STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 3 residents (Resident #2) reviewed for pharmacy services. The facility failed to ensure Resident #2's medication reconciliation log for the Schedule II medication (substances with a high potential for abuse, with use potentially leading to severe psychological or physical dependence) Hydromorphone accurately reflected the number of doses administered. This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain, and a decreased quality of life. The findings included: Record review of the facility provider investigation report written by the facility administrator dated 3/19/25, documented there were incomplete signatures on a residents narcotic log. The report further documented while RN D was counting narcotics with RN E a medication Hydromorphone 1 mg/ml, there was an approximately 18 ml discrepancy on the count. Further review of the provider investigation report documented RN D noted RN E looked at the system and started filling out the narcotic sheet and signed the dosages and left few blank spaces and instructed him to notify some nurses to sign on the blank spaces. Record review of Resident #2's admission sheet dated 5/14/25 documented a [AGE] year-old female originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included cerebral infarction (when blood flow to a part of the brain is obstructed, typically by a blood clot), high blood pressure, epilepsy (seizure disorder), and high cholesterol. Record review of Resident #2's most recent quarterly MDS assessment dated [DATE] documented the resident was severely cognitively impaired for daily decision-making skills and had received scheduled pain medication regimen in the last five days. Record review of Resident #2's comprehensive care plan dated 4/3/25 documented the resident received pain medication related to muscle spasms and had potential for altered comfort related to generalized pain with interventions that included to administer analgesic medications as ordered by physician, observe/document/report adverse reactions to analgesic therapy, and review for medication efficacy. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's MAR (Medication Administration Record) for February 2025 included the following: -Hydromorphone HCl Oral Liquid 1MG/ML, give 1mL by mouth every 4 hours as needed for severe pain. Further review of the MAR noted the resident received one dose on 2/1/25 at 8:15 AM and one dose on 2/2/25 at 9:32 AM each administered by RN E. Record review of Resident #2's MAR for March 2025 included the following: -Hydromorphone HCl Oral Liquid 1MG/ML, give 1mL by mouth every 4 hours as needed for severe pain. Further review of the MAR noted the resident received one dose administered by LVN F on 3/4/25 at 9:47 AM. Record review of Resident #2's narcotic reconciliation log for Hydromorphone noted a remaining balance of 83mLs of medication after a 1mL dose was administered and signed out by LVN F on 3/4/25 on the reconciliation log and documented on the March MAR. Further review of the reconciliation log and the March MAR noted ten 1mL doses of Hydromorphone were administered and signed out by RN E on the reconciliation log (five doses from 3/4/25 to 3/6/25 and five doses from 3/10/25 to 3/11/25) but were not documented on the March MAR. Further review of the reconciliation log and the March MAR noted eight 1mL doses were administered but not signed out on the reconciliation log or documented on the March MAR from 3/7/25 to 3/9/25. During an interview on 5/15/25 at 10:59 AM, RN D stated RN E was the outgoing nurse he received the medication cart from on the day of the Hydromorphone discrepancy. RN D stated he was hesitant to receive control of the medication cart from RN E because of the discrepancy of the count. RN D stated RN E began to sign for some of the missing doses of Hydromorphone on the reconciliation log and then handed off the cart to RN D. RN D stated RN E told him LVN F administered some of the doses to Resident #2 and forgot to sign them out of the log. RN D stated RN E asked him to ask other nurses if they were going to come the next morning to sign the remaining empty spaces on the log. RN D stated when he asked LVN F if he gave the doses of Hydromorphone to Resident #2 and forgot to sign the log, LVN F told him he did not give the doses. RN D stated LVN F told the managers about the discrepancy. During an interview on 5/15/25 at 3:25 PM, LVN F stated there were 84mLs of medication in the Hydromorphone bottle before he gave a dose to Resident #2 on 3/4/25. LVN F stated RN D relayed a message to him that RN E wanted him to sign off on the empty spaces on the reconciliation log for Resident #2's Hydromorphone to make the count right. LVN F stated he looked at the log and saw that RN E had initialed several dates on the log and had left several dates blank for LVN F to initial. LVN F stated the bottle of Hydromorphone contained 65mLs of medication when he received control of the cart from RN D. LVN F stated, Resident #2 did not take the Hydromorphone very often and that it looked suspicious to him that so much was missing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 4:30 PM, the Administrator stated RN D was counting Resident #2's Hydromorphone with RN E during shift change and there was a discrepancy between the amount of medication in the bottle and the amount signed out on the control reconciliation log. The Administrator stated RN E started signing out doses on the blank spaces of the log. The Administrator stated RN E instructed RN D to tell LVN F to initial on the remaining blank spaces to fix the discrepancy. The Administrator stated when RN D told LVN F that RN E wanted him to sign off on the remaining blank spaces, LVN F refused. The Administrator stated LVN F reported the discrepancy to the managers. The Administrator stated as soon as the discrepancy was reported, they printed the March MAR to verify the administration of the Hydromorphone. The Administrator stated she did not see any documentation on the March MAR that the Hydromorphone had been administered to Resident #2 after the dose given by LVN F on 3/4/25. The Administrator stated she started an investigation and had staff who worked in the unit undergo drug testing. The Administrator stated RN E admitted she had initialed several blank spaces on the Hydromorphone reconciliation log and had asked RN D to ask LVN F to do the same. The Administrator stated when she asked RN E why she would sign out doses of Hydromorphone that were not given, RN E insisted they had given the medication but did not sign it out on the log. The Administrator stated RN E said she knew it was wrong to sign off on the blank spaces of the reconciliation log. The Administrator stated the drug screen test was negative for RN E, but RN E was terminated based on falsification of the reconciliation log. The Administrator stated education was given on timely reporting of any discrepancy and reporting suspicious behavior. The Administrator stated she reported the discrepancy to the corporate resource department and to the Medical Director. The Administrator stated her expectation for nurses and medication aides was that they sign the reconciliation log immediately after administering a dose of a controlled medication. The Administrator stated the ADONs were supposed to be checking the integrity of the medication carts at a minimum of once or twice a week, and that medication aides and nurses should be checking the accuracy of the reconciliation logs every shift. Record review of the facility policy titled Documentation of Medication Administration, dated Quarter 3, 2024, noted Administration of medication must be documented immediately after it is given. Record review of the facility policy titled Controlled Substances, dated Quarter 3, 2018, noted Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain resident medical records that were complete and accurately documented for 1 of 2 residents (Resident #1) reviewed for clinical records. Resident #1 was administered supplemental oxygen via nasal cannula, Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) without a physician's order. These failures could place residents at risk of not having accurate medical records and could create confusion in services provided or needed to be provided. Findings included: Record review of Resident #1's face sheet, dated 05/13/2025, indicated Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including cellulitis (a bacterial skin infection that can cause pain, redness, swelling, and warmth in the affected area), peripheral vascular disease (a condition that affects the blood vessels outside the heart and brain), congestive heart failure (a condition where the heart muscle is unable to pump blood effectively enough to meet the body's needs), Type II diabetes (a chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels) and morbid severe obesity with alveolar hypoventilation (a condition characterized by severe obesity and a condition whereby the lungs do not adequately remove carbon dioxide from the blood). Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 15 indicating the resident's cognition was intact. Record review of Resident #1's Baseline Care Plan dated 05/02/2025 indicated under section 3. Vitals, 7. Most Recent 02 sats: 79.0%, Method: BiPAP. Record review of Resident #1's TAR revealed supplemental oxygen, a CPAP or BiPAP were not listed as treatments on the TAR. Record review of Resident #1's consolidated physician orders as of 05/13/2025 revealed there were no orders for supplemental oxygen via an oxygen concentrator, a CPAP or BiPAP machine. Record review of Resident #1's hospital discharge orders dated 05/02/2025 revealed the resident was receiving supplemental oxygen at a rate of 2 L/min and a CPAP while sleeping to treat his morbid obesity with hypoventilation. Record review of Resident #1's progress notes in his electronic health record revealed a nursing progress note dated 05/04/2025 at 4:15 AM by RN C indicating Resident #1's oxygen status fluctuated between 95% - 88% during movement on BiPAP and oxygen via nasal cannula at 3-4 L/min. A nursing progress note dated 05/04/2025 at 11:22 AM by RN B indicated Resident #1 used a CPAP at night or when sleeping and received oxygen via nasal cannula at 5 L/min. A nursing progress note dated 05/09/2025 at 3:53 PM by LVN A indicated Resident #1 received oxygen via nasal cannula at 3 L/min and used a CPAP at night or when sleeping. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/2025 at 2:41 PM, LVN A stated she went by the doctor's orders to determine what the resident was supposed to receive, and sometimes residents tell the nurses what they were supposed to get. If there wasn't a doctor's order, she would call the doctor to get an order and put the order in the resident orders section of the resident's electronic health record for approval by the resident's physician. The lack of an order for oxygen for Resident #1 must have been overlooked. LVN A did not know why it was overlooked. During an interview on 05/15/2025 at 3:11 PM, RN B stated Resident #1 had an oxygen concentrator with a CPAP machine in his room. The oxygen concentrator was set at 5 L/min. When she admitted residents, she verified orders that came with the residents. If there wasn't an order, she called the doctor to obtain an order. Typically, the doctor would order oxygen at a rate of 2-4 L/min to allow for fluctuations and the order would be put into the resident's electronic health record as a physician's order. RN B assumed the nurse got an order for a higher level of oxygen because the hospital did not keep him overnight and she was informed he was a higher L/min level. During an interview on 05/14/2025 at 4:30 PM, the DON stated Resident #1 admitted to the facility on supplemental oxygen 05/02/2025 from the hospital. The facility's nurses reported their findings to the physician, the physician gave verbal orders, and the nurses transcribed the orders in the resident's progress notes. At that point they needed to transcribe the orders into the resident's orders, especially if they were verbal orders, and failed to do so. He did not know why they had not properly transcribed the verbal orders, but it was important for verbal orders to be properly transcribed and signed by the physician. During an interview on 05/14/2025 at 4:35PM, the Administrator stated it appeared the staff missed getting the physician's orders for supplemental oxygen and use of a CPAP machine into the resident's consolidated physician's orders and having the orders signed by the physician. Record review of facility policy Telephone Orders revised February 2014 revealed, I. Verbal telephone orders may only be received by licensed personnel (e.g., RN, LPN/LVN, pharmacist, physician, etc.). Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. 2. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. 3. Telephone orders must be countersigned by the physician during his or her next visit. Record review of facility policy Verbal Orders revised February 2014 revealed, 4. The individual receiving the verbal order must write it on the physician's order sheet as v.o. (verbal order) or t.o. (telephone order). 5. The individual receiving the verbal order will: a. Read the order back to the practitioner to ensure that the information is clearly understood and correctly transcribed; b. Record the ordering practitioner's last name and his or her credentials (MD, NP, PA, etc.); and c. Record the date and time of the order. 6. The practitioner will review and countersign verbal orders during his or her next visit.