

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER The Army Residence Community Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 Crestway Dr San Antonio, TX 78239	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753</p> <p>Based on interview and record review the facility failed to ensure that the comprehensive person-centered care plan described services that are furnished to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 4 residents (#5, #6 and #7) reviewed for care plans in that:</p> <ol style="list-style-type: none"> 1. Resident #5's care plan, undated, did not indicate that Resident #5 had an urinary tract infection, onset date 03/28/2024, and was on an antibiotic, initiated 05/28/2024. 2. Resident #6's care plan, undated, did not indicate that Resident #6 had an upper respiratory infection, onset date 07/20/2024, and was on an antibiotic, initiated 07/20/2024, prior to 07/25/2024. 3. Resident #7's care plan, undated, did not indicate that Resident #7 had an upper respiratory infection, onset date 07/21/2024, and was on an antibiotic, initiated 07/21/2024, prior to 07/25/2024. <p>This deficient practice could affect residents who were on antibiotics.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1) Record review of Resident #5's face sheet, undated, reflected Resident #5 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of osteoporosis (brittle and fragile bones), atrial fibrillation (a quivering, irregular heartbeat), and chronic respiratory failure (syndrome in which the respiratory system fails in one or both of its gas exchange functions: oxygenation and carbon dioxide elimination). <p>Record review of Resident #5's admission MDS, dated [DATE], reflected Resident #5 had a BIMS score of 13, indicating no cognitive impairment.</p> <p>Record review of Resident #5's progress notes reflected an entry by LVN E, dated 03/28/2024 at 5:53p.m. The entry stated a UA result was sent to Resident #5's physician and the physician ordered Levaquin 500mg PO QD x 7 days.</p> <p>Record review of Resident #5's care plan, undated, reflected the absence of a care plan for a urinary tract infection and antibiotic medication.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with LVN D, 07/24/2024 at 2:10p.m., LVN D stated during the interview, Resident #5 had a UTI and received an order from Resident #5's physician for an antibiotic with a start date of 03/28/2024.</p> <p>2. Record review of Resident #6's face sheet, undated, reflected Resident #6 was a [AGE] year-old male who originally admitted to the facility on [DATE]. Resident #6 admitted with diagnoses of a Parkinson's disease (a disorder of the nervous system that affects movement, often including tremors), type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels) and dementia (a general term for impaired ability to remember, think, or make decisions).</p> <p>Record review of Resident #6's admission MDS, dated [DATE], reflected Resident #6 had a BIMS score of 08, indicating moderate cognitive impairment.</p> <p>Record review of Resident #6's infection report, undated, reflected Resident #6 was diagnosed with an upper respiratory infection on 07/20/2024.</p> <p>Record review of Resident #6's July 2024 physician orders reflected an order for Levaquin 500mg tablet QD for infection. The order had a start date of 07/20/2024 and stop date of 07/27/2024.</p> <p>Record review of Resident #6's care plan reflected a care plan for an antibiotic for 7 days related to an infection with a care plan start date of 07/25/2024.</p> <p>During an interview with LVN C, 07/25/2024 at 8:35a.m., LVN C stated Resident #6 was on an antibiotic medication that was scheduled to be administered at 9:00p.m. daily until 07/27/2024.</p> <p>3. Record review of Resident #7's face sheet reflected Resident #7 was an [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of multiple sclerosis (a potentially disabling disease of the brain and spinal cord), type 2 diabetes (is a chronic condition that happens when you have persistently high blood sugar levels), and hyperlipidemia (high fat levels in the blood).</p> <p>Record review of Resident #7's MDS, dated [DATE], reflected a BIMS score of 10 indicating moderate cognitive impairment.</p> <p>Record review of Resident #7's infection report, undated, reflected Resident #7 was diagnosed with an upper respiratory infection on 07/21/2024.</p> <p>Record review of Resident #7's July 2024 physician orders reflected an order for Levaquin 500mg QD x 7days, start date 07/21/2024 and stop date of 07/28/2024.</p> <p>Record review of Resident #7's care plan reflected a care plan for an antibiotic for 7 days related to an infection with a care plan start date of 07/25/2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the MDS Coordinator, 07/25/2024 at 10:04a.m., the MDS Coordinator stated the DON was responsible for care planning any resident infections and antibiotics. The MDS Coordinator stated she was told by the DON in March of 2023 that the DON would be doing the infection and antibiotic care plans. The MDS Coordinator stated the infection and antibiotic care plan would be included in a resident's comprehensive care plan and would be care planned at the time of the infection and antibiotic order. The MDS Coordinator stated the importance of updating a resident care plan at the time of the new infection or order was to have an accurate picture of the resident's condition and to inform staff of the medication and infection related to the resident's quality of care.</p> <p>During an interview with the DON, 07/25/2024 at 11:50a.m. who stated the MDS Coordinator was responsible for updating the resident care plan. The DON said the care plan should be updated at the time of a new infection or medication order and it would be added to a resident's comprehensive care plan. The DON stated updating a resident care plan timely was important because everyone needs to know there is a change in the plan of care and what they need to monitor. The DON further stated the care plan is what we do for the residents, the goals and risks for the resident based on our assessments. We provide resident care based on the care plan.</p> <p>During an interview with the MDS Coordinator, 07/25/2024 at 2:32p.m. stated Resident #5 did not have a care plan for an infection or antibiotic. The MDS Coordinator stated Resident #6 and Resident #7 had upper respiratory infections and stated she added their care plans for the infection and antibiotic after her previous interview, 07/25/2024 at 10:04a.m. and acknowledged by stating, Resident #6 and Resident #7 did not have a care plan prior to 07/25/2024.</p> <p>Record review of facility policy titled Care Plans, Comprehensive Person-Centered, dated 2001 and revision date December 2016) stated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The policy also stated, The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the residents condition.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administration of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #5) of 7 residents reviewed for pharmacy services.</p> <p>Resident #5's March 2024 medication record reflected an order for Levaquin 500mg tab QD with a start date of 03/29/2024 9:00 a.m. and end date of 03/29/2024. The record reflected the medication was not administered on 03/29/2024.</p> <p>This deficient practice could affect residents who receive antibiotic medications and could result in residents not receiving a therapeutic dose.</p> <p>The findings included:</p> <p>Record review of Resident #5's face sheet, undated, reflected Resident #5 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of osteoporosis (brittle and fragile bones), atrial fibrillation (a quivering, irregular heartbeat), and chronic respiratory failure (syndrome in which the respiratory system fails in one or both of its gas exchange functions: oxygenation and carbon dioxide elimination).</p> <p>Record review of Resident #5's admission MDS, dated [DATE], reflected Resident #5 had a BIMS score of 13, indicating no cognitive impairment.</p> <p>Record review of Resident #5's progress notes reflected an entry by LVN E, dated 03/28/2024 at 5:53p.m. The entry stated a UA result was sent to Resident #5's physician and the physician gave an order to start Levaquin 500mg PO QD x 7 days. The entry stated the initial dose was pulled from the medication safe.</p> <p>Record review of Resident #5's progress notes reflected an entry by LVN C, dated 03/28/2024 at 6:50p.m. The entry stated Resident #5 received the initial dose of Levaquin 500 mg for a UTI, Resident #5 tolerated it well and the medication would be continued for the next 7 days.</p> <p>Record review of Resident #5's March 2024 medication record reflected an order for Levaquin 500 mg tablet, one time only for UTI, start date 03/28/2024 at 6:00 p.m. and end date 03/29/2024. The medication is initialed as administered.</p> <p>Record review of Resident #5's March 2024 medication record reflected an order for Levaquin 500mg tab QD with a start date of 03/29/2024 9:00 a.m. and end date of 03/29/2024. The record reflected the medication was not administered on 03/29/2024.</p> <p>Record review of Resident #5's March 2024 medication record reflected an order for Levaquin 500mg tab QHS at hour of sleep for a UTI x 7 days with a start date of 03/30/24 at 9:00p.m. and end date of 04/03/2024. The record reflected the medication was administered daily.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #5's care plan reflected the absence of a care plan for a urinary tract infection and antibiotic medication.</p> <p>During an interview with LVN C, 07/24/2024 at 1:44p.m., LVN C stated she was the Charge Nurse responsible for giving Resident #5 medication on 03/29/2024. LVN C stated she did not give the medication to Resident #5 on 03/29/2024 at 9:00a.m. and said she thought someone else was going to change the order for the medication to be administered at 9:00p.m but could not recall all of the details.</p> <p>During an interview with LVN D, 07/24/2024 at 2:10p.m., LVN D stated she was responsible for reviewing laboratory results for the facility and notified Resident #5's physician of Resident #5's elevated white blood cell count and UA results on 03/28/2024 at 3:42pm. LVN D said the physician ordered Levaquin 500mg QD for 7 days. She stated she entered a one-time dose order for Levaquin for 03/28/2024 at 6:00p.m. so the initial dose would be pulled from the medication safe. LVN D stated she put in an additional order for the Levaquin to start on 03/29/2024 with an end date of 04/04/2024. LVD D stated when she was reviewing Resident #5's MAR on 03/30/2024 around 8:00 p.m., she noticed Resident #5's Levaquin had been discontinued on 03/29/2024. LVN D said she notified the DON and was told to reinstate the medication. LVN D said she wrote another order for Levaquin to be administered with a start date of 03/30/2024 at 9:00p.m. and an end date of 04/04/2024. LVN D stated she called and notified the charge nurse, and the medication was administered.</p> <p>Record review of Resident #5's medication audit log revealed LVN C modified Resident #5's Levaquin order on 03/29/2024 at 8:44a.m. and changed medication stop date from 04/04/2024 to 03/29/2024.</p> <p>During an interview with LVN C, 07/24/2024 at 3:15p.m., LVN C verified it was her name on the audit log that reflected LVN C changed the Levaquin order stop date at 8:44a.m. LVN C said, my only explanation could be that I was going to change the time to give the antibiotic to the evening and never put the order in. LVN C stated antibiotics are important when treating a UTI because the infection can get really bad and if they do not take all the doses, they could become antibiotic resistant.</p> <p>During an interview with Resident #5's physician, 07/25/2024 at 9:37a.m., the physician stated he did not give an order to discontinue the medication on 03/29/2024. The physician stated he was notified by the DON that Resident #5 missed a dose of the antibiotic and instructed the DON to continue the antibiotic. The physician stated it was important for an antibiotic to be given daily as prescribed for a resident with an infection but stated missing one dose of the medication would not cause harm to the resident.</p> <p>During an interview with the DON, 07/25/2024 at 11:50a.m., the DON stated she was informed on the missed antibiotic dose by LVN D on 03/30/2024 and notified the physician of the missed dose. The DON stated she thought the nurse was planning to change the order from 9:00a.m. to 9:00p.m. and never entered the order. The DON stated it was important to not miss a dose of the antibiotic because it needs to be a consistent treatment and we are to follow the physician orders.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility in-service, dated 03/18/2024, stated administering medications: the licensed nurse will follow medication administration guidelines, the licenses nurse/medication aide will ensure that all medications are given as scheduled. At the end of the shift the licensed nurse/medication aide will check using the missing medication tab to ensure all medications and treatments were given as scheduled. If there is medication missing a call to the physician will be made by the licensed nurse and seek physician guidance to see if medication can still be given. In addition, the in-service stated, The licensed nurse will notify the director of nurses of any missing doses, as soon as the nurse is aware. The in-service has 8 nurse signatures, including LVN C.</p>		