need to notify physician/NP of any refusals that keep us from following orders prescribed. The DON and/or designee will complete in-service with team by 6/9/2024. Licensed Nurses on vacation, leave, or unavailable will be trained prior to their next scheduled shift. A Licensed Nurse roster is being utilized to track the Licensed Nurses who have responded and have been in-serviced. The identified Licensed Nurses who are unavailable will attempt to be reached by phone call, text message, and email by DON/Designee. DON/Designee will work with the scheduler and audit daily to ensure any Licensed Nurse will not be scheduled until the necessary in-service has occurred.</p> <p>During an interview on 06/08/24 at 03:02 PM, the DON provided documents titled in-service education attendance record, dated 06/07/24, and facility policy's Change in a Resident's Condition or Status, revised November 2010, and Refusal of Medications and Treatments, Documentation of, revised April 2009. The DON revealed licensed nurses could not work a shift until they have received in-services for following orders and reporting orders that could not be performed and have been sent an email to go to her office to be educated before working a shift.</p> <p>A record review of the facility's nursing roster revealed 23 / 34 licensed nurses were employed. 19 licensed nurses were full time, and 15 licensed nurses were part time.</p> <p>A record review of the facility's nursing roster and schedule revealed 13 nurses worked the 07:00 AM shift to 07:00 PM shift and 10 worked the 07:00 PM to 07:00 PM shift.</p> <p>A record review of the facility's in-service titled Change of Condition; refusal of treatment . dated 06/07/2024, revealed 23 Nurses received the in-service.</p> <p>Interviews:</p> <p>07:00 AM to 07:00 PM shift:</p> <p>7 Of 14 nurses, 50%, who worked the 07:00 AM to 07:00 PM shift were interviewed. A sample of the interviews follow:</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>During an interview on 06/09/24 at 10:53 AM, LVN J revealed he received training on reporting to MD or NP if the resident's doctor's orders were not being fulfilled.</p> <p>During an interview on 06/09/24 at 10:59 AM, ADON D and LVN E revealed they were trained in contacting a resident's MD or NP if they were not able to fulfill doctor's orders. They further revealed they could make person centered changes to help fulfill their orders.</p> <p>During an interview on 06/09/24 at 11:10 AM, RN F, RN G, and LVN H not able to carry out a doctor's order they will notify the doctor or NP. RN gave examples of some doctor's orders that need to be followed.</p> <p>During an interview on 06/09/24 at 02:22 PM, the DON revealed she was in-serviced on change of condition policy and refusal of treatment/medication by the COO.</p> <p>Interviews:</p> <p>07:00 PM to 07:00 AM shift:</p> <p>6 of 9 licensed nurses, 67%, who regularly worked the 07:00 PM to 07:00 AM shift were interviewed. A sample of the interviews follow:</p> <p>During an interview on 06/09/24 at 10:59 AM, LVN I revealed she was trained in contacting a resident's MD or NP if they were not able to fulfill doctor's orders. They further revealed they could make person centered changes to help fulfill their orders.</p> <p>During an interview on 06/09/24 at 12:22 PM, DON revealed LVN C (who regularly worked 6 PM- 6 AM) could not be contacted to be in-serviced. LVN C had been taken off the schedule until she was able to be in-serviced.</p> <p>During an interview on 06/09/24 at 01:28 PM, LVN K revealed she was educated recently to follow doctor's orders and report to doctor or NP if a resident was not able to receive a treatment or medication.</p> <p>During an interview on 06/09/24 at 01:43 PM, LVN L revealed she was in-serviced on how to complete a change in condition assessment and notify doctor if any doctor's orders were not fulfilled.</p> <p>During an interview on 06/09/24 at 01:55 PM, LVN M revealed she was educated recently to follow doctor's orders and contact MD or NP if an order was not fulfilled.</p> <p>During an interview on 06/09/24 at 02:01 PM, LVN N revealed she would contact the doctor if a resident refused treatment, refused medication, or had a change in condition.</p> <p>During an interview on 06/09/24 at 02:09 PM, LVN O revealed he was trained to contact the doctor if medications or treatments were not fulfilled.</p> <p>3.) Physicians/NP partners will be notified to provide team with more concise orders and to consider the nurse's feedback regarding specific resident's characteristics or preferences when deciding a plan of action. The communication with our physician partners will be completed by 6/10/2024.</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>During a joint interview on 06/09/2024 at 11:00 AM the Administrator and the DON stated the facility has partnered with all facility medical providers to have a consensus to develop and implement improved physicians' orders to better reflect residents needs and preferences i.e., may assess while awake, may reattempt x3, and please report to physicians after 2x refusals. the Administrator and the DON stated the facility has sent emails to the medical director and all supporting and attending physicians and nurse practitioners. The Administrator stated the facility held an AD-HOC QAPI meeting to review the Plan of Removal.</p> <p>During an interview on 06/09/2024 at 03:18 PM the Medical Director stated the facility informed him of the immediate jeopardy on 06/08/2024 and the facility held an AD-HOC QAPI meeting to review the immediate jeopardy and develop a plan of removal. The medical Director stated he was given a report for resident #6's missed neurological assessments from 03/23/2024 on 06/08/2023. The Medical Director stated the ideal would be for the prescriber to be given a report when the orders given were not able to be completed.</p> <p>4.) The DON/Designee will review 24-hour report daily for change of condition UDA including neurological checks for any refusals and review for medical provider notification. The Weekend Nurse Manager/Designee will review any refusals and contact DON/Designee if a resident has a refusal to ensure the medical provider has been notified. Audits will be completed daily x14 days, weekly x4 weeks, monthly x3 months, and periodically thereafter.</p> <p>During a joint interview on 06/09/2024 at 11:00 AM the administrator and the DON stated the facility would daily monitor the 24-hour reports for any changes of condition, to include neurological assessments, refusals of any assessments, treatments and or orders: and follow up documentation with reports to physicians. The Administrator and the DON stated the monitoring will be conducted for 14 days, then 4 weeks, and then for 3 months.</p> <p>Record review of Daily Neurological Checks dated 6/8/2024, 6/9/2024 No new neurological checks, created by DON. The Daily Neurological Checks, included Resident name, Date, Notification to family, notification of MD, refusals of vital signs, notification of neurological assessments, Is this care planned and comments sections.</p> <p>Record review of Weekly Neurological Checks blank sheet, includes resident name, date, notification of family, notification of MD, Refusal of vital signs, Notification of neurological assessments, Is this care planned and comments sections.</p> <p>Record review of Monthly Neurological Checks Monthly blank sheet, includes resident name, date, notification of family, notification of MD, Refusal of vital signs, Notification of neurological assessments, Is this care planned and comments sections.</p> <p>Record review of E-Interact Daily Change of Condition Assessment, dated 6/8/2024 and 6/9/2024. This included resident name, date, notification of family, notification of MD, Refusal of vital signs, Notification of neurological assessments, Is this care planned and comments sections.</p> <p>Record review of Daily 24 hour report, dated 6/8/2024, 6/9/2024 revealed no neurological checks for residents.</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>Record review of Weekly 24 hour report, for weekly monitoring blank, included resident name, date, progress note refusals EMR refusals, order note refusals, Is this care planned and comments section.</p> <p>5.) All residents have the potential to be affected by this alleged deficit practice. At risk resident will be identified by reviewing 24 hr. report, (for) changes of condition assessment and neurological checks.</p> <p>A record review of the facility's unit 6's Nurses station 24-hr report revealed no residents were followed for a change of condition and no residents had refused any treatments.</p> <p>Reviews: (Monitoring)</p> <p>1.) Weekly the DON and/or designee will pull all orders from the EHR for any refusals and review for physician and/or NP notification. The administrator will meet with DON weekly to audit and verify this review has been completed. This will be ongoing for the next two months.</p> <p>2.) Reports to the QAPI committee regarding the reviews will be discussed with the team on an ongoing basis.</p> <p>Record review of QAPI Performance for Improvement instructor, Administrator dated 6/8/202 from 9 AM -10 AM. Subject: Notify of Changes. The QUAPI in-service included the Administrator, DON, CDM, Admissions, Business Manager, Maintenance, Housekeeping, ADON, Activity Director, Social Worker, Human Resources and Medical Director. System of Concerns: In-service on Notification of Changes. Concerning IJ F580 Notify of Changes.</p> <p>3.) A corporate designee will audit compliance with orders weekly until stable and monthly for the next six months, quarterly thereafter if stable and report findings to the governing body.</p> <p>During an interview on 06/09/2024 at 03:14 PM the Administrator stated the facility's Chief Operating Officer would have oversight and monitoring the facility's Plan of Removal for the following six months.</p> <p>The Administrator and the DON was informed the Immediate Jeopardy was removed on 06/09/24 at 04:07 PM. The facility remained out of compliance at a severity level of potential harm and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p> | | |

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| <p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay, for 1 of 8 residents (Resident #54) reviewed for their right to voice grievances to the facility.</p> <p>CNA P failed to report and document Resident #54's complaint she was left without a call light, left unattended, and received rushed care.</p> <p>This failure could place residents at risk for harm by not having their grievances addressed.</p> <p>The findings included:</p> <p>A record review of Resident #54's admission record dated 06/06/2024 revealed an admitted [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), glaucoma (a condition where the eye's optic nerve, which provides information to the brain, is damaged and will cause gradual vision loss), atherosclerosis of the aorta (a condition characterized by the gradual buildup of plaque in the largest artery in your body).</p> <p>A record review of Resident #54's annual MDS assessment dated [DATE], revealed Resident #54 was a [AGE] year-old female assessed with an ability to hear as, Moderate difficulty - speaker has to increase volume and speak distinctly, with impaired vision, Impaired - sees large print, but not regular print in newspapers/books, and had clear speech, was attentive, and did not have disorganized thinking. Further review of the assessment revealed Resident #54 had not refused any care provided. Resident #54 was assessed as always incontinent of bowel and bladder. Resident #54 was assessed as, Dependent - Helper does ALL the effort. Resident does none of the effort to complete the activity, Or the assistance of 2 or more helpers is required for the resident to complete the activity for the following abilities:</p> <p>Eating, oral hygiene, toileting hygiene, personal hygiene, shower / bathing dressing, and transferring.</p> <p>Manual wheelchair - Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.</p> <p>Manual wheelchair, Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.</p> <p>(continued on next page)</p> | | |

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| <p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A record review of Resident #54's care plan dated 06/06/2024 revealed, The resident has a potential for communication problem Hearing deficit .The resident will be able to make basic needs known on a daily basis through the review date .Be conscious of resident position when in groups, activities, dining room to promote proper communication with others . Ensure/provide a safe environment: Call light in reach</p> <p>A record review of the facility's grievance report logbook revealed grievances for the last 8 months . A review of the grievances revealed no evidence for a grievance for Resident #54.</p> <p>During an observation and interview on 06/05/2024 at 11:05 AM revealed Resident #54 loudly calling out for attention. Resident #54 was observed seated in her wheelchair in her room positioned mid room equidistant from her bed and the entry door. Resident #54's call light rested upon her bed and out of her reach by an approximate 3 feet. Resident #54 stated she was brought into her room by a CNA and left there without an ability to call for assistance. Resident #54 stated she did not have a call light within her reach. Resident #54 stated she was angry that staff do not take time with their care, (they) rush with care and run off.</p> <p>During an observation and interview on 06/05/2024 at 11:16 AM revealed CNA P entered Resident #54's room responding to Resident #54's loud vocalizations calling out for assistance. Upon CNA P's entrance Resident #54 began with a complaint alleging you left me here .you said you would be right back .I had to yell to get you here . Resident #54 continued in an irritable manner and would often over speak CNA P, .you all are always in a rush and leave CNA P stated she had assisted Resident #54 in her wheelchair to her room and placed Resident #54 where she sat in her wheelchair as observed. CNA P stated Resident #54's call light was on Resident #54's bed and out of reach from Resident #54. CNA P stated she positioned Resident #54 away from her bedside due to Resident #54's preference. CNA P stated she had not attempted to place Resident #54's call light at her side. CNA P then attempted to reposition Resident #54's call light and succeeded to place Resident #54's call light at Resident #54's side, secured to her wheelchair. Resident #54 continued to verbalize irritably, don't tell your stories .you left me here .without lunch .with the button over there CNA P stated she understood Resident #54 had made a complaint and was asked what do you do when a Resident makes a complaint? CNA P stated, I have explained to her (Resident #54) I cannot stay here; I have other work to do. CNA P stated Resident #54 had a desire for someone to stay with her and she could not due to her duties.</p> <p>During an interview on 06/07/2024 at 09:04 AM the DON stated staff should assist residents with a grievance report.</p> <p>During an interview on 06/08/2024 at 02:03 PM the Administrator stated she was unaware of Resident #54's grievance and would look into the event on 06/05/2024 with CNA P and Resident #54. The Administrator stated she would provide a grievance policy.</p> <p>(continued on next page)</p> | | |

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| <p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A record review of the facility's Grievances, Resident / Responsible Party policy dated 08/01/2017, revealed, Policy Interpretation and Implementation: A resident has the right to voice grievances without discrimination or reprisal. Grievances include those with respect to treatment which has been furnished as well as that which has not been furnished; and a resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to behavior of other residents. The resident has the right to obtain a written decision regarding his or her grievance. Grievances are not limited to formal written grievances and may also include residents verbalized complaints to facility staff. It is the intent of this facility to make prompt efforts to resolve including facility acknowledgment of complaints grievances. Staff will work actively towards resolution of complaints and grievances</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 26869</p> <p>Based on observations, interviews and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 6 of 16 (#6 , #3, #38, #56, #57, #120) in that:</p> <ol style="list-style-type: none"> 1. Resident #6 received honey consistency liquids instead of nectar thick liquids. 2. Resident #3 did not have her 1/4 bed [NAME] in her care plan. 2. Resident #38 did not have her indwelling catheter in her care plan. 3. Resident #57 did not have her 1/4 bed rails in her care plan. 4. Resident #120 did not have her 1/4 bed rails in her care plan. 5. Resident #56 did not have his dentures mentioned in his care plan. <p>The facility failed to ensure Resident #6's care plan was comprehensive and updated to reflect Resident #2's doctor's order of needing honey consistency liquids instead of nectar thick liquids. This failure could place residents at risk of not receiving appropriate interventions to meet their current needs.</p> <p>The Findings were:</p> <p>Record review of Resident #6's admission record dated 6/7/2024 revealed a male was admitted on [DATE] with diagnoses that included dementia (loss of thinking, remembering, and reasoning skills), personal history of traumatic brain injury, dysphagia (a condition with difficulty in swallowing food or liquid), cognitive communication deficit, and muscle wasting and atrophy.</p> <p>Record review of Resident #6's annual MDS, dated [DATE], reflected Resident #6's BIMS score was 99, indicating resident was not able to complete the interview with short term and long-term memory problems and severely impaired cognitive skills for daily decision making. It further reflected Resident #6 was severely impaired-never/rarely made decisions. The MDS also indicated Resident #6 was on a mechanically altered diet, requiring change in texture of food or liquids.</p> <p>Record review of Resident #6's care plan, accessed 05/23/24, reflected [Resident #2] has potential nutrition problem r/t mechanically altered diet, revised on 03/06/2024, with an intervention of Administer Nectar thick liquid as ordered., initiated 11/30/2021 with no revision date.</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record Review of Resident #6's Doctor's diet orders reflected honey consistency liquids since 08/30/22.</p> <p>1. Record review of Resident #3's Admission Record dated 6/7/2024 revealed she was admitted on [DATE], age 91 with diagnoses of polyneuropathy, heart failure, cognitive communication deficit, and dementia.</p> <p>Record review of Resident #3's consolidated physician's order 5/16/2023-TRANSFER ASSISTIVE DEVICE: X2, 1/4 rails up as per Dr's order while in bed, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN to avoid injury.</p> <p>Record review of Resident #3's Quarterly MDS dated [DATE] revealed she had a BIMs of 2/15 (severely cognitively impaired), she used a wheelchair to mobilize, she was maximum assistance with transfers.</p> <p>Record review of Resident #3's care plan dated 5/6/2024 revealed no care plan to address the 1/4 side rails.</p> <p>Record review of Resident #3's Transfer Assist Device Assessment form dated 5/16/2023 revealed a recommendation of bilateral 1/4 [NAME].</p> <p>Interview on 6/6/2024 at 4:10 PM LVN Q stated she just changed her bed on Monday of this week.</p> <p>2. Record review of Resident #38's Admission Record dated 6/7/2024, age 99 revealed she was admitted on [DATE] with diagnoses of altered mental status, acute kidney failure, cognitive communications deficit, dementia and retentions of urine.</p> <p>Record review of #38's consolidated physician orders for June 2024 revealed she had an order for indwelling catheter with diagnoses of urine retention.</p> <p>Record review of Resident #38's Quarterly MDS dated [DATE] revealed her BIMS was 99, with short/long-term memory, she used a wheelchair to mobilize, she was dependent with toileting, and had an indwelling catheter.</p> <p>Record review of Resident #38's care plan dated 3/28/2024 revealed she had an indwelling catheter for neurogenic bladder but had no interventions.</p> <p>Observation on 6/5/2024 at 11:40 AM revealed Resident # 38 was in the dining room eating by herself. The indwelling catheter bag was under the wheelchair and had privacy bag.</p> <p>Interview on 6/6/2024 at 6:18 PM with the DON revealed Resident #38 did not have interventions for her indwelling catheter. The DON stated the nursing department, nurse manager (DON, ADON) did the care plans for nursing section in resident care areas. The DON stated the resident interventions were to monitor for quinks, care, size, nursing staff would benefit from seeing care plan. The DON stated nurses look at the care plan for catheters.</p> <p>3. Record review of Resident #57's Admission Record dated 6/7/2024, age 101 revealed he had a diagnosis of diabetes II, need for assistance with personal care, and history of falls.</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of Resident #57's Quarterly MDS dated [DATE] revealed her BIMS score was 6/15 (severe cognitive impairment), used a manual wheelchair, and max assist with transfers.</p> <p>Record review of Resident #57's care plan dated 6/3/2024 revealed no care plan for 1/4 bed rails.</p> <p>Record review of Resident #57's Transfer Assist Device Assessment form dated 5/17/2023 revealed a recommendation of bilateral 1/4 [NAME].</p> <p>Observation on 6/5/2024 at 11:30 AM revealed Resident #57 had 1/4 hand [NAME] in her bed. Resident # 57 was not in the room.</p> <p>Observation on 6/5/2024 at 3:34 PM revealed two 1/4 handrails on Resident #57's bed. Observation of Resident #57 w as sitting in her wheelchair.</p> <p>4. Record review of Resident #120's Admission Record dated 6/7/2024 revealed she was admitted on [DATE], age 65 with a diagnoses of end stage renal disease, diabetes II, abnormal gait/mobility and heart failure.</p> <p>Record review of Resident #120's consolidated physician orders for June 2024 revealed an order for 5/20/2024-TRANSFER ASSISTIVE DEVICE: X2, 1/4 rails up as per physician order while in bed, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN to avoid injury.</p> <p>Record review of Resident #120's Admission MDS dated [DATE] revealed she was BIMS 15/15 (cognitively intact), mobilized in wheelchair, impairment on one side of lower extremity, and roll left and right required partial/moderate assistance.</p> <p>Record review of Resident #120's care plan dated 5/13/2024 revealed no care plan for 1/4 bed rails.</p> <p>Record review of Resident #120's Transfer Assist Device assessment dated [DATE] recommendation left and right 1/4 side rails.</p> <p>Observation on 6/4/20/24 at 11:29 AM revealed Resident #120 was in bed and had two 1/4 side rails on each side of her bed.</p> <p>Interview on 6/7/2024 at 11:50 AM with the ADM stated the 1/4 bed rails risk would be staff does not know the rails were in place. No other response.</p> <p>5. Record review of Resident #56's Admission Record dated 6/9/2024 revealed he was admitted on [DATE], age 89 with diagnoses of alcoholic cirrhosis of liver (impaired liver function caused by formation of scar tissue) and major depressive disorder.</p> <p>Record review of Resident #56's Quarterly MDS dated [DATE] revealed he had a BIMS of 8/15 (moderately cognitively impaired) and nothing noted in Section L- Oral/Dental Status.</p> <p>Record review of Resident #56's care plan, undated, revealed no mention of dentures.</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 06/06/24 at 02:00 PM, Resident #56's RP revealed Resident #56 had been going to the dentist recently to get his dentures fixed.</p> <p>During an interview on 06/06/24 at 01:47 PM, Resident #56's dentist revealed she was seeing Resident #56 to repair his dentures.</p> <p>During an interview on 06/07/24 at 12:13 PM, the DON revealed dentures should be care planned so the CNAs know what to do for the resident's care when it comes to oral care.</p> <p>During an interview on 05/24/24 at 11:19 AM, Speech Therapist C (ST C) revealed if a resident was determined to need honey thickened liquids and received nectar thickened liquids there could be a chance of aspiration where a solid or liquids could get into the airways. She further revealed this could lead to aspiration pneumonia which could cause a resident to be hospitalized. She revealed if a resident was more compromised there could be more severe health consequences, including death. ST C revealed there had been times where a resident may refuse a liquid if they knew they could not tolerate it, which could cause dehydration. She further revealed she had not heard of a resident at this facility complaining about this scenario, however, you may not be able to know this if a resident was nonverbal.</p> <p>During an interview on 05/24/24 at 03:23 PM, the RD revealed the facility was giving resident honey thickened liquids. She further revealed CNAs were providing liquids to Resident #2 in between meals but would have to ask the DON how the CNAs knew what liquids to give Resident #2.</p> <p>During an interview on 05/24/24 03:54 PM, MDS nurse P and MDS nurse Q stated CNAs followed tasks that were developed from care plans. MDS nurse P confirmed Resident #2's care plan reflected an intervention of Administer Nectar thickened liquid as ordered. She further confirmed this would turn into a task on their POC dashboard for the CNAs to follow. MDS nurse Q confirmed Resident #2's POC Shift Dashboard record, accessed on 05/24/24 at 11:01 AM, revealed there was a directive to give Resident #2 Nectar Thick Liquids. MDS nurse P and MDS nurse Q revealed if resident was receiving Nectar thickened liquids and needed honey thickened liquids, this could cause aspiration.</p> <p>Left VM for doctor and NP on 05/24/24 at 3:20 PM.</p> <p>During an interview on 5/30/24 at 02:33 PM, the administrator and the DON revealed nursing staff received liquids from the kitchen, which would be honey thickened liquids. If the kitchen did not give these liquids, the DON would get involved and ensure the correct liquid was given.</p> <p>Record review of the facility's policy, titled Care Plans, Comprehensive Person-Centered, revised March 2022, reflected, 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of the facility policy dated 4/6/2009 revealed The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care of services to the resident. Record Review of POC Shift Dashboard and interview with CNA D, dated 05/24/24 at 11:01 AM, reflected Resident #2 received NUTRITION- Fluids: NECTAR THICK LIQUIDS QShift. CNA D revealed she was following this directive and giving Resident #2 Nectar thickened liquids.</p> <p>There were no observations of Resident #2 receiving nectar thickened liquids. Meals and snacks included honey thickened liquids.</p> <p>48366</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26481</p> <p>26869</p> <p>42402</p> <p>Based on interviews and record reviews the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly for 1 of 8 residents (Resident #6) reviewed for notification.</p> <p>The facility failed to ensure Resident # 6 was assessed as ordered for neuro-checks every 4 hours x 3 days. Resident # 6 was sent to hospital and returned to the facility on [DATE] with new diagnoses to include: cerebral infarction and hemiparesis following cerebral infarction affecting right dominant side, and slurred speech.</p> <p>An Immediate Jeopardy was identified on 6/29/2024 . The IJ template was provided to the facility on [DATE] . While the IJ was removed on 6/30/2024, the facility remained out of compliance at a scope of pattern and a severity level lowered to no actual harm that is not Immediate Jeopardy due to the facility's need to monitor and evaluate the effectiveness of the corrective actions.</p> <p>This failure could result in assessments not being completed as ordered could result in residents' not receiving the necessary care resulting in a decline in health and or death. This could affect all resident with assistive devices and could result in no orders for resident care.</p> <p>The findings included:</p> <p>Record review of Resident #6's admission record, accessed 06/07/24, reflected the resident was admitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing food or liquid) following cerebral infarction (a type of stroke caused by impaired blood flow to the brain) and dementia (neurodegenerative disease that affects memory, thinking and interferes with daily life). It further reflected Resident #6 returned to the facility on [DATE] with new diagnoses to include: cerebral infarction (a type of stroke caused by impaired blood flow to the brain), hemiplegia (weakness of one entire side of the body) and hemiparesis (complete paralysis of one side of the body) following cerebral infarction affecting right dominant side , ataxia (a loss of muscle coordination), and slurred speech.</p> <p>Record Review of nursing progress note, authored by LVN A on 03/22/24 at 1:20 PM, reflected Resident #6's RP reported Resident #6 could not hold her beverage. This progress notes further revealed NP B ordered neuro checks Q 4 hrs x 3days, and to notify NP of any deficit. Record Review revealed Neuro-checks were not started until 4:00 pm.</p> <p>Record review of Orders- Administration Note , authored by LVN C, reflected:</p> <p>03/23/24 at 02:02 AM Neuro check was not done due to [Resident #6] being asleep.</p> <p>03/23/24 at 04:55 AM Neuro check was not done due to[family member] refusal.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Record review of Orders- Administration Note , authored by LVN A, reflected:</p> <p>03/23/24 at 09:06 AM Neuro check was not done due to family member refused since [Resident #6] was sleeping.</p> <p>Record review of nursing notes from 03/23/24 revealed no documentation of NP or MD being notified of neuro checks not being done per order.</p> <p>During an interview on 6/25/2024 at 6:35 pm LVN A revealed she did not explain what could happen if Resident #6 had a stroke to the family, because Resident #6 had a history of having a stroke, so the family knew information about strokes.</p> <p>LVN A said when the resident/family refused neuro checks she did not go back and attempt to reassess the resident until the next 4-hour interval.</p> <p>During an interview on 6/25/2024 at 6:49 pm, LVN C stated Resident #6's family member did not allow her to do one of the neuro checks (12 midnight) 3/23/2024 the resident was sleeping. The Resident refused neuro checks at 4:00 am. LVN C further revealed she did not contact NP B when neuro checks were not done. LVN C also revealed she did not explain what could happen if Resident #6 had a stroke because Resident #6 had a history of having a stroke.LVN C said when the resident/family refused neuro checks she did not go back and attempt to reassess the resident until the next 4-hour interval. She further revealed she tried once, and the resident hit me. The resident said leave me alone.</p> <p>During a telephone interview on 6/28/2024 at 12:30 pm NP B stated she remembers the nurses calling her in March 2024 regarding stroke like symptoms, she doesn't recall the specifics, but she feels they let her know how the resident was based on their long-time knowledge of the resident. The nurses once they found the resident to have a change sent her to the hospital. She stated based on the statements of the nurses was how she was sent to the hospital.</p> <p>Resident #6 was admitted to hospital on 3/23/24 and diagnosed with: cerebral infarction and hemiparesis following cerebral infarction affecting right dominant side, and slurred speech.</p> <p>The plan of removal was submitted by the facility and was accepted on 06/29/24 at 10:07 AM. It was documented as follows:</p> <p>Action to correct and remove IJ:</p> <p>1.) Verify that all assessments were being followed as ordered by physician/NP. The DON and/or designee will complete this by noon 06/29/24.</p> <p>2.) All licensed nurses will be in-serviced regarding the need to notify physician/NP</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>immediately of any refusals that keep us from following physician ordered assessments. The DON and/or designee will complete an in-service with the team by 06/30/24. Licensed Nurses on vacation, leave, or unavailable will be trained prior to their next scheduled shift. A Licensed Nurse roster is being utilized to track the Licensed Nurses who have responded and have been in-serviced. The identified Licensed Nurses who were unavailable will attempt to be reached by phone call, text message, and email by the DON/Designee. The DON/Designee will work with the scheduler and audit daily to ensure any Licensed Nurse will not be scheduled until the necessary in-service has occurred.</p> <p>3.) The DON/Designee will review 24-hour report daily for change of condition UDA (Unified Defined Assessment-a change of condition assessment) including neurological checks for any refusals and review for medical provider notification. The Weekend Nurse Manager/Designee will review any refusals and contact the DON/Designee immediately if a resident has a refusal to ensure the medical provider has been notified. Audits will be completed daily x14 days, weekly x4 weeks, monthly x3 months, and periodically thereafter.</p> <p>4.) All residents have the potential to be affected by this alleged deficient practice. At risk residents will be identified by reviewing 24-hour report, changes of condition assessment and neurological checks.</p> <p>Reviews:</p> <p>1.) Weekly the DON and/or designee will pull all orders from the EHR for any refusals and review for physician and/or NP notification. The administrator will meet with the DON weekly to audit and verify this review has been completed. This will be ongoing for the next two months.</p> <p>2.) Reports to the QAPI committee regarding the reviews will be discussed with the team on an ongoing basis.</p> <p>3.) A corporate designee will audit compliance with orders weekly until stable and monthly for the next six months, quarterly thereafter if stable and report findings to the governing body.</p> <p>The facility's POR verification was as follows:</p> <p>In an interview on 06/29/24 at 12:53 PM the DON stated all but 1 of the 24 nurses had been in-serviced to notify the physician immediately if a resident refused an assessment and the 1 nurse who had not been in-serviced would not be scheduled until they received the in-service.</p> <p>Interviews on 06/29/24 from 12:05 PM to 4:05 PM with 8 nurses (3 RNs and 5 LVNs), five of whom worked the day shift (6 AM to 6 PM) and three of whom worked the night shift (6 PM to 6 AM), revealed they were in-serviced to immediately notify the resident's physician/NP if a resident refused to have an assessment completed, to document the resident refused the assessment in the nurse's progress notes and the physician was notified, and to notify the resident's responsible party.</p> <p>In an interview on 06/29/24 at 4:01 PM, the DON stated she had printed out all the physician orders and verified the assessments had been completed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>In a further interview on 06/29/24 at 4:20 PM, the DON stated there was only one resident who had orders for neurological checks that were initiated on 06/28/24 and completed 06/29/24 and the resident did not refuse the neurological assessments.</p> <p>In an interview on 06/29/24 at 4:52 PM the DON stated she would review the 24-hour reports, the orders in the EHR, and the change of condition reports daily for notation of change of condition in a resident. The DON stated the Weekend Supervisor and the ADON would continue the monitoring when she was not in the facility. The DON stated an ad hoc QAPI meeting was held on 06/28/24 with the Medical Director and department heads in reference to the IJ for not completing an ordered assessment. The DON stated the Chief Operating Officer would conduct weekly audits of the facility's monitoring of compliance with ordered assessments.</p> <p>In an interview on 06/29/24 at 5:09 PM the Administrator stated she reviewed the 24-hour reports with the DON for ordered assessments. The DON in-serviced the nurses on ensuring ordered assessments were completed and to notify the physician immediately if an assessment was refused by the resident. The Administrator stated they would obtain daily the 24-hours reports from the EHR to monitor ordered assessments. The Administrator said an ad hoc QAPI meeting was held on 06/28/24 and not notifying the physician when a resident refused an assessment was reviewed and discussed. The Medical Director, the DON, the ADON and other department heads were present at the ad hoc QAPI meeting. The Administrator stated the Chief Operating Officer would conduct the weekly audits of compliance with monitoring physician order assessments.</p> <p>Record review of an undated, untitled list of nurses revealed 24 nurses were employed at the facility.</p> <p>Record review of the In-Service Education Attendance Record dated 06/28/24, for Completing assessments as ordered per physician/NP, revealed 23 nurses had been in-serviced.</p> <p>Record review of the facility's POR verification binder revealed there were daily, weekly, and monthly monitoring sheets for reviews of the 24-Hour report. The 24-Hour Report monitoring form had columns for the resident's name, date, progress notes refusals, EMH refusals, order note refusals, and if it was care planned.</p> <p>Record review of the facility's POR verification binder revealed on the 24-Hour Report daily monitoring sheets revealed on the first row was handwritten 06/29/24 no refusals (i.e., no refusal of care/medications/assessments). On the second row was handwritten a resident's name, date of 06/30/24, notation the resident refused a medication, it was care planned the resident would refuse the medication, and the physician was informed.</p> <p>Record review of the facility's POR verification binder revealed there were daily, weekly, and monthly monitoring sheets for reviews of the E-Interact Change of Condition Assessment. The E-Interact Change of Condition Assessment monitoring form had columns for the resident's name, date, notification to family, notification to the physician, notification of refusal of treatment, notification of refusal of meds, and if it was care planned.</p> <p>Record review of the Daily E-Interact Change of Condition Assessment form revealed residents who had a change of condition on 06/28/24 and 06/29/24 were listed, all the resident's physicians and RP's were notified and none of the residents refused care or assessments.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Record review of the facility's POR verification binder revealed there were daily, weekly, and monthly monitoring sheets for Neurological Checks audits. The Neurological Checks monitoring form had columns for the resident's name, date, notification to family, notification to the physician, refusals of vital signs, notification of neurological assessments, and if it was care planned.</p> <p>Record review of the Order Listing Report, dated 06/29/24, revealed there was only 1 resident with orders for neurological checks to be completed in a 24-hour period.</p> <p>In an interview on 06/29/24 at 4:20 PM, the DON stated there was 1 resident who had orders for neurological checks and there was another resident who had a fall on 06/28/24 that neurological checks were being done on. Both residents were listed on the Daily Neurological Checks monitoring sheet.</p> <p>Record review of the Daily Neurological Checks monitoring sheet revealed 2 residents were listed on 06/28/24 for neurological checks, their physician's and RP's were notified, and the residents did not refuse the assessment. On 06/29/24 there were no residents with orders for neurological checks.</p> <p>Record review of an In-Service Education Attendance Record, dated 06/28/24, revealed an ad hoc QAPI meeting was held at 6 PM to discuss assessment documentation and all assessments were not being completed as ordered could result in residents not receiving the necessary care resulting in a decline in their health or even death. The meeting was conducted by the Administrator and in attendance were the Medical Director, the Activity Director, the ADON, the DON, the BOM, the dietitian, and the housekeeping director.</p> <p>An Immediate Jeopardy was identified on 6/29/2024 . The IJ template was provided to the facility on [DATE] . While the IJ was removed on 6/30/2024, the facility remained out of compliance at a scope of pattern and a severity level lowered to no actual harm that is not Immediate Jeopardy due to the facility's need to monitor and evaluate the effectiveness of the corrective actions.</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on observations, interviews, and record reviews the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each Resident, for 1 of 7 residents (Resident #170) reviewed for pharmacy services.</p> <p>LVN U dispensed Resident #170's medications (11 pills) and stored them in a small pill cup in the medication cart with the intention of administering the medications at a later time and continued to dispense and administer medications for other residents.</p> <p>This failure could place residents at risk for harm by medication administration errors.</p> <p>The findings included:</p> <p>A record review of Resident #170's admission record dated 06/07/2024 revealed an admitted [DATE] with diagnoses which included hypertension (high blood pressure), diabetes type II (a condition where the body's cells cannot readily accept sugars from the blood), hyperlipidemia (a condition where the blood too much fat (lipids)).</p> <p>A record review of Resident #170's admission MDS assessment dated [DATE] revealed Resident #170 was a [AGE] year-old male assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment.</p> <p>A record review of Resident #170's physicians' orders dated 06/07/2024, revealed Resident #170 was prescribed the following medications to be administered daily at 08:00 AM:</p> <ol style="list-style-type: none"> 1. Amlodipine 5mg (used to trat high blood pressure). 2. Aspirin 81mg (used to prevent heart attacks). 3. Fish oil capsule 1000mg (used for dietary supplement). 4. Lisinopril 40mg (used to treat high blood pressure). 5. Multivitamin (used for a dietary supplement). 6. Sertraline 100mg (used to treat depression). 7. Vitamin C (used as a dietary supplement). 8. Donepezil 10mg (used to treat dementia (a general decline in cognitive abilities that affects a person's ability to perform everyday activities)). 9. Gabapentin 600mg (used to treat nerve pain). <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>10. Hydralazine 50mg (used to treat high blood pressure).</p> <p>11. Sennosides-Docusate Sodium 8.6-50mg (used to treat constipation).</p> <p>During an observation and interview on 06/07/2024 at 08:12 AM revealed LVN U attended her medication cart and was preparing medications for another Resident. Observations of LVN U opening drawers of the medication cart revealed the top drawer had a small clear plastic cup with pills. LVN U stated the cup contained Resident #170's morning medications. LVN U stated she had dispensed Resident #170's medications and attempted to administer Resident #170 his medications and was unable to do so due to Resident #170 was not available and was in the shower. LVN U stated she had stored the loose pills in their pill cup for a later attempt to administer. LVN U stated she then proceeded to dispense and administer medications to other residents.</p> <p>During an observation and interview on 06/07/2024 at 08:20 AM revealed the DON approach the medication cart and inquire of LVN U here status on medication administration and the surveyor reported to the DON that LVN U had Resident #170's medications in a pill cup. The DON inquired of LVN U the nature of the pills in the cup and LVN U reported the pills were dispensed for Resident #170 however Resident #170 was in the shower. The DON stated LVN U should have disposed the medications and would need to re-dispense the medications when Resident #170 became available.</p> <p>During an interview on 06/07/2024 at 0859 AM the DON stated medications should be dispensed and administered prior to dispensing and administering medications for the next Resident.</p> <p>A record review of the facility's policy titled Storage of Medications dated April 2009, revealed, Policy Interpretation and Implementation: Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they were received. Only the issuing pharmacy is authorized to transfer medications between containers. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner</p> <p>A record review of the American Association of Post-Acute Care Nursing's website: Resident Safety and Nurse Workarounds - AAPACN accessed 06/11/2024, titled, Resident Safety and Nurse Workarounds, revealed, Nurse workarounds defined .Nurse workarounds are actions that nurses take to deliver care and accomplish the work assigned to them, despite those actions' deviating from protocol and policy . workarounds occur in SNFs (Skilled Nursing Facility's) .For example, a nurse who pops medication from a multi-dose card and pre-pours pills or places them in medication cups to be administered later, for one or more residents, does not intend to cause harm. Nurses do this so they can dispense medications quickly, saving precious time and allowing them to move on to the next task they must complete. But the intended time-saver exposes patients to the risk of harm. While an error probably will not occur every time a workaround is used, when one does occur, the harm is likely to be significant</p> | | |

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| <p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure a therapeutic diet was prescribed by the attending physician for 1 of 8 residents (Resident #6) reviewed for food and nutrition services.</p> <p>The facility failed to ensure Resident #6 had a physician's order for a pureed diet with nectar thickened liquids. The resident was prescribed a pureed diet with thin liquids and was provided a pureed diet with nectar thickened liquids.</p> <p>This deficient practice could place residents who are provided a modified texture diet at risk poor intake, and weight loss and diminished quality of life.</p> <p>The findings were:</p> <p>Record review of Resident #6's admission record, accessed 06/07/24, revealed the resident was admitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing food or liquid) following cerebral infarction (a type of stroke caused by impaired blood flow to the brain) and mild protein-calorie malnutrition.</p> <p>Record review of Resident #6's significant change in status MDS, dated [DATE], reflected a BIMS score of 99, indicating resident was unable to complete the interview. Further review of this MDS reflected Resident #6's cognitive skills for daily decision making was severely impaired with short term and long-term memory problems. Resident #6's MDS assessment further revealed resident was on a mechanically altered diet-require change in texture of food or liquids while a resident.</p> <p>Record review of Resident #6's physician's orders for May 2024 revealed the following diet order: Special Diet: REGULAR diet Consistency: PUREED texture, Liquid: THIN consistency with an order date of 04/01/2024.</p> <p>Record review of Resident #6's comprehensive person-centered care plan, undated, revealed the following focus area: [Resident #6] has swallowing problems r/t cerebral infarction, dysphagia with interventions to include Special diet: REGULAR diet, Consistency: PUREED texture, Liquid: THIN consistency, initiated 04/01/2024.</p> <p>Record Review of Resident #6's weight loss history revealed no weight loss since 04/01/2024.</p> <p>During an interview on 06/04/24 at 12:10 PM and record review of Resident #6's lunch meal ticket revealed it stated: DIET: Pureed, *Regular, Nectar, Resident #6's RP 1 revealed there was a nectar thickener packet on Resident #6's lunch meal tray and they had to add it to the V8 to make it nectar thickened. Resident #6's RP 1 further revealed she was unaware of the nursing staff thickened the liquids, because it has been their job to thicken the liquids for their mom.</p> <p>(continued on next page)</p> | | |

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| <p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 06/04/24 at 12:19 PM, LVN U revealed Resident #6 should have nectar thickened liquids, according to her meal tray ticket. He further revealed the kitchen was supposed to thicken her fluids to be nectar thickened.</p> <p>During an interview on 06/05/24 at 10:33 AM, Resident #6's RP 2 revealed the family comes to lunch with Resident #6 and had to thicken Resident #6's liquids to nectar consistency. This family member was able to describe the process of thickening Resident #6's liquids. It was later observed that Resident #6 received a nectar thickening packet on her 06/05/24 lunch meal tray ticket to thicken the liquids on her tray ticket.</p> <p>During a combined interview on 06/06/24 at 10:52 AM, the RD revealed Resident #6's family requested for Resident #6 to have nectar thickened liquids. She further revealed she was allowed to downgrade diets from thin to nectar thickened liquids on Point Click Care and meal tray cards. The CDM revealed the kitchen did not thicken liquids to the nectar consistency, because by the time they would get to the resident, the liquids that were thickened in the kitchen would be too thickened and hard to drink. The CDM further revealed the trays that need to have liquids thickened to nectar consistency were sent with packets of thickening agents for the nursing staff to add to liquid when they put the residents' trays down. They both revealed residents needed to have the right consistency as a safety precaution to prevent adverse reactions such as coughing or choking.</p> <p>Record review of the facility's policy Thickened liquids, revised 1/24, reflected the following:</p> <p>Thickened liquids will be available for those who have difficulty swallowing thin liquids. Liquids will be thickened to the degree specified in the physician or designee's orders.</p> <p>Physician/designee orders thickened liquids in medical record.</p> <p>Food and Nutrition Department ensures resident nutrition profile is updated with thickened liquid order and provides thickened liquids per community approved diets.</p> <p>Record review of the facility's policy, Physician delegated diet and nutrition orders, revised 01/24, reflected A resident's attending physician may delegate the task of writing diet orders to a qualified dietitian .</p> | | |

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| <p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>26869</p> <p>Based on interview, and record review, the facility failed to ensure there were no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack was served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span for 3 of 9 residents (confidential residents in group) reviewed for frequency of meals.</p> <p>The facility failed to ensure residents were offered snacks at bedtimes as required due to mealtimes being more than 14 hours apart.</p> <p>This failure could affect all residents who received meals served from the facility's only kitchen by placing residents at risk for, unplanned weight loss, and side effects from medication given without food, and diminished quality of life.</p> <p>Findings included:</p> <p>Record review of the resident snack list (undated), was provided by the DM. There were 4 residents that received three times a day, to include HS snacks. The snack list provided by the DM were residents that had dialysis. There was no resident list with HS snacks provided.</p> <p>Record review of the resident roster dated 6/4/2024 reflected a census of 79 residents.</p> <p>Record review of the posted Meal Service Times in the dining room revealed the following:</p> <p>Breakfast - 7:20 -8:00 AM</p> <p>Lunch - 11:35-12:00 AM</p> <p>Evening meal - 4:20 -5:00 PM- There is no posting to advise any resident a snack or availability of type of snack after specified times.</p> <p>During interview on 6/6/2024 at 1: 00 PM with residents in group of 9 residents, it was brought to the attention of the state surveyors that they have not been made aware of options of a snack which were available to residents. Residents said they were not offered any HS snacks by staff.</p> <p>During interview on 6/6/2024 at 2:29 PM with Restorative Aide/CNA R stated she worked (7-3:30pm) stated there was a snack box in the nursing station refrigerator.</p> <p>During interview on 6/6/2024 at 4:17 PM with LVN Q stated she worked 6AM-6PM. LVN Q stated resident came to staff if they wanted some snacks, such as cookies, chips, sandwiches. LVN Q stated the diabetic resident were able to have snacks for the nursing refrigerator that were low in sugar.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Morningside Manor | | STREET ADDRESS, CITY, STATE, ZIP CODE 602 Babcock Rd San Antonio, TX 78201 | |

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| <p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During interview on 6/06/2024 at 6:15 PM with CNA S stated she worked for 31 yrs., on the 6PM-6AM shift. CNA S stated she provided HS snacks to residents if they asked her. CNA S stated she did not go around and offer residents a snack.</p> <p>During interview on 6/6/2024 at 6:29 PM CNA T stated she worked for 1 year at the in facility. CNA T stated there were resident snacks in the refrigerator behind the nurse's station . CNA T stated she had not offered HS snacks to every resident, only if residents asked her.</p> <p>During interview on 6/6/2024 at 6:33 PM the CDM, director of culinary services, stated she only had a dialysis snack list. CDM stated no other snacks go out from the kitchen.</p> <p>During interview on 6/6/2024 at 6:35 PM with the DM stated they place resident snacks in the nursing station refrigerator.</p> <p>During interview on 6/7/2024 at 11:32 AM with the ADM stated snacks were offered at bedtime to residents, nursing department and anytime a resident request a snack. The ADM stated the bedtime snacks were offered after dinner. The ADM stated if resident were not offered snacks, resident will be hungry and diabetic residents could have an effect on their blood sugars. The ADM stated resident can ask for snacks and nursing department can provided snacks. The ADM stated the Activities department had snacks when they have functions throughout the day. No other response.</p> <p>Record Review of the Facility Policies and Procedures for Resident Food Services dated 5/95 revealed, SNACKS- Procedures: Nursing offers bedtime snacks.</p> |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48366</p> <p>Based on observations, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation.</p> <ol style="list-style-type: none"> 1. There were approximately 5 boxes that appeared to be less than 18 inches from the ceiling, in the walk-in fridge. 2. There was a chocolate pie that was not fully covered in the walk-in fridge. <p>These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <p>During observations and an interview in the initial tour of the kitchen with the CDM on 06/04/24 at 09:02 AM, there were approximately 5 cardboard boxes filled with various food products that appeared to be less than 18 inches from the ceiling, in the walk-in refrigerator. It was also observed there were 2 chocolate pies that were not completely wrapped, and their pie crusts were exposed. The CDM revealed the boxes should not be stored this close to the ceiling and the chocolate pies will be thrown away because she would not be able to serve these food products now. The CDM was not able to identify who could have done this, but the staff were trained on covering food products appropriately for storage and items should be stored more than 18 inches away from the ceiling.</p> <p>Record review of the facility's policy Food storage, revised 02/23/24, reflected All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption., Cover label and date unused portions and open packages., and Store items 6 inches above the floor and 18 inches below sprinklers.</p> |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 26869</p> <p>Based on interview and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 2 of 17 (Residents #25 and #57) residents in that:</p> <ol style="list-style-type: none"> 1. Resident #25 did not have an order or care plan for diabetic shoes in her record. 2. Resident #57 did not have an order or care plan for diabetic shoes in her record. <p>This failure could result in assessments not being completed as ordered could result in residents' not receiving the necessary care resulting in a decline in health and or death. This could affect all resident with assistive devices and could result in no orders for resident care.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #25's Admission Record dated 6/7/2024 revealed the resident was admitted on [DATE], readmitted on [DATE] with diagnosis of Diabetes II. <p>Record review of Resident #25's consolidated physician orders for June 2024 revealed no order in her record for diabetic shoes.</p> <p>Record review of Resident #25's Quarterly MDS dated [DATE] revealed she had a BIMS score of 12/15 (cognitively intact) and diagnosis of Diabetes Mellitus.</p> <p>Record review of Resident #25's Care Plan dated 6/5/2024 revealed she had a diagnosis of diabetes mellites, risk of complications. There was no care plan for diabetic shoes.</p> <p>Record review of Resident #25's comfort feet assessment revealed she had a history of poor circulation. This was signed by physician dated on 4/12/2024.</p> <ol style="list-style-type: none"> 2. Record review of Resident #57's Admission Record dated 6/7/2024, age 101 revealed he had a diagnosis of diabetes II, need for assistance with personal care, and history of falls. <p>Record review of Resident #25's consolidated physician orders for June 2024 revealed no order in her record for diabetic shoes.</p> <p>Record review of Resident #57's Quarterly MDS dated [DATE] revealed her BIMS score was 6/15 (severe cognitive impairment) and was diabetic.</p> <p>Record review of Resident #57's care plan dated 6/3/2024 revealed the resident has diabetes mellitus, risk for complications. There was no care plan for diabetic shoes.</p> <p>Record review of Resident #57's comfort feet assessment revealed she had a history of poor circulation and history of pre-ulcerative callus. This was signed by physician dated on 4/12/2024.</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 - Few</p> | <p>Interview on 6/5/2024 at 11:33 AM with Resident #25, she stated, and Resident #57 had been waiting in their diabetic shoes and not sure they were coming.</p> <p>Interview on 6/05/24 at 3:32 PM Resident #57 said she had not received her diabetic shoes and it's been about 2-3 weeks.</p> <p>Interview on 6/6/2024 at 3:44 PM with Social Worker (SW) stated she had a company come into the facility, stating they were giving residents with diabetes free shoes. The SW stated she had residents interested in the diabetic shoes and made an order and will be delivered tomorrow.</p> <p>Interview on 6/7/2024 at 4:30 PM with the DON, she stated she was not aware residents were getting diabetic shoes delivered today. The DON expected the physician to know, have an order and care plan.</p> <p>Interview on 6/7/2024 at 4:23 PM the ADM stated the shoe company came in and was offering free diabetic shoes to residents. The ADM stated she was not aware that residents were going to have diabetic shoes delivered today.</p> <p>Interview on 6/7/2024 at 4:28 PM the ADM stated the SW did not bring up that the shoe company had assessed and ordered diabetic shoes for residents. The ADM stated she will find a policy.</p> <p>Interview on 6/7/2024 at 4:35 PM with shoes representative stated he had a list resident who were diabetic from the facility. The shoes representative stated they completed an assessment that included to measure residents' feet and if the residents' met criteria, they will send the prescription and will get the orders signed by the physician. The shoe representative stated then they would order the shoes for residents. Once the diabetic shoes were ready, they would deliver the diabetic shoes to the residents. The diabetic shoe company delivered 10 resident's shoes today, 6/7/2024. The shoe representative stated they had 4 more residents that needed approval from insurance.</p> <p>Interview on 6/7/2024 at 4:39 PM with the ADM stated she was not sure why the diabetic shoe company had the original physician orders for the diabetic shoes. ADM stated the orders for the Diabetic shoed for Resident #25 and #57 and should be in resident chart. The ADM stated the SW never discussed in morning meetings or with ADM, that residents had ordered the diabetic shoes from the comfort shoes.</p> <p>Interview on 6/7/2024 at 5:03 PM the ADM/DON stated Resident #57 and Resident #25 did not have orders for diabetic shoes in the facility records. The DON/ADM were not aware that residents #25 and #57 were getting diabetic shoes, today.</p> <p>Interview on 6/9/2024 at 1:06 PM with ADM and DON stated they did not have a policy on diabetic shoes/DME/resident devices.</p> | | |