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	12/19/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observation, interviews, and record reviews the facility failed to ensure each resident was treated with respect, dignity, and care for 1 of 4 dining rooms (Station 4 dining room) observed for resident rights. The facility failed to ensure CNA W and CNA X were not using their personal phones while in the dining room, sitting with residents on 12/18/24. This failure could place residents at risk of not being treated with dignity and respect. Findings included: Record review of Resident #62's Admission Record, dated 12/16/2024, reflected Resident #62 was initially admitted on [DATE] and readmitted on [DATE]. Resident #62 was noted to be [AGE] years old. Resident #62 was diagnosed with mononeuropathy (damage that happens to a single nerve which can cause pain, loss of movement and/or numbness). Record review of Resident #62's Annual MDS assessment, dated 09/30/2024, reflected Resident #62 had a BIMS of 15, indicating intact cognition. Interview and observation on 12/18/24 at 12:26 PM revealed CNA W and CNA X were on their respective personal cell phones while sitting at a dining table with 2 unidentified residents present. CNA X revealed she was not supposed to be on her phone. Attempted interview on 12/18/24 at 12:30PM. The residents did not respond. Interview on 12/18/24 at 12:52 PM with the DON revealed CNAs were not allowed on their phones in the dining room because they were to help the residents with what the residents needed. Interview on 12/19/24 at 04:25 PM with Resident #62 revealed nursing staff stay on their phones. He had seen them answering calls and making calls in the dining room. He had not seen them on their phones while feeding residents but had seen them make phone calls while they were waiting for meal trays. Resident #62 revealed the nursing staff do not seem to care. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy Quality of Life-Dignity, revised August 2009, reflected Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 50531 Based on interview and record review, the facility failed to provide notice to residents of the change as soon as was reasonably possible when changes in coverage were made to items and services covered by the Medicare and/or Medicaid state plan for 2 of 3 residents [Resident #95, Resident #001] reviewed for Medicaid and Medicare Coverage Liability Notices. The facility failed to ensure Resident # 95 and Resident #001 were provided a Skilled Nursing Facility Advance Beneficiary Notice of non-coverage Form CMS-10055 [SNF ABN] that informs a Medicare beneficiary that Medicare will no longer pay for skilled services when discharged from skilled services at the facility prior to completion of covered stay or covered days being exhausted when he/she was discharged from Medicare Part A skilled nursing services. This failure placed residents, or their representatives, at risk for not being fully informed about services covered by Medicare Part A and not being aware of changes to provided services. Findings included: Record review of the facility Beneficiary Notice Worksheet (undated) revealed Resident #95 and #001 had been discharged from a Medicare covered Part A stay with benefits remaining within the six months prior to survey. Record review of the entrance conference worksheet for the Advanced Benificiary notice for Resident #001 completed a Part A skilled stay on 8/31/24. Record review of the entrance conference worksheet for the Advanced Benificiary notice for Resident #95 completed a Part A skilled stay on 9/30/24. Record Review from June 2024 to December 2024 revealed no documentation of SNF ABN notice isseued for Resident #001. Record Review from June 2024 to December 2024 revealed no documentation of SNF ABN notice isseued for Resident #95. Interview with ADM on 12/19/24 at 2:00 PM revealed that Resident #001 completed his Medicare Part A stay on 8/31/24 and remained in the facility. Resident #001 did not utilize the full 100 days of Medicare part A, so he had days remaining. Resident # 001 should have received a SNF ABN. The facility failed to provide Resident #001 a SNF ABN. ADM confirmed facility is expected to follow the rules of Medicare Part A and the Medicare Claims Processing Manual for financial liability protections. The failure for the SNF ABN having not been provided was human error. Resident #001 was never placed in any harm or at risk for denial to participate in Medicare Part A moving forward. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADMIN on 12/19/24 2:00 PM revealed that Resident #95 completed her Medicare Part A stay on 9/30/24 and remained in the facility. Resident #95 did not utilize the full 100 days of Medicare part A, so she had days remaining. Resident #95 should have received a SNF ABN. The facility failed to provide Resident #95 a SNF ABN. ADM confirmed facility is expected to follow the rules of Medicare Part A and the Medicare Claims Processing Manual for financial liability protections. The failure for the SNF ABN having not been provided was human error. Resident #95 was never placed in any harm or at risk for denial to participate in Medicare Part A moving forward. Interview with ADMIN on 12/19/24 2:00 PM confirmed facility's guidelines for determination to issue a SNF ABN according to Section 20.2 of the Medicare Claims Processing Manual, Chapter 30 and CMS requirements to issue an ABN when a Medicare service is not reasonable and necessary under program standards, when providing custodial care.

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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** 46447 Based on interview, and record review the facility failed to ensure the comprehensive assessment accurately reflected the resident's status for 2 (Resident #26 and Resident #49) of 3 residents reviewed for accuracy of assessments. 1. The facility failed to accurately code Resident #26's smoking status on his modified significant change comprehensive assessment. 2. The facility failed to accurately code Resident #49's smoking status on his significant change comprehensive assessment. These failures could place residents at risk of improper or incorrect care and services necessary for their physical, mental, and psychosocial well-being. The findings included: 1. Record review of Resident #26's Admission Record, dated 12/18/2024, reflected Resident #26 was admitted on [DATE]. Resident #26 was noted to be [AGE] years old. Record review of Resident #26's Diagnosis Report, undated, reflected Resident #26 was diagnosed with right knee effusion (excess fluid accumulates in and around the right knee, can result in swelling, pain, stiffness, or reduced mobility), muscle wasting and atrophy (the shrinking of muscle or nerve tissue), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #26's Modified Significant Change MDS assessment, dated 11/13/2024 and signed as completed on 11/19/2024 by the DON, reflected Resident #26 under Section J- Health Conditions for Current Tobacco Use (J1300), completed by MDS H on 11/15/2024, was not a current tobacco user. Record review of Resident #26's Smoking- Safety Screen, dated 11/08/2024, reflected Resident #26 smoked 5-10 cigarettes per day. Record review of Resident #26's Care Plan, undated, accessed 12/18/2024, reflected Resident #26 was a smoker, had been educated on the facility smoking policy, and was deemed safe to smoke independently; date initiated: 11/04/2024 and date revised: 11/23/2024. 2. Record review of Resident #49's Admission Record, dated 12/18/2024, reflected Resident #49 was initially admitted on [DATE] and readmitted on [DATE]. Resident #49 was noted to be [AGE] years old. Record review of Resident #49's Diagnosis Report, undated, reflected Resident #49 was diagnosed with paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), muscle wasting and atrophy (the shrinking of muscle or nerve tissue), and hepatic encephalopathy (nervous system disorder where the liver can't adequately remove toxins which can lead to brain damage). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #49's Significant Change MDS assessment, dated 09/11/2024 and signed as completed on 09/20/2024 by the DON, reflected Resident #49 under Section J- Health Conditions for Current Tobacco Use (J1300), completed by MDS H on 09/12/2024, was not a current tobacco user. Record review of Resident #49's End of PPS (Prospected Payment System) MDS assessment, dated 11/10/2024 and signed as completed on 11/14/2024 by the DON, does not include a Current Tobacco Use section. Record review of Resident #49's Smoking- Safety Screen, dated 09/04/2024, reflected Resident #49 smoked 2-5 cigarettes per day. Record review of Resident #49's Smoking- Safety Screen, dated 11/08/2024, reflected Resident #49 smoked 2-5 cigarettes per day. Record review of Resident #49's Care Plan, undated, accessed 12/17/2024, reflected Resident #49 was a smoker, had been educated on the facility smoking policy, and was deemed safe to smoke with supervision; date initiated: 08/28/2024 and date revised: 08/28/2024. During an interview on 12/19/2024 at 02:06 p.m., the MDS F stated she started working at the facility on October 1, 2024. She stated it was the responsibility of the person signing off on the MDS Assessment, which would be the RN, to ensure the MDS information was correct. She also stated the person entering the information was responsible for ensuring they entered correct information. She stated for current tobacco use, she would interview the resident and review the resident's safe smoking assessment. She stated for both Resident #26's and Resident #49's MDS assessments, MDS H completed the Current Tobacco Use sections. She stated she did not know why MDS H coded either resident the way he did but that it was most likely a mistake due to MDS H not working in the facility and had missed the necessary documentation. She stated she did not believe these errors would have impacted the residents' care because they were both assessed for smoking status and had care planned appropriate interventions. During an interview on 12/19/2024 at 03:18 p.m., the DON stated when completing the MDS assessments, staff compare documentation of individual assessments. She stated in the end, the RN that signs the assessment was responsible for ensuring accuracy of the assessment, but a corporate MDS nurse also oversaw the MDS assessments. The DON confirmed both Resident #26 and Resident #49 were current smokers. She stated that since both residents have current care planned smoking interventions and safe smoker assessments, the incorrect coding of their MDS assessments would not have impacted their care. During an interview on 12/19/2024 at 05:46 p.m., MDS H stated he worked for another nursing facility. He stated he started as a MDS Nurse in April 2024 and was still in training when he was asked to assist [Nursing Facility R] with their MDS Assessments. He stated that due to his inexperience, he did not know to ask for additional documentation from the facility when completing the resident's risk assessments, such as the smoking status on the MDS assessment. He stated he never reviewed the residents' smoking safety screen assessments at that time and relied on nursing assessments and documentation to complete the MDS assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy, Resident Assessment Instrument, dated revised September 2010, reflected 7. All persons who have completed any portion of the MDS Resident Assessment Form MUST sign such document attesting to the accuracy of such information.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on interview and record review, the facility failed to develop a baseline care plan including the minimum healthcare information necessary to properly care for the resident within 48 hours of the resident's admission, for 1 (Resident #30) of 30 residents reviewed, in that: Resident #30's baseline care plan was not completed within 48 hours of the resident's admission on 08/12/2024. This failure could place newly admitted residents at risks of not receiving the proper care and continuity of services. The findings were: Record review of Resident #30's face sheet, dated 12/19/2024, revealed she was an [AGE] year-old woman admitted to the facility on [DATE] with diagnoses which included: Chronic Kidney Disease-Stage 3; Type 2 Diabetes Mellitus (chronic condition where the body has trouble controlling blood sugar); Dementia (a general term for loss of memory, and other cognitive abilities) ; Schizophrenia (mental illness that affects how a person thinks, feels and behaves); Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and Anxiety Disorder (mental health disorder characterized by feelings of worry, fear and anxiety strong enough to interfere with daily life). Record review of Resident #30's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 14, indicating intact cognition. Further review revealed she was assessed as needing a wheelchair for mobility, and was dependent in toileting hygiene, lower body dressing and personal hygiene and needed substantial/maximal assistance with showering, and upper body dressing. Record review of Resident #30's Care Plans Screen in her clinical record as of 12/19/2024, revealed her initial Care Plan completed was her Comprehensive Care Plan completed 08/21/2024, 9 days after her admission on 08/12/2024. During an interview with MDS-F and MDS-G on 12/19/2024 at 11:39 a.m., MDS-F stated she was one of 2 MDS Nurses at the facility and she had been at the facility 2 months. MDS-G stated he just started in the position 2 weeks ago. MDS-F stated baseline care plans were due within 48 hours of a resident's admission and confirmed that Resident #30's Baseline Care Plan was not done within 48 hours after her admission, and stated Resident #30's first Care Plan done was the Comprehensive Care Plan completed 9 days after her Admission. MDS-F stated that completion of Baseline Care Plans was the responsibility of the MDS Nurse, but noted there has been a lot of turnover in the MDS Nurse position in the past few months and that was probably why Resident #30's Baseline Care Plan was not completed on time. MDS-F further stated that not having the Baseline Care Plan completed within 48 hours could result in staff not having all the information they needed to provide good care to the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, Care Plans - Baseline, revised 2016, revealed, To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission and The interdisciplinary team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 46447 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for 3 of 30 residents (Resident #22, Resident #31, and Resident #53) reviewed for quality of care. 1. The facility failed to ensure Resident #22's Humalog KwikPen insulin (a lightweight pen that is prefilled with insulin, a hormone that helps the body use glucose for energy) was given per physician order. 2. The facility failed to ensure Resident #31's HgA1c lab (a blood test that measure the average blood sugar level of the past 3 months) was drawn every 3 months as per physician order. 3. The facility failed to ensure Resident #53's Midodrine HCl (a medication used to treat low blood pressure) was given per physician order. These failures could place residents at risk of not receiving care to maintain optimum health and placing them at risk for decline in health. Findings included: 1. Record review of Resident #22's Admission Record, dated 12/18/2024, reflected Resident #22 was initially admitted on [DATE] and readmitted on [DATE]. Resident #22 was noted to be [AGE] years old and on hospice services. Record review of Resident #22's Diagnosis Report, undated, accessed 12/18/2024, reflected Resident #22 was diagnosed with dementia (a general term for impaired ability to remember, think, or make decisions), senile degeneration of brain (loss of intellectual ability associated with old age), and type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel) with hyperglycemia (high sugar levels in the blood). Record review of Resident #22's Quarterly MDS assessment, dated 09/18/2024 and signed as completed on 09/22/2024 by the DON, reflected Resident #22 had a BIMS of 2, indicating severe cognitive impairment, had an active diagnosis of diabetes mellitus, had a life expectancy of less than 6 months, and received insulin injections 7 of the last 7 days monitored for insulin injections. Record review of Resident #22's Care Plan, undated, accessed 12/18/2024, reflected Resident #22 had a history of noncompliance with her medication regimen; date initiated: 12/08/2024. One of the interventions included, Allow the resident to make decisions about treatment regimen, to provide sense of control; date initiated: 12/08/2024. Resident #22 was also noted as having a desired weight loss and on a controlled carbohydrate diet; date initiated: 08/16/2024 and revised on 08/16/2024. One of the interventions included Administer medications as ordered. Monitor/Document for side effects and effectiveness; date initiated: 08/16/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22's Order Audit Report for physician order, order date 07/10/2024, status noted as active, Humalog KwikPen 100 Unit/Ml Solution pen-injector, revealed the following procedure: Inject as per sliding scale: If 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units, subcutaneously [applied under the skin] before meals and at bedtime related to type 2 diabetes mellitus with diabetic chronic kidney disease. Record review of Resident #22's December 2024 MAR revealed on 12/05/2024 and 12/07/2024, Resident #22's BS (blood sugar) was 150 for her 0600 (06:00 a.m.) administration; however, the code 13, noted under chart codes as No Insulin Required, was coded by LPN K. Record review of Resident #22's Progress Notes on 12/05/2024 and 12/07/2024 did not reveal notes regarding insulin not required. During an interview with Resident #22 on 12/19/2024 at 10:28 a.m., she stated she had no concerns with her insulin administration. She stated her blood sugars go up and down. During an interview with MD D on 12/19/2024 at 10:43 a.m., MD D revealed he had not been notified of any insulin errors or concerns. He stated Resident #22's sliding scale order was arbitrary (based on personal choice) and her having not received her prescribed 2 units when her blood sugar was at 150 would have had no impact on her health. During an interview with LPN K on 12/19/2024 at 11:13 a.m., LPN K stated Resident #22's blood sugars were always in range, and he did not need to administer insulin for her. LPN K stated that to him, when Resident #22's blood sugar was at 150, he did not see a reason to administer insulin because Resident #22 was in range, so he would hold the insulin. He stated that having held the insulin when Resident #22 was at 150 had not caused any harm and Resident #22 was very aware and able to notify him if she had concerns. During an interview with the DON on 12/19/2024 at 03:18 p.m., the DON stated to monitor medication administrations, the facility performed check-offs with the nurses, held in-services, and reviewed daily reports that show which medication administrations were coded with an exception code or those marked as not completed. The DON stated that if the physician order said to give insulin at 150, she would expect the nurse to administer the insulin and follow the physician order. She stated that the nurse was to call the physician and obtain a hold order if they are not giving the insulin. The DON stated that the impact on the resident for not administering the insulin when the blood sugar was 150 would depend on the resident and on when and what the resident's next meal was. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #31's face sheet dated 12/18/2024, revealed she was a [AGE] year-old woman initially admitted on [DATE] and readmitted on [DATE], with diagnoses which included: cerebral infarction (stroke), quadriplegia (paralysis which affects all 4 limbs), and type 1 diabetes mellitus without complications (lifelong condition where the pancreas makes little or no insulin, leading to high blood sugar levels). Record review of Resident #31's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment and active diagnosis of Diabetes Mellitus. Record review of Resident #31's care plan initiated on 08/17/2021 reflected a focus area of Diabetes Mellitus with goal of will have no complications related to diabetes . Record review of Resident #31's Physician Order Summary dated 12/19/2024 revealed an order dated 07/29/2024 for: HgA1C Q 3 months Record review of Resident #31's lab results in her clinical record reveal her only HgA1C lab was drawn 07/27/2024. During an interview with the DON on 12/19/2024 at 10:50 a.m., the DON confirmed the last HgA1C lab for Resident #31 was drawn on 07/27/2024, and that per physician orders, another HgA1C should have been drawn 3 months later in October 2024. She stated she contacted the Doctor, who changed the order effective today to HgA1C every 6 months, however, she confirmed that per existing orders at the time, Resident #31's HgA1C lab was due in October and was not done. The DON stated she did not know why the lab was not drawn but will look into it. The DON further stated that it was important to draw labs as ordered by the Physician to monitor Resident #31's diabetic status. 3. Record review of Resident #53's Admission Record, dated 12/16/2024, reflected Resident #53 was initially admitted on [DATE] and readmitted on [DATE]. Resident #53 was noted to be [AGE] years old. Record review of Resident #53's Diagnosis Report, undated, accessed 12/18/2024, reflected Resident #53 was diagnosed with dysphagia (difficulty swallowing) following cerebral infarction (a disruption in the brain's blood flow), heart failure (heart muscle is weakened and cannot pump enough blood to meet the body's needs), and end stage renal disease (condition where the kidneys reach an advanced state of loss of function) with dependence on renal dialysis (a medical procedure that replicates the function of the kidneys by removing waste products and excess fluid from the blood). Record review of Resident #53's Quarterly MDS assessment, dated 10/02/2024 and signed as completed on 10/07/2024 by the DON, reflected Resident #53 had a BIMS of 15, indicating he was cognitively intact. His primary medical condition for admission was stroke (when blood flow to a part of the brain is interrupted). He had active diagnoses of heart failure, hypertension (high blood pressure), renal insufficiency, renal failure, or end-stage renal disease; and diabetes mellitus. He was taking antianxiety and anticoagulant medications and received dialysis treatment. (continued on next page)

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	12/19/2024

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Oak Park Nursing and Rehabilitation Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #53's Care Plan, undated, accessed 12/16/2024, reflected Resident #53 had several medications with a black box warning (required warnings for certain medications that carry serious safety risks), including Midodrine, which indicated a need for staff to closely evaluate and monitor the potential benefits and risks of the medication; date initiated: 08/16/2022 and date revised: 10/16/2024. Resident #53 was also noted as having congestive heart failure; date initiated: 04/30/2022 and revised on 10/19/2022. One of the interventions included Give cardiac medications as ordered.; date initiated: 04/30/2022. Record review of Resident #53's Order Audit Report for physician order, order date 10/04/2024, status Active, Midodrine HCl Tablet 10 mg, revealed the following procedure: Give 1 tablet by mouth one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for hypotension [low blood pressure] give on dialysis days only. Hold if SBP > 110. Record review of Resident #53's December 2024 MAR revealed on 12/06/2024, Resident #53's SBP was 119 for his 0400 (04:00 a.m.) administration; however, his record indicated the medication was checked as Administered by LPN K. Record review of Resident #53's Progress Notes on 12/06/2024 did not reveal notes regarding Midodrine HCl given outside physician order parameters. During an interview with Resident #53 on 12/19/2024 at 10:11 a.m., he stated he only took the blood pressure pill on dialysis days, and it was given only when his blood pressure was low. He stated his blood pressure had been controlled with the medications. During an interview with MD D on 12/19/2024 at 10:43 a.m., MD D revealed he could not recall having been notified of Resident #53's Midodrine HCl having been administered outside parameters. He stated the Midodrine HCl having been administered with Resident #53's systolic blood pressure at 119 would be less worrisome than if it was 130 or 140. He stated 119 was not that high and he did not believe the medication would have caused any harm to Resident #53 with his systolic blood pressure at that level. During an interview with LPN K on 12/19/2024 at 11:13 a.m., LPN K stated he did not recall administering Resident #53's Midodrine HCl on 12/06/2024 with a systolic blood pressure at 119. He stated he did recall holding Resident #53's blood pressure mediation before, and also recalled being called by the dialysis center because Resident #53's blood pressure was bottoming out (getting too low) during his dialysis appointment. LPN K stated, orders are orders but I use my nursing judgment. He stated that he would give Resident #53 his Midodrine HCl because he knows that the dialysis treatment will cause Resident #53's blood pressure to drop. LPN K stated, in his nursing opinion, he would not have held Resident #53's Midodrine HCl when the systolic blood pressure was 119 because Resident #53 would have been going to dialysis right after the medication administration and the dialysis would make Resident #53's blood pressure go down. LPN K stated he would give the medication to ensure Resident #53's blood pressure remained stable at an appropriate level. During an interview with the DON on 12/19/2024 at 03:18 p.m., the DON indicated that if the physician order said to hold the medication if the systolic blood pressure was over 110, then the Midodrine HCl should have been held when the systolic blood pressure was 119. She stated that the nurse was to reach out to the physician and get approval to administer the medication if outside parameters. The DON revealed she was not aware of this medication administration outside parameters. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy, Administering Medications, dated revised December 2012, reflected Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 3. Medications must be administered in accordance with the orders, including any required time frame.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on interview and record review, the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission for 1 of 2 residents (Resident #13) reviewed for physician services. The facility failed to ensure Resident #13 was seen by a physician within the first 30 days of his admission to the facility. This failure could place the residents at risk for medical conditions not being identified, care needs not being met, and a decline in health status. The findings included: Record review of Resident #13's Admission Record, dated 12/16/2024, reflected Resident #13 was admitted on [DATE]. Resident #13 was noted to be [AGE] years old. Record review of Resident #13's Diagnosis Report, undated, accessed 12/19/2024, reflected Resident #13 was diagnosed with quadriplegia (paralysis of all four limbs), polyneuropathy (a disorder that damages the peripheral nerves, which control the movement of the arms and legs), and hypertensive heart disease (heart problems caused by high blood pressure) without heart failure (heart muscle is weakened and cannot pump enough blood to meet the body's needs). Record review of Resident #13's Quarterly MDS assessment, dated 11/13/2024 and signed as completed on 11/15/2024 by the DON, reflected Resident #13 had a BIMS of 15, indicating he was cognitive intact. His primary medical condition for admission was traumatic spinal cord dysfunction (a debilitating condition caused by spinal cord damage). He was noted as having received PRN (as needed) pain medication with reported pain almost constantly over a 5-day period. Record review of Resident #13's Physician Progress Notes, reviewed on 12/18/2024, revealed Resident #13 was first seen by a physician, MD D, on 07/06/2024, 60 days after Resident #13's admission. During an interview with Resident #13 on 12/16/2024 at 12:10 a.m., Resident #13 stated he had problems with his doctor when he was first admitted . He stated the doctor was not responding to his medication concerns and/or the nurses were not telling the doctor about his concerns. He stated he had seen his physician and the nurse practitioners since he was admitted and he was getting better, but he felt the communication with the physician team was a problem. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MD D on 12/19/2024 at 10:43 a.m., MD D revealed as a group, his team goes to the nursing facility two to three times a week. He stated he goes to the facility every week to two weeks. MD D stated for the initial visit, it would depend on who will see the patient, either himself, one of the nurse practitioners, or another physician. MD D stated he could not recall when he first completed a visit with Resident #13, but he would hate for his documentation to be viewed as if he had not been seeing the resident. MD D stated he would often see and visit with Resident #13 in the hall, but he was not sure if he had documented those visits. MD D confirmed the physician note dated July 2024 was his first comprehensive note for Resident #13. MD D revealed Resident #13's care would not have been impacted by a late physician visit because Resident #13 was seen by the nurse practitioner who was able to provide a high level of care. On 12/19/2024 at 04:14 p.m., a Request List, dated 12/19/2024, was sent to the ADMIN. The list included a request for a facility policy on Physician Services- Frequency of visits and Initial Assessment. The Texas Administrative Code, Title 26, Part 1, Chapter 554, Subchapter M, Rule title Frequency of Physician Visits was provided by the facility. Record review of Texas Administrative Code, Frequency of Physician Visits, dated transferred effective January 15, 2021, reflected Physician visits must confirm to the following schedule: . (2) Medicaid-certified facilities and Medicare skilled nursing facilities. (A) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (B) A physician visit is considered timely if it occurs no later than ten days after the date the visit was required. (C) Except as provided in paragraph (3) of this section 19.1205(c) of this subchapter (relating to Physician Delegation of Tasks), all required visits must be made by the physician personally. (3) Medicare skilled nursing facilities. At the option of the physician, required visits in Medicare skilled nursing facilities after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or an advanced practice registered nurse in accordance with 19.1205 of this subchapter. 48366

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33866 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the appropriate identifying accessory and cautionary labeling instructions, and 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 3 of 30 residents (Residents #37, #22, and #53) reviewed for pharmaceutical services, in that: 1. The Hall 100 Nurse's cart contained a Glargine Kwik Pen for Resident #37 which was marked with an open date of 11/3/2024, making it past 28 days from its open date, meaning it was expired. 2. The facility failed to ensure Resident #22's Humalog KwikPen insulin (a lightweight pen that is prefilled with insulin, a hormone that helps the body use glucose for energy) was given per physician order. 3. The facility failed to ensure Resident #53's Midodrine HCl (a medication used to treat low blood pressure) was given per physician order. These failures could place residents at risk of not receiving care to maintain optimum health and placing them at risk for decline in health. The findings were: 1.Record review of Resident #37's face sheet the revealed resident was a [AGE] year-old woman with a re-admitted [DATE] and diagnoses that included: Cerebral infarction (stroke) and Type 2 Diabetes Mellitus (chronic condition where the body has trouble controlling blood sugar). Record review of Resident #37's Order Summary dated 12/19/2024 revealed an order for Basaglar Kwik Pen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) inject 30 unit subcutaneously at bedtime for DM [Diabetes Mellitus] Observation on 12/17/2024 at 5:15 p.m. of the 100 Hall Nurse's medication cart revealed a Glargine insulin Kwik Pen for Resident #37 with an open date of 11/03/2024 written in black marker on the outside of the pen. During an interview with LVN -M on 12/17/2024 at 5:20 p.m., LVN-M confirmed the Glargine insulin Kwik Pen for Resident #37 had an open date of 11/03/2024 and stated that the insulin is only good for 28 days past its open date, so therefore this Glargine insulin Kwik Pen was expired as it had passed the 28-day mark. LVN-M stated that was it was his responsibility as the Nurse using this cart to ensure that expired medications were removed from the medication cart and that each Nurse was responsible for marking open dates upon initial use for each medication. LVN-M stated that insulin that is expired may not be as effective and should not be administered to residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 12/17/2024 at 5:30 p.m., the DON stated she had been made aware of the medication storage concerns, and she stated that each Nurse or Medication Aide was responsible for maintaining their medication carts, which included removing any expired medications. The DON stated that all insulin pens should be marked with the open date, and that they were only good for 28 days past their open date and should be removed and disposed of properly after the 28 days had passed. She stated that the insulin could start losing its efficacy past that 28-day mark. Record review of facility policy titled Storage of Medications revised November 2020 revealed Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 2.Record review of Resident #22's Admission Record, dated 12/18/2024, reflected Resident #22 was initially admitted on [DATE] and readmitted on [DATE]. Resident #22 was noted to be [AGE] years old and on hospice services. Record review of Resident #22's Diagnosis Report, undated, accessed 12/18/2024, reflected Resident #22 was diagnosed with dementia (a general term for impaired ability to remember, think, or make decisions), senile degeneration of brain (loss of intellectual ability associated with old age), and type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel) with hyperglycemia (high sugar levels in the blood). Record review of Resident #22's Quarterly MDS assessment, dated 09/18/2024 and signed as completed on 09/22/2024 by the DON, reflected Resident #22 had a BIMS of 2, indicating severe cognitive impairment, had an active diagnosis of diabetes mellitus, had a life expectancy of less than 6 months, and received insulin injections 7 of the last 7 days monitored for insulin injections. Record review of Resident #22's Care Plan, undated, accessed 12/18/2024, reflected Resident #22 had a history of noncompliance with her medication regimen; date initiated: 12/08/2024. One of the interventions included, Allow the resident to make decisions about treatment regimen, to provide sense of control; date initiated: 12/08/2024. Resident #22 was also noted as having a desired weight loss and on a controlled carbohydrate diet; date initiated: 08/16/2024 and revised on 08/16/2024. One of the interventions included Administer medications as ordered. Monitor/Document for side effects and effectiveness; date initiated: 08/16/2024. Record review of Resident #22's Order Audit Report for physician order, order date 07/10/2024, status noted as active, Humalog KwikPen 100 Unit/Ml Solution pen-injector, revealed the following procedure: Inject as per sliding scale: If 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units, subcutaneously [applied under the skin] before meals and at bedtime related to type 2 diabetes mellitus with diabetic chronic kidney disease. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #22's December 2024 MAR revealed on 12/05/2024 and 12/07/2024, Resident #22's BS (blood sugar) was 150 for her 0600 (06:00 a.m.) administration; however, the code 13, noted under chart codes as No Insulin Required, was coded by LPN K. Record review of Resident #22's Progress Notes on 12/05/2024 and 12/07/2024 did not reveal notes regarding insulin not required. During an interview with Resident #22 on 12/19/2024 at 10:28 a.m., she stated she had no concerns with her insulin administration. She stated her blood sugars go up and down. During an interview with MD D on 12/19/2024 at 10:43 a.m., MD D revealed he had not been notified of any insulin errors or concerns. He stated Resident #22's sliding scale order was arbitrary (based on personal choice) and her having not received her prescribed 2 units when her blood sugar was at 150 would have had no impact on her health. During an interview with LPN K on 12/19/2024 at 11:13 a.m., LPN K stated Resident #22's blood sugars were always in range, and he did not need to administer insulin for her. LPN K stated that to him, when Resident #22's blood sugar was at 150, he did not see a reason to administer insulin because Resident #22 was in range, so he would hold the insulin. He stated that having held the insulin when Resident #22 was at 150 had not caused any harm and Resident #22 was very aware and able to notify him if she had concerns. During an interview with the DON on 12/19/2024 at 03:18 p.m., the DON stated to monitor medication administrations, the facility performed check-offs with the nurses, held in-services, and reviewed daily reports that show which medication administrations were coded with an exception code or those marked as not completed. The DON stated that if the physician order said to give insulin at 150, she would expect the nurse to administer the insulin and follow the physician order. She stated that the nurse was to call the physician and obtain a hold order if they are not giving the insulin. The DON stated that the impact on the resident for not administering the insulin when the blood sugar was 150 would depend on the resident and on when and what the resident's next meal was. 3. Record review of Resident #53's Admission Record, dated 12/16/2024, reflected Resident #53 was initially admitted on [DATE] and readmitted on [DATE]. Resident #53 was noted to be [AGE] years old. Record review of Resident #53's Diagnosis Report, undated, accessed 12/18/2024, reflected Resident #53 was diagnosed with dysphagia (difficulty swallowing) following cerebral infarction (a disruption in the brain's blood flow), heart failure (heart muscle is weakened and cannot pump enough blood to meet the body's needs), and end stage renal disease (condition where the kidneys reach an advanced state of loss of function) with dependence on renal dialysis (a medical procedure that replicates the function of the kidneys by removing waste products and excess fluid from the blood). Record review of Resident #53's Quarterly MDS assessment, dated 10/02/2024 and signed as completed on 10/07/2024 by the DON, reflected Resident #53 had a BIMS of 15, indicating he was cognitively intact. His primary medical condition for admission was stroke (when blood flow to a part of the brain is interrupted). He had active diagnoses of heart failure, hypertension (high blood pressure), renal insufficiency, renal failure, or end-stage renal disease, and diabetes mellitus. He was taking antianxiety and anticoagulant medications and received dialysis treatment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #53's Care Plan, undated, accessed 12/16/2024, reflected Resident #53 had several medications with a black box warning (required warnings for certain medications that carry serious safety risks), including Midodrine, which indicated a need for staff to closely evaluate and monitor the potential benefits and risks of the medication; date initiated: 08/16/2022 and date revised: 10/16/2024. Resident #53 was also noted as having congestive heart failure; date initiated: 04/30/2022 and revised on 10/19/2022. One of the interventions included Give cardiac medications as ordered.; date initiated: 04/30/2022. Record review of Resident #53's Order Audit Report for physician order, order date 10/04/2024, status Active, Midodrine HCl Tablet 10 mg, revealed the following procedure: Give 1 tablet by mouth one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for hypotension [low blood pressure] give on dialysis days only. Hold if SBP > 110. Record review of Resident #53's December 2024 MAR revealed on 12/06/2024, Resident #53's SBP was 119 for his 0400 (04:00 a.m.) administration; however, his record indicated the medication was checked as Administered by LPN K. Record review of Resident #53's Progress Notes on 12/06/2024 did not reveal notes regarding Midodrine HCl given outside physician order parameters. During an interview with Resident #53 on 12/19/2024 at 10:11 a.m., he stated he only took the blood pressure pill on dialysis days, and it was given only when his blood pressure was low. He stated his blood pressure had been controlled with the medications. During an interview with MD D on 12/19/2024 at 10:43 a.m., MD D revealed he could not recall having been notified of Resident #53's Midodrine HCl having been administered outside parameters. He stated the Midodrine HCl having been administered with Resident #53's systolic blood pressure at 119 would be less worrisome than if it was 130 or 140. He stated 119 was not that high and he did not believe the medication would have caused any harm to Resident #53 with his systolic blood pressure at that level. During an interview with LPN K on 12/19/2024 at 11:13 a.m., LPN K stated he did not recall administering Resident #53's Midodrine HCl on 12/06/2024 with a systolic blood pressure at 119. He stated he did recall holding Resident #53's blood pressure mediation before, and also recalled being called by the dialysis center because Resident #53's blood pressure was bottoming out (getting too low) during his dialysis appointment. LPN K stated, orders are orders but I use my nursing judgment. He stated that he would give Resident #53 his Midodrine HCl because he knows that the dialysis treatment will cause Resident #53's blood pressure to drop. LPN K stated, in his nursing opinion, he would not have held Resident #53's Midodrine HCl when the systolic blood pressure was 119 because Resident #53 would have been going to dialysis right after the medication administration and the dialysis would make Resident #53's blood pressure go down. LPN K stated he would give the medication to ensure Resident #53's blood pressure remained stable at an appropriate level. During an interview with the DON on 12/19/2024 at 03:18 p.m., the DON indicated that if the physician order said to hold the medication if the systolic blood pressure was over 110, then the Midodrine HCl should have been held when the systolic blood pressure was 119. She stated that the nurse was to reach out to the physician and get approval to administer the medication if outside parameters. The DON revealed she was not aware of this medication administration outside parameters. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interview and record review, the facility failed to ensure residents' pharmacist medication regimen review recommendations were reviewed by the resident's attending physician and the physician documented what, if any, action has been taken to address them, for 1 of 6 residents (Residents #2) whose records were reviewed for pharmacy services. After 11/18/24 medication review for Resident #2, the facility failed to add a doctor's order as was recommended by the pharmacist and approved by MD D. This failure could place residents at risk for significant health status declines. The findings included: Record review of Resident #2's admission record, dated 12/19/24, reflected a [AGE] year-old resident initially admitted on [DATE] with diagnosis to include type 2 diabetes, hypertension (high blood pressure), chronic kidney disease. Record review of Resident #2's quarterly MDS Assessment, dated 12/06/24, reflected Resident #2 had a BIMS score of 9 out of 15, indicating moderate cognitive impairment. Record review of Resident #2's Consultant Pharmacist/Physician Communication, signed by MD D on 11/18/24, reflected Resident has an order for Bumetanide and Glipizide. Please consider BMP and [HgbA1c] every 6 months. Record review of Resident #2's doctor's orders as of 12/19/24 reflected no orders of BMP or HgbA1c. Resident #2's doctor's orders reflected Bumetanide Oral Tablet 1 MG and glipizide oral tablet 5 MG. During an interview on 12/18/24 at 06:12 PM, ADON A revealed not updating Resident #2's doctor's orders as was recommended by the pharmacist and approved by MD D was an oversight and they will change Resident #2's doctor's orders immediately. During an interview on 12/19/24 at 11:15 AM, the DON revealed it was important to follow an order to check a resident's A1c to monitor the A1C for the resident's health. During an interview on 12/19/24 at 04:00 PM, the DON revealed she was going to implement audits of various things like the pharmacy reviews to ensure the facility was not overlooking pharmacy and doctor recommendations. Requested policy for pharmacy reviews on 12/23/24 at 12:18 PM. No policy received. Requested policy for following doctor's orders on 12/19/24 at 03:09 PM, 12/19/24 at 04:14 PM, and 12/23/24 at 12:18 PM. No policy received.

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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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33866 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions for 2 of 4 medication carts (Hall 100 Nurse's and Medication Aide carts) reviewed for medication labeling and storage, in that: 1. The Hall 100 Nurse's cart contained a plastic bag which contained (3) opened and used Lispro insulin Kwik Pens for Resident #29, but only one of the Lispro Kwik Pens had an open date, resulting in no way for the Nurse to tell how long the other (2) pens had been opened, and if they were past their expiration dates. 2. The Hall 100 Medication Aide's cart contained (2) loose pills in single separate blister packs on the bottom of the 3rd drawer of the medication cart, with no pharmacy label on the pills with the resident's name and any cautionary information. These failures could place residents at risk of receiving expired or incorrect medications. Findings included: 1. Record review of Resident #29's face sheet revealed the resident was a [AGE] year-old-woman with an admitted [DATE] and diagnoses which included: Metabolic Encephalopathy (disturbance of brain function) and Type 2 Diabetes Mellitus. Record review of Resident #29's Order Summary dated [DATE] revealed an order for Humalog Kwik Pen Subcutaneous Solution Pen-injector 100unit/ml (Insulin Lispro) inject as per sliding scale Observation on [DATE] at 5:15 p.m. of the 100 Hall Nurse's medication cart revealed a plastic bag containing (3) Lispro insulin Kwik Pens with a pharmacy label for Resident #29 on the outside of the plastic bag. All three of the Lispro insulin Kwik Pens had been opened and used (as indicated by content of solution in vial), but only one of the pens had an open date written on the outside of the pen of [DATE]. The other two Kwik Pens had no open date. During an interview with LVN -M on [DATE] at 5:20 p.m., LVN-M stated that there should not be more than one insulin pen for each resident opened and being used at any one time, as the insulin pens were to be kept refrigerated until opened, at which time they could be stored at room temperature but were good for only 28 days past their open date. He stated that if the insulin pens did not have an open date, there was no way to tell when the medication would be expired. LVN-M stated that each Nurse was responsible for marking open dates upon initial use for each medication. LVN-M stated that insulin that is expired may not be as effective and should not be administered to residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on [DATE] at 5:08 p.m. of the 100 Hall Medication Aide medication cart revealed (2) single pills in separate individual blister packs laying loose on the bottom of the 3rd drawer of the medication cart. The pills were labeled as: Diltiazem 120mg and Metoprolol 100mg. The pills were not labeled with pharmacy label with Resident's name or any cautionary information. During an interview with MA-O on [DATE] at 5:13 p.m. MA-O state that the pills should not have been laying loose in the medication cart like that without a corresponding pharmacy label with Resident's name and stated that she did not leave the pills there, noting other medication aides use the same cart on other shifts. She stated she would remove the pills from the medication cart for proper disposal. During an interview with the DON on [DATE] at 5:30 p.m., the DON stated she had been made aware of the medication storage concerns, and she stated that each Nurse or Medication Aide was responsible for maintaining their medication carts, which included ensuring all medications were properly labeled, and marked with open dates and cautionary information. The DON stated that all insulin pens should be marked with the open date, and that they were only good for 28 days past their open date and should be removed and disposed of properly after the 28 days had passed. She stated that the insulin could start losing its efficacy past that 28-day mark, and if the open date was not marked, there was no way to tell when the insulin was expired. The DON further stated that there should not be any loose prescribed medications in the cart that were not labeled with Resident's name and cautionary information. Record review of facility policy titled Storage of Medications revised [DATE] revealed 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interview and record review, the facility failed to ensure labratory services were provided to meet the needs of the resident in accordance with professional standards of practice, and for 1 of 30 residents (Resident #31) reviewed for labratory service. The facility failed to ensure Resident #31's HgA1c lab (a blood test that measure the average blood sugar level of the past 3 months) was drawn every 3 months as per physician order. These failures could place residents at risk of not receiving care to maintain optimum health and placing them at risk for decline in health. Findings included: Record review of Resident #31's face sheet dated 12/18/2024, revealed she was a [AGE] year-old woman initially admitted on [DATE] and readmitted on [DATE], with diagnoses which included: cerebral infarction (stroke), quadriplegia (paralysis which affects all 4 limbs), and type 1 diabetes mellitus without complications (lifelong condition where the pancreas makes little or no insulin, leading to high blood sugar levels). Record review of Resident #31's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment and active diagnosis of Diabetes Mellitus. Record review of Resident #31's care plan initiated on 08/17/2021 reflected a focus area of Diabetes Mellitus with goal of will have no complications related to diabetes . Record review of Resident #31's Physician Order Summary dated 12/19/2024 revealed an order dated 07/29/2024 for: HgA1C Q 3 months Record review of Resident #31's lab results in her clinical record reveal her only HgA1C lab was drawn 07/27/2024. During an interview with the DON on 12/19/2024 at 10:50 a.m., the DON confirmed the last HgA1C lab for Resident #31 was drawn on 07/27/2024, and that per physician orders, another HgA1C should have been drawn 3 months later in October 2024. She stated she contacted the Doctor, who changed the order effective today to HgA1C every 6 months, however, she confirmed that per existing orders at the time, Resident #31's HgA1C lab was due in October and was not done. The DON stated she did not know why the lab was not drawn but will look into it. The DON further stated that it was important to draw labs as ordered by the Physician to monitor Resident #31's diabetic status.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observation, interview, and record review, the facility failed to follow menus for 1 of 1 resident meals (dinner meal on 12/18/2024) reviewed for menus in that: The facility failed to follow the menu for residents on pureed diets for the dinner meal on 12/18/2024. This failure could place residents who consume food prepared by the facility kitchen at risk of not having their nutritional needs met and/or weight loss. The findings included: Record review of Fall Winter Menu Week 4 2024-2025 for Wednesday (Day 25) Supper reflected Sloppy [NAME], Tater Tots, and Coleslaw. Record review of the pureed substitutes for Day 25 menu was Pureed Sloppy [NAME], Pureed Tater Tots, and Pureed Soft Cooked Vegetables. Record review of Pureed Tater Tots included ingredients Chicken Base, Water, and Tater Tots. Record review of Pureed Soft Cooked Vegetables included ingredients Soft, Cooked vegetable and Margarine, Solids. During an interview while [NAME] Y pureed food preparation for 12/18/24 dinner on 12/18/24 at 02:27 PM, [NAME] Y revealed she did not need to puree tater tots because they were going to make instant mashed potatoes instead. Observation revealed [NAME] Y pureed cabbage for the vegetable portion. [NAME] Y revealed she added 1 tablespoon of chicken base and 1 tablespoon of lemon pepper to the pureed soft, cooked vegetable. During an interview on 12/19/24 at 09:49 AM, the CDM revealed they used instant mashed potatoes instead of pureed tater tots because it was not possible for the pureed tater tots to get to the right pureed consistency. She further revealed this substitution was to ensure resident safety and prevent choking. The CDM revealed the kitchen added lemon pepper and chicken base to the pureed soft, cooked vegetables for flavor and because this would ensure residents would eat these foods. The CDM revealed she did not have a substitution log to reflect using instant mashed potatoes instead of pureed tater tots or the change in the soft, cooked vegetable. During an interview on 12/19/24 at 10:01 AM, the RD revealed the kitchen should have a substitution log if they did not follow the menu. She revealed the kitchen did not substitute frequently so she could not recall the last time she signed this log. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/24 at 04:00 PM, ADON B revealed it was important to follow recipes for the health of the residents, to ensure weights were stabilized, and to control sodium intake as needed. Record review of facility's policy, revised April 2007, Standardized Recipes reflected, Standardized recipes shall be developed and used in the preparation of foods.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48366 Based on observation, 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, in that: 1. In a refrigerator, there were foods that were not labeled with the name of the food product and discard dates. 2. In the walk-in refrigerator, there were food products that needed to be discarded as it was past their use-by dates. 3. Dietary Aide T and [NAME] U had nose rings while handling food. 4. In the food preparation area, there were personal beverages and outside food in a to-go container. 5. Dietary Aide V documented the refrigerator temperature was 42*F on 12/01/2024. Dietary Aide V did not assess what could have caused this temperature reading, which was the kitchen's protocol. 6. Dusty debris was on the chains above the food preparation area that held cooking ware. These failures could place residents who consumed meals and/or snacks prepared in the facility kitchen in danger of food-borne illness. The findings were: 1. Interview and observations of one of the refrigerators on 12/16/24 at 10:09 AM (initial kitchen tour) revealed prepared salads were not labeled with a discard date. The only date on the wrapped food product was 12/15/24. The CDM revealed this was the date Dietary Aide T prepared these. The CDM and Dietary Aide T revealed the prepared food products should have a discard date. It was also observed drinks were not labeled correctly as cranberry and apple juice but were labeled as C and A on the lids of these cups. The CDM revealed these should not be labeled as C and A. 2. Interview and observations on 12/16/24 at 10:09 AM (initial kitchen tour) revealed in one of the walk-in refrigerators, ham salad had a use by date of 12/15/24 and cheese with a use by date of 12/13/24. The CDM revealed these food products should not be in the walk-in refrigerator and threw these food products out. 3. Observation on 12/16/24 at 10:09 AM (initial kitchen tour) revealed Dietary Aide T had a nose ring while preparing for 12/16/24 lunch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation on 12/18/24 at 11:30 AM revealed [NAME] U had a nose ring while checking temperatures for 12/18/24 lunch. The CDM revealed these nose rings were okay because they were small enough and there was not a regulation that stated facial jewelry was not allowed while working in the kitchen. 4. Interview and observation on 12/18/24 at 11:30 AM revealed a few personal beverages of soda in the food preparation area. There was a bag of condiments and some food in a to-go Styrofoam container in a plastic bag. The CDM revealed the food container should not be there, but it was okay to have the personal beverages in this area. 5. Record Review on 12/18/24 at 11:30 AM of December 2024 Refrigerator temperatures reflected 42*F documented on December 1st for the evening shift by Dietary Aide V. During an interview on 12/18/24 at 02:27 PM, the CDM revealed she asked Dietary Aide V, who works in the evening, about this temperature and Dietary Aide V revealed the temperature was 42*F because they took the temperature after the refrigerator door had been opened. Dietary Aide V revealed she had checked the temperature a little bit later and it was less than 40*F but she did not write this number down. The CDM revealed the temperature may be more than 40*F if the temperature was taken during service or right after the door had been opened for some time. The CDM revealed she trained all the evening staff to call her anytime the temperatures were not within normal limits and the CDM would solve any possible issue. 6. Interview and observation on 12/18/24 at 11:30 AM revealed dusty debris on the apparatus that was holding hanging kitchen utensils. The CDM revealed this needed to be cleaned and maintenance was to come and clean this dust. Record Review of facility's policy, revised November 2022, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, reflected Jewelry will be kept to a minimum. Record Review of U.S. Food and Drug Administration's 2022 Food Code reflected, 2-303 Jewelry 2-303.11 Prohibition. Except for a plain ring such as a wedding band, while preparing FOOD, FOOD EMPLOYEES may not wear jewelry . Record Review of U.S. Food and Drug Administration's 2022 Food Code reflected, 2-302.12 Food Storage Containers, Identified with Common Name of Food . working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT . shall be identified with the common name of the FOOD. Record review of facility's policy, revised November 2022, Food Preparation and Service, reflected All food service equipment and utensils will be sanitized according to current guidelines and manufacturers' recommendations. Record Review of U.S. Food and Drug Administration's 2022 Food Code reflected, 3-307 Preventing Contamination from Other Sources 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's policy, revised November 2022, Refrigerators and Freezers reflected, . Refrigerators keep foods at or below 41*F . Record review of facility's policy, revised November 2022, Food Receiving and Storage, reflected, All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). Record Review of U.S. Food and Drug Administration's 2022 Food Code reflected, 3-5 Limitation of Growth of Organisms of Public Health Concern 3-501 Temperature and Time Control 3-501.12 Time/Temperature Control for Safety Food, Slacking . (A) Under refrigeration that maintains the FOOD temperature at 5*C (41*F) or less . 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) . READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES .

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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** 46447 Based on interviews and record review, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 5 residents (Resident #62) reviewed for clinical records. 1. The facility failed to ensure LPN J accurately documented on Resident #62's MAR (Medication Administration Record) when on 12/02/2024 she held the physician ordered Losartan Potassium (a blood pressure medication) because the resident's blood pressure was outside the approved range. 2. The facility failed to obtain signed consents for antipsychotic medications for Resident #73 who was administered Risperdal Oral Tablet 0.5 MG (Risperidone) related to bipolar disorder). (Risperidone is an atypical antipsychotic used to treat schizophrenia and bipolar disorder) and required a written signature on Form 3713, Nursing Facility Consent for Antipsychotic or Neuroleptic Medication Treatment. 3. The facility failed to obtain signed consent for Resident #60's antipsychotic medication for Quetiapine fumarate Tablet 50 MG related to Schizoaffective Disorder, Bipolar type. (Quetiapine fumarate (also known as Seroquel) is an atypical antipsychotic used to treat Schizophrenia and Bipolar disorder) and required a written signature on Form 3713, Nursing Facility Consent for Antipsychotic or Neuroleptic Medication Treatment. 4. The facility failed to obtain signed consents for Resident #91's antipsychotic medications Risperdal 1MG for Antipsychotic (Risperdal, also known as Risperidone, is an atypical antipsychotic used to treat schizophrenia and bipolar disorder) and for Paroxetine 10MG (Paroxetine, also known as Paxil, is an antidepressant that belongs to a group of drugs called Selective Serotonin Reuptake Inhibitor (SSRI) and is used to treat depression, anxiety, or other disorders) that were administered to him required a written signature on Form 3713, Nursing Facility Consent for Antipsychotic or Neuroleptic Medication Treatment. These deficient practices could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. Findings included: 1. Record review of Resident #62's Admission Record, dated 12/16/2024, reflected Resident #62 was initially admitted on [DATE] and readmitted on [DATE]. Resident #62 was noted to be [AGE] years old. Record review of Resident #62's Diagnosis Report, undated, accessed 12/18/2024, reflected Resident #62 was diagnosed with mononeuropathy (damage that happens to a single nerve which can cause pain, loss of movement and/or numbness), chronic obstructive pulmonary disease (a type of progressive lung disease), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #62's Annual MDS assessment, dated 09/30/2024 and signed as completed on 10/07/2024 by the DON, reflected Resident #62 had a BIMS of 15, indicating he was cognitively intact. He had an active diagnosis of hypertension (high blood pressure). Record review of Resident #62's Order Audit Report for physician order, order date 12/01/2023, status Active, Losartan Potassium Oral Tablet 25 mg (Losartan Potassium), revealed the following procedure: Give 25 mg by mouth one time a day related to essential (primary) hypertension .Hold if SBP [systolic blood pressure] less than 110 DBP [diastolic blood pressure] less than 60, or HR [heart rate] less than 60. Record review of Resident #62's December 2024 MAR revealed on 12/02/2024, Resident #62's blood pressure was 104/56 for his 0800 (08:00 a.m.) administration; however, his record indicated the Losartan Potassium medication was checked as Administered by LPN J. Record review of Resident #62's Progress Notes on 12/02/2024 did not reveal notes regarding Losartan Potassium given outside physician order parameters. During an interview with Resident #62 on 12/16/2024 at 11:45 a.m., Resident #62 stated he had no concerns about his medications having been messed up. During an interview with LPN J on 12/19/2024 at 09:57 a.m., LPN J stated when administering medications, she would first click Yes on the medication administration screen when preparing the medication for administration and then click Complete after the medication was administered. She stated for medications with a parameter, such as the Losartan Potassium, she would have kept that medication in a separate container from the other medications ready for administration in case it was required to be held due to the parameters or if the medication was refused by the resident. She stated for Resident #62's Losartan Potassium order, she would have held the medication when his blood pressure was at 104/56 because it was under the administration parameters for the systolic blood pressure and diastolic blood pressure. She stated she did not remember her administration on 12/02/2024, but had to assume she checked the wrong button, Complete, in error. She stated she thinks she held the medication. During an interview with MD D on 12/19/2024 at 10:43 a.m., MD D revealed if Resident #62 had received his Losartan Potassium when his blood pressure was at 104/62, it could have impacted Resident #62 but would not have caused an emergency. MD D stated that if he had been notified of this error, he would have asked the staff to continually check Resident #62's blood pressure and to ask Resident #62 how he was feeling. MD D stated he did not recall any notifications of this error. During an interview with the DON on 12/19/2024 at 03:18 p.m., the DON indicated that if the physician order said to hold the medication if the systolic blood pressure was under 110 and if the diastolic blood pressure was under 60, then the Losartan Potassium should have been held when the blood pressure was 104/56. She stated that if this medication was administered outside of parameters, it could have impacted the resident. She stated that her expectation was for the nurse to reach out to the physician and document what the physician said when administering a medication outside the ordered parameters. The DON revealed she was notified by LPN J of this error on this day, 12/19/2024 about 5 minutes prior to the current interview. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy, Administering Medications, dated revised December 2012, reflected Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . 3. Medications must be administered in accordance with the orders, including any required time frame. 2. Record review of Resident #73's Admission record revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses of Type II Diabetes mellitus, Epilepsy, Generalized anxiety disorder, Unspecified Developmental Delays, bipolar Disorder, current episode depressed, severe, without psychotic features. Record review of Resident #73's Quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 4 indicating severe cognitive impairment for daily decision making and took antipsychotic medications during the last 7 days. Record review of Resident #73's care plan reflected it contained a care area under Psychosocial Well-Being, last edited on 8/26/24, that stated the resident has a mood problem r/t anxiety disorder, bipolar disorder without psychotic features and was seen by psych services with interventions to administer medications as ordered. Record review of Resident #73's December active physicians orders as of 12/19/24 revealed an order dated 6/24/24 for Risperdal Oral tablet 0/5 MG (Risperidone) Give 1 tablet by mouth two times a day. Record review of Resident #73's medical record revealed no consent for Risperdal obtained. 3. Record review of Resident #60's Admission record revealed an [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses of unspecified Dementia, Schizoaffective Disorder, Bipolar Type, Major Depressive disorder, anxiety disorder, chronic pain syndrome, Hypertension, Congestive heart failure, Hyperlipidemia. Record review of Resident #60's Quarterly MDS assessment dated [DATE] revealed the resident had a BIMS score of 6 indicating severe cognitive impairment for daily decision making and took antipsychotic medications during the last 7 days. Record review of Resident #60's care plan reflected it contained a care area last edited 2/9/22 that stated resident used psychotropic medications: Quetiapine. Record review of Resident #60's December active physicians orders as of 12/19/24 revealed an order dated 10/24/22 for Quetiapine Fumarate Tablet 25 MG, Give 2 tablet my mouth two times a day related to Schizoaffective Disorder, Bipolar Type. Record review of Resident #60's medical record revealed no consent for Quetiapine obtained. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of Resident #91's admission record revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE] with diagnoses of Unspecified dementia, major depressive disorder, unspecified psychosis, visual loss, hearing loss, Chronic kidney disease, Stage 4, convulsions, benign prostatic hyperplasia. Record review of Resident #91's Comprehensive MDS assessment dated [DATE] revealed the resident has a BIMS score of 5 indicating severe cognitive impairment for daily decision making and took antipsychotic medications during the last 7 days. Record review of Resident #91's care plan reflected it contained a care area last edited 10/10/24 that stated resident is at risk for potential complications from antipsychotic medication and a care area last edited 10/10/24 that stated resident used antidepressant medication (Paroxetine) r/t depression. Record review of Resident #91's medical record reveal no consent for Risperdal or Paroxetine obtained. Record review of Resident #91's December active physicians orders as of 12/18/24 revealed an order dated 9/30/24 for Risperdal 1 MG (Risperidone) Give 0.5 tablet by mouth at bedtime for Antipsychotics and an order dated 9/30/24 for Paroxetine HCl oral Tablet 10 MG (Paroxetine HCl) Give 1 tablet by mouth at bedtime for depression. During an interview on 12/18/24 at 2:50 PM with LVN C revealed that charge nurses can obtain verbal or written consent from resident and/or responsible party for psychotropic medications. During an interview on 12/18/24 at 3:06 PM, LVN A revealed that floor nurses can obtain the verbal or written consent and that she is reviews the orders every morning to ensure consents are obtained. During an interview on 12/19/24 at 3:30 PM, DON stated that when an order was received, staff reach out to family to let them know of new medications. The DON stated that if resident and/or responsible party decline to give consent, medication is not given. The DON stated consents are kept in a binder and reviewed monthly during time frame when pharmacy review was completed. DON stated that medications cannot be started if consent was not obtained and could adversely affect residents if medication is warranted. DON confirmed that facility did not obtain appropriate consent for psychotropic and antipsychotic medications. Record review did not reveal the required Form 3713 for written consent to receive antipsychotic medication for any of the above medications for resident #60 (Risperdal), #73 (Quetiapine) and #91 (Risperdal) and did not reveal facility consent for psychotropic medications for Resident #91's use of Paroxetine . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, revised March 2019, stated, Management 4. The resident and family/representatives will be informed of the resident's condition as well as the potential risks and benefits or proposed interventions and 10, When medications are prescribed for behavioral symptoms, considerations will include: a. Rationale for use; d. Potential risks and benefits of medications as discussed with the resident and/or family; f. Dosage; g. Duration. Per LTCR Provider Letter PL 2022-11, Title consent for Antipsychotic and Neuroleptic Medications issued 5/5/22, under 26 TAC 554.1207 a resident receiving antipsychotic or neuroleptic medications must provide written consent. 2.1 Consent for Antipsychotic and Neuroleptic medications with for 3713 revealed if the antipsychotic or neuroleptic medication is being prescribed to a resident for the first time, a nursing facility must complete form 3713 before the first dose is administered.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician and others participating in the provision of care for 1 of 2 residents (Resident #22) reviewed for hospice services. The facility failed to maintain required hospice forms and documentation, that included the current hospice plan of care to ensure Resident #22 received adequate end-of-life care. This failure could place the residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. The findings included: Record review of Resident #22's Admission Record, dated 12/18/2024, reflected Resident #22 was initially admitted on [DATE] and readmitted on [DATE]. Resident #22 was noted to be [AGE] years old and on hospice services. Record review of Resident #22's Diagnosis Report, undated, accessed 12/18/2024, reflected Resident #22 was diagnosed with dementia (a general term for impaired ability to remember, think, or make decisions), senile degeneration of brain (loss of intellectual ability associated with old age), and type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel) with hyperglycemia (high sugar levels in the blood). Record review of Resident #22's Quarterly MDS assessment, dated 09/18/2024 and signed as completed on 09/22/2024 by the DON, reflected Resident #22 had a BIMS of 2, indicating severe cognitive impairment and had a life expectancy of less than 6 months. Record review of Resident #22's Care Plan, undated, accessed 12/18/2024, reflected Resident #22 was on hospice and had a terminal prognosis (medical condition with likely outcome of eventual death) related to senile degeneration of brain; date initiated: 08/21/2024 and revised on 10/26/2024. Record review of Resident #22's Order Summary Report, dated 12/18/2024, reflected order Admit to [Hospice S] dx [diagnosis]: senile degeneration of brain. Order dated 07/31/2024 and status noted as Active. Observation and record review of Resident #22's physical hospice binder on 12/19/2024 at 10:25 a.m. revealed initial hospice plan of care, certification period and current benefit period/range: 07/24/2024 to 10/21/2024. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN J on 12/19/2024 at 10:26 a.m., LPN J stated the Hospice S nurse for Resident #22 had recently changed. LPN J stated she did not know if the Hospice S nurse brought any paperwork with her at her last visit. During an interview with Resident #22 on 12/19/2024 at 10:28 a.m., Resident #22 stated she felt the facility was communicating well with Hospice S and she had not had any problems with her care provided by Hospice S or Nursing Facility R. Record review of Resident #22's electronic record on 12/19/2024 at 01:25 p.m. revealed no evidence of the current hospice plan of care. During an observation and interview with ADON B on 12/19/2024 at 02:14 p.m., ADON B stated he, ADON A, and the DON coordinate with the hospice providers. He stated that the ADONs were typically assigned their own halls, he was assigned Resident #22's hall, but that they coordinated with each other as well. He stated the current care plan should be up to the hospice to bring in. ADON B was observed reviewing Resident #22's hospice binder and confirmed the current plan of care was not present. ADON B stated the facility social worker, SW I, and the MDS Nurse would typically get the forms from the hospice, but it was primarily the social worker, who was involved in the facility contracts. ADON B stated he could call Hospice S and they would send the updated plan of care. During an interview with SW I on 12/19/2024 at 02:23 p.m., SW I stated she communicated with the hospice companies regarding the referral process, but the nursing staff did facilitation of care. SW I stated the facility did review the hospice books, both nursing staff and herself. SW I stated for hospice, she primarily provided assistance with certain forms (identified two Medicare and Medicaid forms that allow for billing), but was unsure who was responsible in verifying a current plan of care form was present. SW I stated that responsibility would be nursing. SW I stated Resident #22 had a care plan meeting since she went on hospice and her hospice care had been very good. SW I stated the facility not having an updated hospice Plan of Care for Resident #22 would not have impacted her care. During an interview with the DON on 12/19/2024 at 03:18 p.m., the DON stated the social worker was in charge of the hospice binders. She stated the nurses help but the system fell on the social worker. The DON stated that the facility had facility care plans for residents, so the hospice care plan would only refer to the hospice's care. The DON stated Resident #22's care would not have been impacted by not having a current hospice plan of care because the facility care was based on the facility care plan. The DON stated that if there were any changes in the hospice's plan of care, it would have been communicated to the nursing staff on the facility's internal communication report. The DON stated there had not been any concerns with communication with the hospice providers. During an observation and record review on 12/19/2024 at 03:48 p.m., received updated hospice plan of care, benefit period dates: 10/22/2024 to 12/19/2024. Document noted to have been printed on 12/19/2024 at 04:18 p.m. Eastern Time Zone (03:18 p.m. Central Standard Time). Nursing Facility R was in Central Standard Time zone. Record review of Hospice S contract with Nursing Facility R, dated as signed 10/21/2022, by Area of [NAME] President of Operations for Hospice S and the ADMIN of Nursing Facility R. The contract reflected under 1. Definitions . (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.11 'Plan of Care' means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by the Hospice IDG [group of qualified individuals employed or contracted by Hospice] in coordination with Facility and each Patient's attending physician, if any. The Plan of Care must reflect goals of each Patient and his or her family and interventions based on the problems identified in each Patient's assessments. The Plan of Care will reflect the participation of the Hospice, Facility, a Patient and his or her family to the extent possible. Specifically, the Plan of Care includes: (i) identification of the Hospice Services, including interventions for pain management and symptom relief, and Facility Services needed to meet a Patient's needs and the related needs of his or her family; (ii) a statement of the scope and frequency of such Hospice Services and Facility Services; (iii) measurable outcomes anticipated from implementing and coordinating the Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Patient; (v) medical supplies and appliances necessary to meet the needs of the Patient; and (vi) documentation of the Patient's or representative's level of understanding, involvement and agreement with the Plan of Care . 2. Responsibilities of Facility . 2.1.2.3 Facility Representative. Facility shall designate the Director of Nursing as the individual in Facility who shall be responsible for implementation of the provisions of this Agreement (Facility Representative). Facility shall notify Hospice if an individual other than the Director of Nursing is designated as the Facility Representative . 2.8 Coordination of Care . 2.8.4 Designated Facility Member. Facility shall designate a member of Facility's interdisciplinary team who is responsible for working with Hospice representative to coordinate care to each Patient provided by Facility and Hospice .Facility's designated team member shall be responsible for: .(v) obtaining patient-specific information from Hospice as required by applicable laws and regulations; . Record review of facility policy, Hospice Program, dated revised July 2017, reflected under Policy Interpretation and Implementation, 12. Our facility has designated See Administrator for Contract (Name) (Title) to coordinate care provided to the resident by our facility staff and the hospice staff. (Note: this individual is a member of the IDT [Interdisciplinary Team] with clinical and assessment skills who is operating within the State scope of practice act). He or she is responsible for the following: . d. Obtaining the following information from the hospice: (1) The most recent hospice plan of care specific to each resident;.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 4 of 12 residents (Residents #74, #20, #40 and #54) reviewed for infection control in that: 1. The facility failed to ensure CNA-Q followed proper infection control practices by not changing gloves and sanitizing hands after touching privacy curtain to pull it around the bed, then proceeding with catheter and peri-care with Resident #74. 2. The facility failed to ensure CNA-P followed proper infection control practices while emptying the colostomy bag for Resident #20 by not changing her gloves after emptying the colostomy bag into a basin, and before touching the bathroom door handle and shower handle when taking the basin to the bathroom to empty and rinse the basin. 3. The facility failed to ensure LVN-N washed or sanitize her hands after picking up a pen she dropped from the floor, and before proceeding with medication administration to Resident #40. 4. The facility failed to ensure LVN-L followed Enhanced Barrier Precautions (EBP) when she did not wear a gown while administering medications via g-tube for Resident #54. These failures could place residents at risk for cross contamination and the spread of infection. Finding included: 1. Record review of Resident #74's face sheet, dated 12/19/2024, revealed he was a [AGE] year old man who was initially admitted [DATE], with re-admission 08/08/2023 and with diagnoses which included: Obstructive Hydrocephalus (blockage of flow of cerebrospinal fluid), Obstructive and Reflux Uropathy (condition where flow of urine is blocked) and Hydronephrosis with renal and ureteral calculous obstruction (condition where one or both kidneys swell due to a blockage in urinary tract). Record review of Resident #74's Quarterly MDS dated [DATE] revealed a BIMS score of 5, indicating severe cognitive impairment. Further review revealed Resident #74 was assessed as having an indwelling catheter (including suprapubic catheter - a medical device that drains urine from bladder used when the urethra is damaged or blocked) and being totally dependent with toileting hygiene. Record review of Resident #74's Physician Order Summary dated 12/19/2024 revealed an order to Flush Supra Pubic with 60cc NS for irrigation every shift related to: Obstructive and Reflux Uropathy . Observation on 12/17/2024 at 1:33 p.m. revealed CNA-Q, after washing her hands and applying gloves, grabbed the privacy curtains to pull them around Resident #74's bed, touching the curtain in several places with her gloved hand as she tried to unarm the curtains so that the curtains would close. After pulling the curtains closed, and without changing gloves and re-sanitizing her hands, CNA-Q proceeded to clean Resident #74's supra-pubic catheter and provide peri care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CAN-Q on 12/17/2024 at 1:52 p.m., CAN-Q stated she had worked at the facility over [AGE] years and had been trained in peri and catheter care and infection control, and that they get competency checked all the time. CNA-Q stated she should have sanitized her hands and changed gloves after touching the privacy curtain, but she was focused on getting the catheter care done and had not realized she had touched the curtains. CNA-Q stated that by not changing her gloves and sanitizing her hands after touching the privacy curtain, it could spread germs from the curtain to the resident. 2. Record review of Resident #20's face sheet dated 12/19/2024 revealed he was a [AGE] year-old man with an admitted [DATE], and with diagnoses which included: Dementia (general term for loss of memory, language and problem solving abilities), Obstructive Uropathy (condition where flow of urine is blocked), Paranormal Hernia (type of incision hernia that allows protrusion of abdominal contents through the abdominal wall defect created during bosomy formation) and Colostomy (surgical procedure that creates a new opening in your abdominal wall for feces to come out and is collected in an attached pouch. Record review of Resident #20's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 9, indicating moderate cognitive impairment and further review revealed he was assessed under Bowel and Bladder as having both a Colostomy and being totally dependent in the care of the colostomy. Observation on 12/17/2024 at 2:27 p.m. revealed CNA-P placed a towel over Resident #20's lap, placed a basin on the towel and under his colostomy pouch, and emptied the contents of Resident #20's colostomy pouch into the basin. After the colostomy pouch was emptied, CNA-P folded/rolled the end of the pouch to seal the pouch wiping away excess feces/liquid with her gloved hand. CNA-P was then observed to carry the basin to the bathroom, opening the bathroom door by turning the handle with the same gloved hand that she had just used to empty the contents of the colostomy bag, emptied the fecal contents of the basin into the toilet, then turned on the shower spray by turning the shower handle on with the same gloved hand to rinse the basin, dumped the rinse water in toilet, then turned off the shower spray by turning the shower handle with the same gloved hand. During an interview with CNA-P on 12/17/2024 at 2:40 p.m., CNA-P stated she did touch the bathroom door handle, and shower handle with the same gloves on she had used to empty the colostomy bag, but she did that because she did not know where to place the basin down so that she could change her gloves. She stated that touching the door and shower handles with the same gloves she used to empty the colostomy pouch could spread germs. Further interview revealed CNA-Q stated she had received training in colostomy care and infection control and had also passed a competency check on colostomy care, but at that time, she did not use a basin, but rather a smaller container. She stated she used a basin this time because the contents of Resident #20's colostomy pouch were very liquid and would splash when emptied. Record review of CNA-P's competency evaluation worksheet in Colostomy Care dated 10/13/2024 revealed CNA-P was checked of as being competent in all steps in the evaluation worksheet, which included: Use toilet tissue to remove excess feces from the end of the pouch opening. Place the toilet tissue in the trash bag and Once the pouch is emptied, place the bedpan on the paper towel on the over-bed table. Cover the bedpan with another paper towel to help minimize odor and Use a pre-moistened washcloth to clean the end of the pouch. Refold the washcloth as necessary. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 12/17/2024 at 4:05 p.m. revealed LVN-N was standing next to the medication cart, preparing Resident #40's medications for administration, when she took a pen from her pocket to punch a hole in a medication blister pack, dropped the pen on the floor, picked up the pen from the floor with her hand, and without sanitizing or washing her hands proceeded to remove the medication from the blister pack, place the medication into a medicine cup and take it into Resident #40's room for administration. During an interview with LVN-N on 12/17/2024 at 4:10 p.m., LVN-N stated she knew she was supposed to wash or sanitize her hands after touching the pen and the floor, but just forgot. She stated she has received training in infection control and medication administration, and that not washing or sanitizing her hands after touching the floor and then administering medications could result in cross contamination and the spread of germs. Record review of LVN-N's Competency Skills Validation for Medication Pass Procedure dated 10/10/2024 revealed she had been checked off as showing competency in all areas of the Medication Pass Procedure. 4. Record review of Resident #54's face sheet dated 12/19/2024 revealed she was a [AGE] year-old woman with an admitted [DATE] and re-admission on 04/21/2024, and with diagnoses which included: Non-traumatic intracerebral hemorrhage (bleeding in brain), Dysphagia (difficulty swallowing) following intracranial hemorrhage and Gastrostomy status (presence of a surgically created opening into stomach used to provide nutritional support). Record review of Resident #54's Physician Order Summary dated 12/18/2024 revealed an order for Enteral Feed Order three times a day for weight management. Give 1 carton Jevity 1.5 237ml tid with meals. Further review revealed an Order dated 11/18/2024 for Enhanced Barrier Precautions. Observation on 12/18/2024 at 11:41 a.m. revealed LVN-L not wearing a gown, only gloves to administer bolus feeding of Jevity 1.5 via Resident #54's G-tube. There was no EBP sign posted inside or outside her room, no PPE supply available immediately near or outside/inside her room nor trash can near the exit for discarding PPE after removal. Interview with LVN-L on 12/18/2024 at 12:23 p.m. revealed she had been working at the facility only about one month and had heard about Enhanced Barrier Precautions, but thought they were only supposed to be used when working with people who had foley catheters. LVN-L stated she had not received training in Enhanced Barrier Precautions when she was hired, and she did not have a clear understanding of what they were or when they should be used. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 12/18/2024 at 12:26 p.m., the DON stated that Enhanced Barrier Precautions should be used whenever administering feedings or medications via a G-tube, and that this entailed wearing both gown and gloves. She stated this is to help prevent the spread of infection and she will ensure staff are trained and the EBP sign is posted inside Resident #54's room above her bed. Upon further interview, the DON stated that Nurse's should wash or sanitize their hands after touching the floor or other objects in environment such as privacy curtains to prevent cross contamination. The DON also stated that staff should change gloves and sanitize their hands after emptying a colostomy bag, and before touching other items in the environment, again to prevent the spread of infection. The DON stated that all the Nurse's and CNA's had received training in hand hygiene, infection control, and all the Nurse's had received training in medication administration and received periodic competency checks. Record review of the facility policy titled Handwashing/Hand Hygiene revised August 2019, revealed under #7 of the policy: Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations: .c. Before preparing or handling medications and .l. After contact with objects in the immediate vicinity of the resident Record review of the facility policy titled Enhanced Barrier Precautions dated 4/2024 revealed a definition of: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high-contact resident care activities. Listed under Initiation of Enhanced Barrier Precautions, included indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. Under the section Implementation of Enhanced Barrier Precautions, the following steps are included: Make gowns and gloves available immediately near or outside/inside of the resident's room and PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. Further steps include: Position a trash can inside the resident's room and near the exit for discarding PPE after removal .