STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455742	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev at San Antonio	7703 Briaridge Drive San Antonio, TX 78230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on interview and record review, the facility failed to ensure MDS assessments accurately reflected the resident's status for 1 of 14 Residents (Resident #1) whose MDS records were reviewed for accuracy. Resident #1's quarterly MDS assessment, dated 05/08/2024, reflected Resident #1 did not have physical behavioral symptoms directed toward others such as hitting, kicking, pushing, grabbing, and/or abusing others sexually. However, Resident #1's nursing note, dated on 05/03/24, indicated Resident #1 hit another resident's left arm on hallway 300. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #1's electronic face sheet, dated 08/08/2024, reflected the resident was admitted to the facility on [DATE]. Resident #1's diagnoses included: end stage renal disease (the kidneys lose the ability to remove waste and balance fluids), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), schizoaffective disorder (mental disorder with mood disorder such as depression), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of Resident #1's quarterly MDS assessment with an ARD of 05/08/2024 reflected the resident scored an 13/15 on her BIMS which signified the resident was cognitively intact, and E0200 Behavioral symptom was code 0 (behavior not exhibited) to the question of presence of symptoms and their frequency for physical behavioral symptoms directed toward others such as hitting, kicking, pushing, grabbing, and/or abusing others sexually. Record review of Resident #1's comprehensive care plan, revised on 05/03/2024, reflected [Resident #1] is aggressive as evidence by yelling out at staff or other resident related to ineffective coping skills, poor impulse control, and intervention: Administer medications as needed, assess and anticipate resident's needs, give the resident as many choices as possible, and psychiatric consult as indicated. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Nurses Note, dated 05/03/2024, reflected [Resident #1] was observed hitting another resident to her left arm on the hallway. [Resident #1] was separated from each another. Incident reported to the administrator. Head to toe assessment performed, no injury noted at this time, [Resident #1] agreed of hitting resident and stated I know I was not supposed to hit her [Resident #1] is placed on 24 hours watched. Interview on 08/08/2024 at 2:12 p.m. Resident #1 stated she was feeling safe in the facility. Resident #1 refused further interview. Interview on 08/08/2024 at 3:13 p.m. with the Social Worker who stated Resident #1 hit another resident's left arm on 05/03/2024 on the 300 hallway. The social worker coded 0 (behavior not exhibited) to the question of presence of symptoms and their frequency for physical behavioral symptoms directed toward others such as hitting, kicking, pushing, grabbing, and/or abusing others sexually to Resident #1's quarterly MDS dated [DATE] because the social worker thought this incident was isolated because Resident #1 had only this incident since the resident was admitted . Further interview with the social worker stated she should have coded 1 (behavior of this type occurred 1 to 3 days) because Resident #1 hit another resident's left arm on 05/03/2024 she stated, It was mistake. Interview on 08/08/2024 at 2:22 p.m. with the MDS nurse LVN A stated LVN A had final responsibility for MDS assessment of Resident #1 even though the social worker had responsibility coding to Resident #1's MDS section E Behavior. Because Resident #1 had one episode of physical aggressive behavior directed toward others on 05/03/2024, it should have been coded as 1 (behavior of this type occurred 1 to 3 days). The MDS was inaccurate. Further interview with the MDS nurse LVN A stated the potential harm was because of inaccurate MDS, the facility might miss Resident #1's pattern of the physical aggressive behaviors, and it could result in inaccurate care to the resident. Record review of the facility policy, titled MDS 3.0 Completion, undated, reflected According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI (Resident Assessment Instrument) specified by the State. Record review of the CMS MDS 3.0 Manual dated October 2023 reflected in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interview, and record review, the facility failed to ensure residents drug regiment was free from unecessary drugs (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 14 (Resident #1) residents reviewed for pharmacy services. The facility failed to monitor Resident #1's side effects and behaviors regarding the resident's olanzapine (antipsychotic medication) for schizoaffective disorder, busPIRone (antianxiety medication) for anxiety disorder, and Sertraline (antidepressant) for depression related to schizoaffective disorder from 11/17/2023 to 08/08/2024. This failure placed the residents at risk of side effects and adverse reactions to the medications as ordered by the physician and a delay in treatment and worsening of their condition. Findings included: Record review of Resident #1's electronic face sheet, dated 08/08/2024, reflected the resident was admitted to the facility on [DATE]. Resident #1's diagnoses included: end stage renal disease (the kidneys lose the ability to remove waste and balance fluids), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), schizoaffective disorder (mental disorder with mood disorder such as depression), and anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of Resident #1's quarterly MDS assessment with an ARD of 05/08/2024 reflected the resident scored an 13/15 on her BIMS which signified the resident was cognitively intact, and Resident #1 was taking antipsychotic, antianxiety, and antidepressant as ordered. Record review of Resident #1's comprehensive care plan, revised on 11/09/2023, reflected [Resident #1] uses anti-anxiety medications for anxiety disorder, antidepressant, and antipsychotic medications for schizoaffective disorder and intervention: administer these medications as ordered, monitor side effects every shift, and monitor behaviors. Record review of Resident #1's physician order, dated 11/17/23, reflected the resident had the orders of busPIRone HCL oral tablet 10 mg give 1 tablet by mouth two times a day related to anxiety disorder, olanzapine tablet 5 mg give 1 tablet by mouth two times a day for schizoaffective disorder, and sertraline HCL oral tablet 100 mg give 1 tablet by mouth one time a day for depression related to schizoaffective disorder. Record review of Resident #1's medication administration record, dated from 08/01/2024 to 08/31/2024, reflected sertraline was scheduled to the morning time, busPIRone was scheduled to 9 am and 5 pm, and olanzapine was scheduled to 7 am and 3 pm. Further record review of Resident #1's medication administration record reflected there were no sections for monitoring side effects and behaviors regarding using an antipsychotic medication, antianxiety medication, and antidepressant. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/08/2024 at 2:12 p.m. revealed Resident #1 was on the bed in her room and Resident #1 did not reveal any side effects related to antipsychotic medication, antianxiety medication, and antidepressant such as tremors, shuffling gait, rigid muscles, and vomiting. Interview on 08/08/2024 at 2:12 p.m. with Resident #1 stated she denied difficulty swallowing, dry mouth, social isolation, loss of appetite, and fatigue. Interview on 08/08/2024 at 2:00 p.m. with LVN B stated Resident #1 did not have side effects and adverse behaviors related to antipsychotic medication, antianxiety medication, and antidepressant, such as tremors, shuffling gait, rigid muscles, vomiting, difficulty swallowing, dry mouth, social isolation, loss of appetite, and weight loss. Interview on 08/08/2024 at 2:13 p.m. with DON stated Resident #1 was taking olanzapine (antipsychotic medication) for schizoaffective disorder, busPIRone (antianxiety medication) for anxiety disorder, and Sertraline (antidepressant) for depression related to schizoaffective disorder, but the facility did not monitor the side effects and behaviors related to these medications as evidence by no monitoring sections on Resident #1's medication administration record. The facility nurses should have monitored side effects and behaviors everyday regarding Resident #1's antipsychotic medication, antianxiety medication, and antidepressant as a plan of care. Further interview with the DON revealed she did not know what reason the facility did not monitor, and the potential harm was the facility nurses could not notice side effects or adverse behaviors related to Resident #1's antipsychotic medication, antianxiety medication, and antidepressant. Record review of the facility policy, titled Use of psychotic medications, revised 11/2017, reflected . 10. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis such as in accordance with nurse assessment and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 of 1 medication room reviewed for storage, in that: The facility's narcotic box located inside a refrigerator in the only medication room was not permanently affixed compartment when Resident #2's Lorazepam was stored inside the narcotic box on 08/07/2024. This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed mediations. The findings included: Record review of Resident #2's electronic face sheet, dated 08/09/2024, reflected the resident was admitted to the facility on [DATE] with diagnoses included: Alzheimer's disease (destroys memory and other important mental functions), muscle wasting and atrophy (decrease in size and wasting of muscle tissue), and anorexia (eating disorder causing people to obsess about weight and what they eat). Record review of Resident #2's physician order, dated 08/03/2024, reflected Lorazepam Oral Concentrate 2 mg/ml Give 0.25 ml by mouth every one hour as needed for anxiety/agitation/restlessness for 30 days. Observation on 08/07/2024 at 12:09 p.m. revealed there was a refrigerator for medications in the medication room, and inside the refrigerator was one locked narcotic box. The narcotic box did not affix permanently to compartment of the refrigerator, and there was a Resident #2's one bottle of Lorazepam 2mg/ml inside the narcotic box. Interview on 08/07/2024 at 12:09 p.m. DON stated the narcotic box inside the refrigerator in the medication room did not permanently affix to the compartment of the refrigerator, so anybody might take the narcotic box from the refrigerator and medication room. Inside the narcotic box was Resident #2's one bottle of Lorazepam 2mg/ml. According to the facility policy the narcotic box should have been affixed permanently to the compartment of the refrigerator. The potential harm was Resident #2 could not take her Lorazepam as ordered due to missing the drug. Record review of the facility policy, titled Medication Storage, revised 11/2017, reflected 2. Narcotic and controlled substances: . b. Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in refrigerator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39049 Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #3) of 14 residents reviewed for accuracy and completeness of clinical records. LVN C administered Resident #3's hydrocodone-acetaminophen 5-325 mg one tablet on 5/14/2024, 5/15/2024, 5/17/2024, and 5/23/2024 as ordered and documented the dates on Resident #3's narcotic counting sheet but did not document them on Resident #3's medication administration record. This failure placed facility residents at risk for incorrect medication administrations due to misinformation by incomplete and inaccurate medical record. Findings included: Record review of Resident #3's electronic face sheet, dated 08/09/2024, reflected the resident was admitted to the facility on [DATE] with diagnoses included: type 2 diabetes mellitus (trouble controlling blood sugar), atherosclerotic heart disease of native coronary artery (buildup of fats, cholesterol and other substances in and on the walls of the heart arteries), hypertension (high blood pressure), pain in left arm, and anxiety disorder ((feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of Resident #3's quarterly MDS assessment with an ARD of 07/03/2024 reflected the resident scored an 14/15 on his BIMS which signified the resident was cognitively intact. Record review of Resident #3's comprehensive care plan, dated 10/11/2023, reflected [Resident #3] us at risk for acute pain and had chronic pain, and intervention: administer analgesia per physician orders. Record review of Resident #3's physician order, dated 02/12/2024, reflected the resident had the order of Norco tablet 5-325 mg (Hydrocodone-acetaminophen) give one tablet by mouth every 4 hours as needed for pain. Do not exceed 3 gram of acetaminophen in 24 hours. Record review of Resident #3's narcotic counting sheet for Norco tablet 5-325 mg (Hydrocodone-acetaminophen), dated from 03/16/2024 to 05/23/2024, reflected LVN C administered Norco tablet 5-325 mg (Hydrocodone-acetaminophen) one tablet by mouth to Resident #3 on 05/14/2024, 05/15/2024, 05/17/2024, and 05/23/2024 as ordered. Record review of Resident #3's medication administration record, dated from 05/01/2024 to 05/31/2024, reflected there was no documentation by LVN C on 05/14/2024, 05/15/2024, 05/17/2024, and 05/23/2024 regarding administering Norco tablet 5-325 mg (Hydrocodone-acetaminophen) to Resident #3. Record review of Drug check summary dated 05/24/2024, reflected LVN C had negative results to all drug tests such as oxycodone, opiate, and morphine. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/07/2024 at 1:30 p.m. Resident #3 stated he received pain medications whenever the resident requested his Norco tablet 5-325 mg (Hydrocodone-acetaminophen) but did not remember exact dates when the resident received the pain medication. Interview on 08/07/2024 at 3:55 p.m. with LVN C stated LVN C conducted pain assessment to Resident #3 and gave the resident's Norco tablet 5-325 mg (Hydrocodone-acetaminophen) one tablet by mouth to Resident #3 and documented on the narcotic counting sheet on 05/14/2024, 05/15/2024, 05/17/2024, and 05/23/2024 but did not document on Resident #3's medication administration record because LVN C forgot charting them on Resident #3's medication administration record. Further interview with the LVN C stated she had been working as a floor nurse for just three weeks and was very busy for those dates which could have caused her to forget charting on Resident #3's medication administration record. Interview on 08/09/2024 at 5:50 p.m. DON stated LVN C did not document Resident #3's Norco tablet 5-325 mg (Hydrocodone-acetaminophen) one tablet by mouth to the resident's medication administration record, and the medication was narcotic. The facility had LVN C to take drug test on 05/24/2024 according to the facility policy, and the results were all negatives. LVN C should have documented Resident #3's Norco tablet 5-325 mg (Hydrocodone-acetaminophen) on the resident's medication administration record after administering the pain medication to the resident. The potential harm was Resident #3 could receive incorrect doses of pain medication due to inaccurate documentations on the resident's medication administration record. Record review of the facility policy, titled Medication Administration, revised 11/2017, reflected 17. Sign medication administration record after administered. For those medications requiring vital signs, record the vital signs onto the medication administration record. 18. If medication is a controlled substance, sign narcotic book.