STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675509	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklane West Healthcare Center	2 Towers Park LN San Antonio, TX 78209

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 7 residents (Resident #3) reviewed for care plans. The facility failed to develop a person-centered care plan with interventions that addressed Resident #3's ADL needs; indwelling catheter use; diagnoses and treatments including blood pressure, antidepressants, and antiplatelet medications; dietary needs, including requiring a mechanically altered diet; therapy; and discharge planning. This deficient practice could affect residents and place them at risk for not having their needs and preferences met. Findings included: Record review of Resident #3's Admission Record, dated 10/25/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Acute Kidney Failure (condition in which kidneys suddenly are unable to filter waste from blood), Dysphagia (difficulty swallowing) , cognitive communication deficit (difficulty with thinking and language) , Chronic Obstructive Pulmonary Disease (lung diseases that block airflow and make it difficult to breathe) , Chronic Kidney Disease (condition in which kidneys are damaged and cannot filter blood) , atherosclerotic heart disease (damage in the heart's major blood vessels) , Dementia (group of thinking and social symptoms that interferes with daily functioning) , Hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone) , Hyperlipidemia (high levels of fat in the blood) , Depression (low mood) , Post-traumatic stress disorder (mental health condition caused by an extremely stressful or terrifying event) , Hypertension (high blood pressure), Angina Pectoris (chest pain caused by reduced blood flow to the heart), Muscle Weakness, Benign Prostatic Hyperplasia (prostate gland enlargement that can cause difficulty with urination), history of falls, and urine retention. Record review of Resident #3's Progress Note, dated 9/27/24, revealed the resident was admitted to the facility for rehabilitation and strengthening due to reoccurring falls. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #3's comprehensive MDS, dated [DATE], revealed the resident had a BIMS score of 13, indicating intact cognition. Further review of the MDS revealed: Resident #3 felt down, depressed, or hopeless on several days; required setup or clean-up assistance with eating and oral/personal hygiene, partial/moderate assistance with toileting hygiene, shower/bathe self, and putting on/taking off footwear; supervision/touch assistance with dressing upper/lower body; indwelling catheter and occasionally incontinent of bowel; active diagnoses included: CAD, Hypertension, BPH, Renal Insufficiency, Renal Failure, or ESRD, Hyperlipidemia, Thyroid Disorder, Dementia, Depression, PTSD, Asthma, COPD, or Chronic Lung Disease, Acute Kidney Failure, Dysphagia, Cognitive Communication Deficit, Muscle Weakness, Repeated Falls, Retention of Urine, and Pyuria; received pain medication regimen in the last 5 days; mechanically altered diet; was at risk of developing pressure ulcers/injuries; received antidepressant and antiplatelet medication; ST to start 9/30/24, PT to start 9/28/24; resident preferred to discharge to the community. The MDS assessment revealed related care area (CAA) triggers included Communication, ADL Function/Rehabilitation Potential, Urinary Incontinence, and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pressure Ulcer, and Psychotropic Drug Use. Record review of Resident #3's Care Plan, dated 10/11/24, revealed three focus areas: code status, activity involvement, and an actual fall on 10/6/24. Record review of Resident #3's Order Summary Report, dated 10/26/24, revealed orders for the following: Regular diet (mechanical soft - chopped texture), monitoring for side effects of anti-anxiety and anti-depressant medications, behavior monitoring, monitor/report s/s of bleeding, catheter care, code status, skilled services, may crush medications, activities as tolerated, siderails, pain monitoring/assessment, monitor/record/report s/s of UTI, PT/OT/ST eval/TX, and privacy bag/leg strap for catheter. During an interview on 11/3/24 at 4:08 pm, the MDS Nurse said he remembered completing Resident #3's MDS assessment dated [DATE]. The MDS Nurse further stated resident care plans were completed by the IDT within seven days of completing the MDS assessment. The MDS Nurse said the care plans were based on the MDS assessment. The MDS Nurse further stated he did not develop or modify resident care plans, but the ADON was responsible for the care plans. The MDS Nurse said he believed Resident #3's care plan was completed by LVN L. During a telephone interview on 11/4/24 at 4:06 pm, LVN L said she only completed specific portions of the resident care plans, falls and weights. LVN L further stated she did not know who was assigned to complete the rest of the care plan. LVN L said she was not familiar with Resident #3 but did modify his care plan after he sustained a fall on 10/6/24, adding the fall and interventions to his care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/4/24 at 4:21 pm, the DON said comprehensive care plans were completed after the MDS assessments were completed. The DON further stated the MDS Nurse reviewed the care plans after every annual assessment, but the nurse managers were able to update care plans as well along with the IDT. The DON said there was an ADON responsible for completing the falls and weights section of the care plans, another ADON responsible for completing the psychotropic and infection control section and the wound care nurse completed the skin portion of the care plans. The DON further stated the MDS nurses were responsible for completing a comprehensive review of the care plans to ensure other needs, such as: nutrition, allergies, and diagnoses, were included in the care plans. The DON said reviews were completed with the annual and quarterly assessments, of there was a change in resident condition and as needed. The DON said the completion of Resident #3's care plan was an IDT approach. The DON said she did not believe the MDS assessment was relevant to the care plan unless it was an annual MDS assessment. The DON further stated resident care plans were to be reviewed after each MDS assessment. The DON said upon every annual or new admission MDS assessment there were specific care areas triggered to be added to the care plans if needed. The DON said Resident #3's care plan was completed before she began her employment with the facility and did not know why Resident #3's care plan did not include ADL needs, Indwelling catheter use, diagnoses and treatments including blood pressure, antidepressants, and antiplatelet medications; dietary needs including requiring a mechanically altered diet, therapy, and discharge planning. The DON further stated the MDS nurse was responsible for adding the listed areas to the care plan within 14 days after the MDS assessment was completed. The DON said she did now know why this was not done. The DON further stated she believed staff should audit their own sections of the care plan but was not sure who audited the care plans. The DON said it was important for care plans to be complete/accurate because staff should be able to look at the care plan and know what the residents' needs were. During a telephone interview on 11/6/24 at 11:35 am, the Administrator said his expectation was that once the care plans were executed that they be accurate. The Administrator further stated clinical issues could arise due to inaccuracies in the care plans because the residents' needs were not addressed. The Administrator said there were other ways to know what the residents' needs were, but this included the care plan. Record review of facility's policy, titled Comprehensive Person-Centered Care Planning last revised 12/2023, revealed: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .4. The facility IDT will develop and implement a comprehensive person-centered, culturally-competent, and trauma-informed care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment .resident's goals and desired outcomes, preferences for future discharge and discharge plan .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on interview and record review, the facility failed to provide routine and emergency drugs and biologicals to its residents for 1 of 3 residents (Resident #3) reviewed for medication administration. The facility failed to administer Carvedilol (a medication used to treat HTN) to Resident #3 per physician's orders. This deficient practice could place residents at risk of not receiving the therapeutic benefit of prescribed medication or a decline in health. Findings included: Record review of Resident #3's Admission Record, dated 10/25/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Acute Kidney Failure (condition in which kidneys suddenly are unable to filter waste from blood), atherosclerotic heart disease (damage in the heart's major blood vessels), Hypertension (high blood pressure), and Angina Pectoris (chest pain caused by reduced blood flow to the heart). Record review of Resident #3's comprehensive MDS, dated [DATE], revealed the resident had a BIMS score of 13, indicating intact cognition. Further review of the MDS revealed: active diagnoses included Hypertension. Record review of Resident #3's Care Plan, dated 10/11/24, revealed it did not include a focus or interventions for the diagnosis of Hypertension. Record review of Resident #3's Order Summary Report, dated 10/26/24, revealed: Carvedilol oral tablet 12.5 MG two times a day for HTN, verbal order, dated 10/21/24, received by LVN K. Record review of Resident #3's MAR for October 2024, revealed: Carvedilol oral tablet 12.5 MG two times a day for HTN. Further review revealed a 4 was documented by MA C on 10/22/24 for the AM shift. During an interview on 10/26/24 at 1:30 pm, the DON said she thought MA C must have held Resident #3's Carvedilol on 10/22/24 due to best practice, she knew not to give it because of the parameters. The DON further stated MA C probably knew from experience that the medication should not have been given even though there were no parameters. The DON said the physicians enter their own orders in PCC and she did not see any special instructions for the new order, the parameters were left out. The DON further stated the nurse should have followed up with the MD and added parameters to the order. The DON said when LVN K reviewed the order she should have clarified it with the MD because the previous order had parameters. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/2/24 at 2:43 pm, the MD said there may have been a change in Resident #3's Carvedilol but did not have his notes available. The MD said he did not recall discussing parameters with the order change on 10/21/24. The MD further stated he did not typically enter parameters; the nurses had his parameters for the blood pressure medications. The MD said his expectation was for the nurses to apply the parameters to the order when there was a change in the order or a new order. During an interview on 11/3/24 at 3:09 PM, MA C said she did not recall entering 4 for the administration on 10/22/2024 during the AM 07 administration pass. MA C said the staff had parameters and they went by the parameters. MA C further stated if vital signs were below the parameters, she held the medication and notified the nurse that the medication was held. MA C said she did not remember that day (10/22/24) but if she held a medication, she used the below parameters code on the EMAR. MA C said there were numbers used on the EMAR and thought the code for hold was 12. MA C said If the medication was for blood pressure and did not have parameters, she told the nurse but did not remember that day. MA C said the physicians had different parameters, so she always spoke with the nurse to make sure she was doing the right thing. MA C further stated the nurses called the physicians to clarify parameters. MA C said when medications had parameters, they were in the EMAR. During a telephone interview on 11/3/24 at 3:32 pm, RN G said she did not know what medications Resident #3 received on 10/22/24. RN G further stated the MD wrote his own orders and the nurses transcribed them. RN G said most of the nurses knew when a medication should be given and when it should be held and added those parameters to the orders when necessary. The process was if the MA had a question, they went to the nurse and the nurse checked the parameters and called the physician if there were questions. During an interview on 11/3/24 at 4:41 pm, LVN K said she did not know any of Resident #3's medications and did not process an order for his blood pressure medication that she could recall. LVN K said RN G was the nurse that was typically responsible for Resident #3. Record review of the facility's policy, titled Medication Error Reporting and Follow Up, undated, revealed: .2. The Director of Nursing or Designee must immediately implement and follow the physician's orders .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 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 7 residents (Resident #3) reviewed for clinical records. The facility failed to ensure Resident #3's EMR reflected accurate HR on 10/20/24. These failures could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #3's Admission Record, dated 10/25/24, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Acute Kidney Failure (condition in which kidneys suddenly are unable to filter waste from blood), atherosclerotic heart disease (damage in the heart's major blood vessels) , Hypertension (high blood pressure), and Angina Pectoris (chest pain caused by reduced blood flow to the heart). Record review of Resident #3's comprehensive MDS, dated [DATE], revealed the resident had a BIMS score of 13, indicating intact cognition. Further review of the MDS revealed: active diagnoses included Hypertension. Record review of Resident #3's Care Plan, dated 10/11/24, revealed it did not include a focus or interventions for the diagnosis of Hypertension. Record review of Resident #3's Order Summary Report, dated 10/26/24, revealed: Carvedilol oral tablet 25 MG two times a day for HTN HOLD for Systolic BP <100, Diastolic <60, Pulse <60, dated 9/27/24 (discontinued) and Carvedilol oral tablet 12.5 MG two times a day for HTN, dated 10/21/24. Record review of Resident #3's Pulse Summary, dated 10/25/24, revealed a HR of 2 bpm documented on 10/20/24 at 6:08 pm by LVN I. Record review of Resident #3's MAR for October 2024, revealed: Carvedilol oral tablet 25 MG two times a day for HTN, hold for systolic BP <100, diastolic <60, pulse <60. Further review of the MAR revealed a pulse of 2 was documented on 10/20/24 for the evening shift by LVN I. During a telephone interview on 10/26/24 at 1:30 pm, the DON said she and the ADONs were responsible for ensuring accuracy of resident records. The DON further stated records were reviewed daily for accuracy. During a telephone interview on 11/3/24 at 3:33 pm, LVN I said the initials [NAME] on Resident #3's MAR on 10/20/24 was likely hers as she just had her last name changed. LVN I said she did not remember documenting a 2 for Resident #3's pulse on 10/20/24 and that it was most likely an error. LVN I said Resident #3 seemed normal. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/6/24 at 11:35 am, the Administrator said he expected medical records to be accurate. The Administrator further stated inaccuracies in resident records may interfere with physician and other practitioners' picture of the residents' status and his expectation was for documentation to be accurate. Record review of the facility's policy titled Charting and Documentation, revised July 2017, revealed: .All services provided to the resident .or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .2. The following information is to be documented in the resident medical record: a. Objective observations .d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident .3. Documentation in the medical record will be objective .complete, and accurate . Record review of the facility's policy titled Medical Record, Content of, revised 08/2007, revealed: .All physicians, nursing staff and other health care professionals involved in the resident's care will be responsible for making prompt, appropriate entries in the record .