

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER San Pedro Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 515 W Ashby Pl 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)
<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** 34469</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to ensure the accurate administration of medications for 1 of 4 residents (Resident #1) reviewed for medication administration.</p> <p>The facility failed to ensure Resident #1 received his scheduled Alprazolam Oral Tablet .5 MG in accordance with his physician's orders.</p> <p>This failure could place residents at risk of not receiving the therapeutic benefits of their medications.</p> <p>Findings included:</p> <p>Record review of Resident #1's electronic face sheet, not dated, indicated Resident #1 was a [AGE] year-old male originally admitted on [DATE]. Resident #1's diagnoses included: Quadriplegia, muscle weakness, myocardial infarction, schizoaffective disorder, psychotic disorder, major depress, pain, and anxiety.</p> <p>Record review of a significant change MDS assessment dated [DATE] indicated Resident #1 had a BIMS score of 14, which indicated Resident #1 was cognitively intact. Further review revealed Resident #1 had a PHQ9 Score of 8 which indicated a depression severity of mild.</p> <p>Record review of a care plan dated 1/2/2024, stated, (Resident #1) is at risk for impaired cognitive function/dementia or impaired thought processes r/t major depressive disorder with psychosis, anxiety, depression. Interventions included, Administer medications as ordered.</p> <p>Record review of physician order dated 2/12/2024, stated, ALPRAZolam Oral Tablet 0.5 MG - Give 1 tablet by mouth every 8 hours for anxiety.</p> <p>Record review of MAR/TAR dated 3/2024 revealed, ALPRAZolam Oral Tablet 0.5 MG - Give 1 tablet by mouth every 8 hours for anxiety, had an 2 (Hold/See Nurses Notes) entered for dose on 3/21/2024 for scheduled administration at 2:00 PM.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of MAR/TAR dated 3/2024 revealed, ALPRAZolam Oral Tablet 0.5 MG - Give 1 tablet by mouth every 8 hours for anxiety, had an H entered (On hold by physician) for dose on 3/22/2024 for scheduled administration at 6:00 AM.</p> <p>Record review of MAR/TAR dated 3/2024 revealed, ALPRAZolam Oral Tablet 0.5 MG - Give 1 tablet by mouth every 8 hours for anxiety, had an H' entered (On hold by physician) for doses on 3/22/2024 for scheduled administration at 2:00 PM.</p> <p>Record review of Resident #1's progress note for 3/21/2024 at 10:30 PM, drafted by LVN, A, stated, Patient pending medication to be delivered and advised on call placed to hospice in effort to obtain as required. Patient states understanding. Continuous monitoring in place for delivery.</p> <p>Record review of Resident #1's progress note for 3/22/2024 at 2:14 PM, drafted by LVN B, stated, Pending delivery of medication from hospice. Spoke to social worker from hospice who stated he would relay the message to nurse. Med on hold until delivered. Will resume once received.</p> <p>Observation and interview on 3/27/2024 at 2:52 PM, Resident #1 was observed in a shower chair pending a shower. During an interview at this time, Resident #1 was pleasant and denied experiencing pain at the time. Resident #1 mentioned that he had several missed doses of his prescribed ALPRAZolam several days prior. Resident #1 was asked if he knew why this occurred and responded, I'm not sure if hospice messed up or the facility. When asked how Resident #1 felt during as a result of his missed doses, he responded, I sort of felt crazy.</p> <p>Interview on 4/1/2024 at 10:55 AM, LVN A (Treatment Nurse), said Resident #1 was very pleasant and seemed to have been adapting more over time. She said her and the resident had a good relationship and he was on hospice services. LVN A said the Resident #1 frequently refused wound care at times and had some weight loss lately due to refusal to eat at times but said she would document when that occurred and would also inform the other nurses. LVN A said Resident #1 was good at asking for assistance and when he needed to have his needs met. LVN A said Resident #1 was very alert and oriented. When asked if Resident #1 ran out of medication recently, LVN A said staff had been calling Resident #1's hospice provider to refill the medications. She said staff usually contact the hospice provider to ensure meds are ordered 5 days before running out and said staff were attempting to contact the hospice provider but were unsuccessful. LVN A said it would be a concern if Resident #1 was without both his anti-anxiety medications for an extended period of time because he depended on the medication for a significant amount of time. LVN A stated Resident #1 went several days without the medications but was unsure how long. When asked if she had noticed a change in Resident #1's behaviors when he ran out of medication, LVN A responded that she did not and denied ever hearing the LVN A express suicidal ideations. LVN A said Resident #1 only asked about his medication one time to follow up on the status of his medications and said she and Resident #1's charge nurses were following up with the resident during that time. When asked if the facility had a backup plan in anticipation of residents running out of controlled medications, such as an eket, LVN A said the facility had a machine which was stocked with multiple medications including narcotics but said she did not pass medications and did not have access to the machine. LVN A stated that if Resident #1 were to run out of medications, staff should be able to access the machine to administer the needed medications until they are filled. When asked if LVN A knew why staff did not access this machine to administer Resident #1's prescribed medications, LVN A replied, no sir, I don't know.</p> <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>Interview and record review on 4/1/2024 at 12:51 PM, the DON agreed Resident #1 did not receive his scheduled Alprazolam Oral Tablet .5 MG on 3/21/2024 at 2:00 PM, 3/22/2024 at 6:00 AM, and 3/22/2024 at 2:00 PM.</p> <p>Telephone interview on 4/2/2024 at 8:11 AM, RN C confirmed Resident #1 had missed several doses of his prescribed Alprazolam Oral Tablet .5 MG on 3/21/2024 and 3/22/2024. RN C said Resident #1 was upset about missing his medications but said the resident did not appear anxious during that time but said Resident #1 felt like facility staff had done this on purpose.</p> <p>Telephone interview on 4/2/2024 at 11:15 AM, Hospice Nurse D said her agency had no record of facility staff notifying their agency to fill a prescription of ALPRAZolam prior to Resident #1 running out. Hospice Nurse D confirmed the ALPRAZolam was delivered to the facility on [DATE] and said it was the facility's responsibility to ensure Resident #1 received his ordered doses even if/when he ran out.</p> <p>Record review of facility policy, Nursing Clinical - Administration of Drugs, (not dated), stated, It is the policy of this facility that medications shall be administered as prescribed by the attending physician.</p>		