STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455789	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Park Nursing and Rehabilitation Center	7302 Oak Manor Dr San Antonio, TX 78229

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, and misappropriation of property for 1 of 6 residents (R #2) reviewed for abuse. The facility did not properly monitor or put in place preventative measures for R #2 to prevent an act of sexual abuse on 05/04/2024 by R#1. On 05/04/24 around 9:30 PM, R #1, intoxicated and aggressive, was not monitored and left unsupervised in his room for 15 minutes. R #1 left his room and was found at 9:45 PM by CNA C engaged in a sexual act with R#2 (non-consenting adult). R#1 had undressed R#2's top and engaged in sucking her breast. The non-compliance was identified as PNC. The IJ began 05/04/24 and ended 11/25/24. The facility had corrected the non-compliance before the survey began. This failure could place residents at risk for sexual abuse, suffering injury, a diminished quality of life, psychosocial harm, and/or death. The findings were: Record review of R #1's EMR and face sheet, dated 12/02/24, reflected an admitted [DATE], readmitted [DATE], discharged [DATE] with diagnoses that included: alcohol abuse with alcohol induced anxiety disorder, alcohol use, major depressive disorder, lack of coordination, and difficulty in walking. The resident was a male age [AGE] years old. Resident #1 was his own RP and had a family listed as an emergency contact. Record review of R# 1's Care Plan, dated 04/05/24, did not include the resident drank alcohol. Record review of R#1's MDS, dated [DATE], reflected: the resident's BIMS Score was 15 (cognitively intact). ADLs included: R #1 had a urostomy and was occasionally incontinent of bowel. Range of motion was upper extremity no impairment, lower extremity impairment on one side. R #1 utilized a wheelchair. Independent with walking/transfers (01/20/24 MDS). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455789	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER: Oak Park Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7302 Oak Manor Dr San Antonio, TX 78229	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R#1's order summary dated 05/06/24 reflected: diagnoses given to the resident included Alcohol Abuse with alcohol-induced anxiety .Alcohol Use, unspecified with unspecified alcohol-induced disorder . No orders were present involving any interventions for alcohol abuse or use. No order to stop medications when the resident was actively drinking. Order existed for managing anxiety and depression. Resident had order for anxiety (Duloxetine 30 mg 1 tab for Major Depression). Record review of R#2's EMR and face sheet, dated 12/02/24, reflected an admitted [DATE] and re-admission 07/19/23 with diagnoses that included: dementia unspecified severity with other behavioral disturbance, anxiety disorder, need for assistance with personal care, seizures, depression, and history of falling. The resident was a female age [AGE] years old. Resident #2 was listed as her own RP. Record review of R#2's Care Plan, dated 09/26/24, revealed, the goals and interventions included: (hospice care) dementia and administer medications as scheduled, ADL self-care deficit, impaired cognitive function/impaired thought processes related to dementia-administer medications as ordered and keep the routine consistent and try to provide consistent care givers as much as possible to decrease confusion. R#2 had communication problem related to cognition and senile degeneration of brain. R #2 also had impaired visual function. Record review of R#2 's MDS, dated [DATE], reflected: BIMS Score was 00 (severe impairment). ADLs were listed as always incontinent. Transfer and bed Mobility were dependent on staff assistance. ROM was listed as no impairment. Record review of facility's Form 3613 dated 05/10/24 reflected: Incident: R#1went into R#2's room and was witnessed making sexual contact on R#2's breast. R#2 was assessed with no injuries or psychosocial trauma. R#1 was placed on one-to-one monitoring pending arrest by law enforcement. R#1 was arrested for public intoxication and immediately discharged from the facility. Form 3613 read, [R#1] was issued a citation for coming in contact with [R#2's] breast while she was sleeping. Record review of R#1's nurse note dated 5/5/24 authored LVN B reflected: law enforcement was called and Case # assigned (SAPD 24097970 officer #1786). R#2 was arrested for PI. Record review of R#2's nurse note dated 05/04/24 at 10:50 PM, authored by LVN B, reflected resident was assessed and no negative findings. Q 15 minutes checks were initiated. Record review of R#2's 72-hour 15 minutes monitoring sheet revealed checks were done every 15 minutes from 5/04/24 to 5/06/24 every shift. Record review of R#2's nurse note dated 05/05/24 authored by LVN B reflected resident was sent to the ER for an assessment and returned the same day. Observation and interview on 12/02/24 at 2:30 PM, R#2 was in bed, not alert or oriented. Music playing as an activity. Resident yelled out noises with no meaning. Resident could not answer any direct questions. Resident did not recognize or acknowledged the presence of the surveyor in the room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/02/24 at 2:45 PM, Hospice LVN D stated: the resident was under hospice care for senile degeneration of the brain since May 2024 LVN D stated the resident was unable to protect herself or yell out for help. LVN D stated that another resident [R#1] walked into her room in the past [05/04/24], and the resident [R#2] was sent to the ER for an evaluation involving an allegation of sexual abuse. During an interview on 12/02/24 at 3:15 PM, LVN E stated, nursing practice was to notify the MD and law enforcement when a resident was belligerent, under the influence, and refused an assessment. LVN E stated that a belligerent resident who could be a danger to self or others would need close monitoring pending new orders from the MD; and any directions from law enforcement. During an interview on 12/02/24 at 4:44 PM, the DON stated: she did not know what nurse allowed R#1 who was intoxicated to enter the facility on 05/04/24. The DON stated that the nursing practice for an intoxicated resident was to check vitals, call MD for guidance and monitor the resident for vital sign, and changes and behaviors. The DON stated that resident had to be monitored; but she could not give an explanation why R#1 was not monitored for a lapse of 10-15 minutes on 5/4/24 from 9:30 PM-9:45 PM. During an interview on 12/03/24 at 9:20 AM, LVN D stated she got a call from either LVN E or the DON that R#1 was found in R#2's room and suckling R#2's nipple or breast. LVN D stated by nursing practice the nurse that escorted the resident to the room should had maintain visual contact of the resident pending MD or nurse management guidance. During a telephone interview on 12/03/24 at 9:55 AM, LVN B stated: R#1 returned late at night intoxicated by himself and LVN A let him in the facility. LVN B stated, no assessment outside the facility was done because resident was belligerent. LVN B stated, whenever a resident was drinking an assessment was required; but the resident refused. LVN B sated, We took him [R#1] to his room and call 911 and the MD, because the resident was belligerent and refused an assessment. By the time the police came the resident was not in his room. [CNA C] found him in another room performing an inappropriate sexual act. LVN B stated I had to do documentation and lost sight of the resident. When the law enforcement arrived, it was when we realized the resident was missing It was 15 minutes I lost sight of the resident. LVN stated, that through hindsight she would have had the other nurse [LVN A] watch over R#1. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/03/24 at 11:00 AM, the Administrator stated: HHS was contacted on 05/04/24 at 11:45 PM; incident occurred on 05/04/24 at 10:30 PM. The Administrator stated the Incident involved R #1 going into R#2's 's room and was witnessed making sexual contact on R#2's breast. R#2 was assessed with no injuries or psychosocial trauma. The Administrator stated R#1 was placed on one-to-one monitoring pending arrest by law enforcement. The Administrator stated that an assessment needed to be completed when a resident returned intoxicated or smelled of alcohol and it required that the MD was notified. The Administrator stated that monitoring of a resident did not require constant visual contact and every two hours check on the resident was nursing practice. The Administrator stated that R#1 had issues with alcohol. The Administrator stated that it was not the first time the resident appeared to use alcohol in the past; but the resident was not a sexual predator. The Administrator stated that in the past the facility would allow the resident back into his room; but there were no documented interventions for R#1's use of alcohol. The Administrator stated the nursing staff based on history believed the resident would remain in his room. The Administrator stated, It did not rise to the level of one-on-one .we let him stay in his room .cannot explain what was going through his head .there was no indication he was going to do this . The Administrator stated that there was no indication that R#1was a danger to self or others requiring constant one on one monitoring. The Administrator stated, after the incident preventative measures put in place included: non-verbal residents were assigned roommates; R#1 was arrested. Staff completed 100 % in-service on abuse and neglect. The Administrator stated a head-to-toe assessment was done on all non-verbal residents. R#1 was assigned a temporary roommate and moved closer to the nurse station. During telephone interview on 12/03/24 at 2:25 PM, Law Enforcement Officer F stated that R#1 was arrested on 05/04/24 for public intoxication and was a suspect for sexual abuse of R#2. During telephone interview on 12/03/24 at 5:00 PM, LVN A stated the timeline was: she and LVN B escorted R#1 into the facility on [DATE] around 8:30 PM. R#1 was intoxicated and belligerent and refused an assessment. The ADON [LVN E] and MD were called. The ADON recommended to LVN A and LVN B to call law enforcement. Pending the arrival of law enforcement R#1 was taken to his room in Hall 300. LVN A stated that she returned to her duties in another hall and expected LVN B to monitor R#1. LVN A stated that when the resident [R#1] was not found in his room around 9:30 PM, she participated in the search of R#1. LVN A stated that around 9:45 PM, R#1 was found in R#2's room by CNA C. During a telephone interview on 12/4/24 at 8:00 PM, CNA C, (employed for 9 weeks), stated,: on 05/4/24 she was in another hall doing ADL care for a resident. She responded to LVN A's request at 9:30 PM to assist in the search for R#1 in Hall 300. CNA C stated she found R#1, at 9:45 PM, in R#2's room kneeling on the floor mat and having in his mouth R#2's breast. CNA C startled R#1 and he stopped the behavior and said nothing about the incident. CNA C requested nursing assistance and R#1 was escorted to his room and monitored one-on-one until law enforcement arrived. Record review of written statement dated 05/04/24 authored by CNA C stated: around 9:30 PM, LVN A walked in the facility with paramedics in search of R#1. LVN A stated that R#1 was not in his room (room [ROOM NUMBER]) and a search was started and R#1 was found in R#2's room where I (CNA C) witnessed [R#2] asleep in bed with her eyes closed and [R#1] on his knees on the floor mat kneeling over [R#2] with her shirt up .I loudly said, what are you doing? [R#1] at this time removed his mouth off [R#2's] left breast . LVN A and LVN B were informed of the incident. CNA C stayed with R#1 until he was escorted by the police out of the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of LVN B's written statement undated reflected: R#1 was escorted to facility by [LVN A] given the resident had fallen outside. R#1 was under the influence of alcohol and refused an assessment and was belligerent. LVN B called the ADON and was directed to call 911. LVN B stated, By the time the police arrived, and fire dept. arrived patient went out of his room. The resident was found in R#2's room. Record review of R#1's Nurse note dated 05/05/24 by LVN B repeated the same information as the written statement namely: R#1 was escorted to facility by [LVN A] given the resident had fallen outside. R#1 was under the influence of alcohol and refused an assessment and was belligerent. LVN B called the ADON and was directed to call 911. LVN B stated, By the time the police arrived, and fire dept. arrived patient went out of his room. The resident was found in R#2's room. Observation on 12/05/24 at 1:45 PM to 1:52 PM of Snap shots from the Administrator's iPhone reflected that at 20:30 (8:30 PM) R#1 was at the nurse station near hall 300. Next snapshot reflected that R#1 came out of his room at 21:27 (9:27 PM). No other snapshots were provided by the Administrator after R#1 exited his room at 9:27 PM. During an interview on 12.05/24 at 1:52 PM, after observing the snap shots with the administrator, the administrator stated: from 8:30 PM to 9:27 PM the resident was being monitored by nursing staff. The Administrator stated that based on the CNA's note (CNA C) the resident had left his room between 9:30 PM to 9:45 PM. Administrated stated, based on CNA C's written statement, R#1 was found at 9:45 PM in R#2's room involved in an inappropriate sexual behavior. The Administrator stated that no documentation existed that the facility did 15-minute checks from 8:30 PM to 9:27 PM. [surveyor requested evidence that 15-minute checks were done and documented on 05/04/24 because the facility stated 15 minutes checked were done.]. Record review of the facility's Abuse policy dated April 2001 read: 2. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. a Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. b. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. c. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology . 3. Sexual abuse is non-consensual sexual conduct of any type with a resident. a. Sexual contact with a resident who lacks the cognitive ability to consent is considered non-consensual and therefore, constitutes abuse. b. Consent that is obtained through intimidation, coercion or fear is not valid. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. The resident's capacity to consent to sexual conduct is carefully evaluated as part of the initial assessment and care planning process. Verification of PNC Observation on 12/05/24 at 9:50 AM, R#2 was in her room, door open, sitting on a special W/C facing TV (TV was on). R#2 was not alert or oriented. Resident was clean, no smell of odors. There was no signs of pain or distress. Resident did not have a roommate. Observation on 12/05/24 from 3:00 PM-3:15 PM reflected three residents with dementia and a BIMS of zero and could not communicate had a roommate that was alert and oriented. During interviews on 12/03/24 from 11:00 AM to 12/04/24 to 9:30 AM, 9 day shift staff 1 (7 AM-3 PM) (1 SW, 5 LVN, 2 CNA, and 1 Housekeeper), and 2 staff evening shift (3 PM-11PM) and 2 nigh shift staff (2 LVN) reflected return demonstration on abuse and neglect with the highlight to report any act or suspicion of abuse or neglect to the Abuse Coordinator, the Administrator. Record review of facility's investigation file reflected: HHS contacted on 5/4/24 at 11:45 PM; incident occurred on 05/05/24 at 10:30 PM. t R#2 was assessed and showed no signs and symptoms of injuries or change of conditions or behaviors. R#1 was immediately discharged from the facility. Inservice training was started 05/05/24 and ended 11/25/24. Police report # 24097970 was present; type of offense was PI. Head to toe assessment for all non-interview-able residents was completed. Interview with all verbal residents reflect no abuse. Lastly, alert, and oriented residents were placed with residents with dementia that could not communicate. Record review of R#1's nurse note dated 5/5/24 authored LVN B reflected: law enforcement was called and Case # assigned (SAPD 24097970 officer #1786). R#2 was arrested for PI. Record review of R#2's nurse note dated 05/04/24 at 10:50 PM, authored by LVN B, reflected resident was assessed and no negative findings. Q 15 minutes checks were initiated. Record review of R#2's 72-hour 15 minutes monitoring sheet revealed checks were done every 15 minutes from 5/04/24 to 5/06/24 every shift. Record review of R#2's nurse note dated 05/05/24 authored by LVN B reflected resident was sent to the ER for an assessment and returned the same day. Record review of R#2's skin assessments dated 05/01/24 and 05/06/24 reflected skin intact. Record review of R#2's pain assessment dated [DATE] reflected no distress, pain, or discomfort. Record review of facility's assessment of resident safety sheets dated 05/04/24 reflected that 10 interview-able residents were interviewed, and all felt safe. Record review of facility's staff roster dated 12/02/24 reflected 158 employees. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's abuse/neglect signed in sheets reflected 100 % of staff attended the training from 05/05/24 to 11/25/25 [total staff on 12/02/24 was 158]. Record review of list provided by facility on 12/05/24 reflected three alert and oriented residents were placed with residents with dementia and a BIMs of zero and could not communicate. R#2 had no roommate. Record review of facility's Abuse, neglect, Exploitation or Misappropriation policy, dated revised April 2021, reflected one was present and in effect and required staff to report incidents or suspicion of abuse and/or neglect. The non-compliance was identified as PNC. The IJ began 05/04/24 and ended 11/25/24. The facility had corrected the non-compliance before the survey began. At exit, the Administrator did not provide written evidence that on 05/04/24 from 8:30 PM to 9:27 PM the facility documented 15-minute checks for R#1 while resident was in his room.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical and nursing needs for 1 of 6 residents (R# 1), reviewed for care plans. R#1's care plan did not contain measurable goals and objectives for alcohol use and abuse from, although the resident had five documented episodes of alcohol intoxication or smelled of alcohol. This non compliance was identified and corrected prior to entrance. This failure could place residents at risk for not receiving the care and treatments listed in the care plan and could lead to a diminished quality of life associated with alcohol use and abuse. The findings were: Record review of R #1's EMR and face sheet, dated 12/02/24, revealed an admitted [DATE], readmitted [DATE], discharged [DATE] with diagnoses that included: alcohol abuse with alcohol induced anxiety disorder, alcohol use, major depressive disorder, lack of coordination, and difficulty in walking. The resident was a male age [AGE] years old. Resident #1 was his own RP and had a family listed as an emergency contact. Record review of R#1's MDS, dated [DATE], reflected: the resident's BIMS Score was 15 (cognitively intact). ADLs included: R #1 had a urostomy and was occasionally incontinent of bowel. Range of motion was upper extremity no impairment, lower extremity impairment on one side. R #1 utilized a wheelchair. Independent with walking/transfers (01/20/24 MDS). Record review of R#1's CP, undated, reflected no goal for alcohol abuse and for alcohol use or behaviors associated with alcohol use. The CP further had no interventions for R#1's history of alcohol abuse and alcohol use. Record review of R#1's order summary dated 5/06/24 reflected: diagnoses given to the resident included Alcohol Abuse with alcohol-induced anxiety .Alcohol Use, unspecified with unspecified alcohol-induced disorder . No orders were present involving any interventions for alcohol abuse or use. No order to stop medications when the resident was actively drinking. Order existed for managing anxiety and depression. Resident had order for anxiety (Duloxetine 30 mg daily). Record review of R#1's nurse notes reflected the resident actively used alcohol on five documented occasions. The five documented occasions were: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Note dated 3/18/23 authored by RN J read: .Resident was found in the common area passed out drunk .Due to the resident being intoxicated, there was no reasoning with him. He continued to yell and be belligerent with staff. After approximately 30-40 minutes of resident yelling, he then went to his room as asked. DON was called and notified as well as [MD]notified. Nurse Note dated 03/21/23 authored by LVN E read: .pt remain [out] entire shift until returned escorted by police due to inebriated. pt returned to room and went to bed. Nurse Note dated 05/5/2023 authored by LVN G read, .Resident [R#1] returned from leave of absence at 11:20pm drunk escorted by wound care nurse . Nurse Note dated 6/4/2023 authored by LVN G read: Resident [R#1] signed himself up on 3-11 shift got back at 3:40am drunk stated that, he had a fall on his way back to facility. Resident appeared very drunk. CNA escorted resident back to his room . Nurse Note dated 08/05/23 authored by LVN H read, .resident [R#1] returned from out on pass smelling of alcohol with small amount of emesis .noted. During an interview on 12/4/24 at 11:55 AM, MDS Nurse I stated: the CP was updated based on new assessments or a change of condition by the ID team; and quarterly. LVN I stated, the ID team included the MD. The MDS Nurse stated based on 5 progress notes stating R #1 was actively using alcohol the CP should have been updated. LVN I stated, the CP should have had interventions dealing with risk of injury to the resident [R#1] or others. LVN I stated, the CP was a tool that coordinated care and communicated to staff the interventions required for R#1. LVN I stated she had no explanation why the CP was not updated the four times the resident actively used alcohol outside the facility and came back to the facility intoxicated. During a telephone interview on 12/4/24 at 12:10 PM, the MD stated: That is a good question that medications should be stopped when the resident was actively using alcohol . The MD stated he could not comment on what needed to be put in the CP as an intervention for alcohol use or abuse. During an interview on 12/04/24 at 1:17 PM, ADON LVN E stated: he had worked in the facility for the past two years and was selected as ADON last year. The ADON stated the CP was updated based on a new assessment, change of condition, or when a resident exhibits negative behavior for example, using drunks, drinking, or wondering into another resident's room. The ADON stated, the purpose of a CP was to capture interventions and coordinate care among the ID team. The ADON stated, yes, the CP required new interventions if the resident [R#1] showed a pattern of drinking. The ADON stated he did not know why the CP was not updated for R#1' drinking behavior. During an interview on 12/04/24 at 1:58 PM, the DON stated that she had been employed for the past three years and became the DON the past 5 months. The DON stated a resident's CP was updated when there was a change of condition, new behaviors affecting residents, new assessments, or when resident displayed signs and symptoms of drug use, alcohol use, or aggression to other residents or staff. The DON stated that the R#1's CP should have been updated to reflect alcohol use on 3/18/23, 5/5/23, 6/4/23, and 8/5/23 because it allowed for the need or no need for interventions. The DON stated the IDT met every 3 months but did not address R#1's drinking behavior. The DON stated the MD was notified and issued no new orders. However, the DON stated the CP should have been updated with interventions; for example, hold the medication with MD approval if the resident was actively drinking. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 3:42 PM, LVN K (ADON, employed 1-year full) time stated: a CP was updated quarterly and when there were incidents or there was a change of condition. LVN K stated the CP needed to be updated if a resident showed a history of repeated alcohol use, drug use, or any inappropriate behaviors. LVN K stated the MD needed to be notified for any recommendations involving the update of the CP. LVN K stated for a resident abusing alcohol over a period to time the CP needed to reflect any new interventions for example, if a resident was suspected of drinking the MD should be consulted about not giving medication until the resident was sober. LVN K stated that, yes the CP should have been updated given there were notes of R#1 using alcohol and smelled of alcohol. LVN K stated the CP needed an update because of safety involving medications. LVN K stated she could not provide a reason why the CP was not updated in the past involving R#1. Verification of PNC Record review of facility's discharge sheet dated 12/02/24 reflected R#1 was discharged on [DATE]. Record review of R#3's CP (dated 12/15/22), R#4's CP (dated 12/04/24), R#5's CP (dated 6/10/24), R#6's CP (dated 04/29/24), and R#7's CP (dated 12/04/24), captured goals and interventions dealing with alcohol use and/or abuse. Record review of the facility's Care Plans, Comprehensive Person-Centered policy, dated revised December 2026, read: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents 'condition change.