| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675697 | A. Building<br>B. Wing | 06/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Army Residence Community Health Care Center | 7400 Crestway Dr<br>San Antonio, TX 78239 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident with an indwelling foley catheter received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #16) reviewed for quality of care.<br><br>Resident #16's foley catheter came apart from the drainage bag during incontinent care after being stretched and fell on the resident's bed. The nurse attempted to reconnect the same drainage bag and tubing to the indwelling foley catheter.<br><br>These failures could result in pain, urinary tract infections, and urinary complications.<br><br>The findings were:<br><br>Record review of Resident #16's undated face sheet revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included flaccid neuropathic bladder (an underactive bladder doesn't contract enough leading to urinary retention or the inability to fully empty the bladder), muscle weakness, and other abnormalities of gait and mobility (abnormal walking pattern and the ability to move freely, coordination).<br><br>Record review of Resident #16's admission MDS dated [DATE] revealed the resident's speech was clear, she was able to understand and make herself understood. The resident had a BIMS of 15 indicating she was cognitively intact. The resident used a manual wheelchair and a walker and was dependent on staff for perineal hygiene and for rolling left and right. The resident had an indwelling foley catheter and was frequently incontinent of bowel and the resident had no infections including urinary tract infections.<br><br>Record review of Resident #16's undated care plan revealed a problem with a start date of 4/20/25 for the indwelling foley catheter for urinary retention. The goal was to manage catheter care appropriately to prevent infection or trauma. The interventions included to provide catheter care as scheduled and PRN, change the catheter bag per physician's order, keep the catheter system a closed system as much as possible , and to manipulate tubing as little as possible during care. And another problem with a start date of 4/20/25 for indwelling catheter for urinary retention and a failed voiding trial on 4/30/25 with a goal to show minimal signs of UTI's or complications with the catheter. Interventions included to change the foley catheter, tubing and bag per physician's order.<br><br>(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 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #16's consolidated physician orders dated 6/5/25 revealed an order with a start date of 5/14/25 to change the foley bag as indicated such as infection, obstruction, or when the closed system was compromised PRN.<br><br>In an observation and interview on 6/4/25 at 2:00 p.m. of perineal and incontinent care for Resident #16 performed by RNA A and RNA B. RNA A and RNA B assisted the resident to turn on her left side towards RNA B with the foley bag still connected to the bed railing on the opposite side (right side of the bed) and it was stretched from the rail to the leg strap support on the resident's right thigh. The resident was assisted to turn even more which stretched the catheter drainage bag tubing tightly, and I brought staff's attention to the tubing being stretched from the bed rail to the resident's leg strap on her right thigh area to avoid injury to the resident. Before staff could correct the stretched tubing, it came apart from the foley catheter with a popping sound with the foley catheter still being attached to the leg band and the bag tubing end laying on the bed behind the resident. RNA A continued incontinent care and the back of his gloved hand touched the drainage tubing connection port that was laying on the bed. I stopped the staff from continuing incontinent care to address the foley catheter system and Resident #16 denied any pain, pulling, or discomfort to the indwelling foley catheter. The resident was assisted to turn on her back and RNA B went to notify the nurse while RNA A picked up and held the foley catheter before the Y area of the end of the catheter before the connection point and drainage tubing port just before the connection ending. The foley catheter remained strapped into the leg band on the residents right thigh. LVN C entered the room and took the end of the drainage bag tubing from RNA A and was about to connect the foley catheter back to the same drainage tubing and I intervened and stopped her from continuing to prevent injury to the resident. I asked her if she was going to connect the foley catheter back to the same drainage tubing and she stated yes, she was. I explained that the drainage tubing had been lying on the bed and had touched the back of RNA A's glove. LVN C stated she was not aware the tubing port had touched anything and would get a new foley drainage bag and tubing and did not connect the same drainage bag to the foley catheter.<br><br>In an interview on 6/4/25 at 2:25 p.m. LVN C stated she did not know the tubing had touched any other surface and thought it was held the entire time by RNA A when she took it from him to reconnect it. LVN C stated if she had known it had touched another surface, she would have gotten a new foley bag and tubing immediately. LVN C stated she had been trained on foley catheter care. LVN C stated the possible consequences of not using a new foley catheter drainage bag and tubing could be the possibility of introducing bacteria and infection to the resident.<br><br>In a joint interview on 6/4/25 at 2:50 p.m., RNA A and RNA B both stated they should have moved the foley drainage bag prior to turning the resident and they normally did but they were both really nervous being observed by the state surveyor and that was what made them forget to do it. RNA A and RNA B both stated they had never had a catheter come apart before and were so nervous they did not act immediately. RNA A and RNA B both stated they had been trained on perineal, incontinent, and catheter care.<br><br>In an interview on 6/4/25 at 3:00 p.m. LVN C stated she had been trained on foley catheters and she should have replaced it immediately with a new foley drainage bag regardless of whether it touched anything or not. LVN C stated the possible risks or consequences of not replacing the drainage bag and tubing with a new one were exposing the resident to bacteria and possibly a UTI.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an observation and interview on 6/5/25 at 11:00 a.m. the DON stated both RNA A and RNA B were trained on perineal care, catheter care, and incontinent care and return demonstrated for their skills review and LVN C had been trained on foley catheter insertion and care. The trainings were provided and verified. RNA A and RNA B training and skills checklist was completed on 2/19/25. LVN C training and skills checklist was completed on 2/11/25.<br><br>In an interview on 6/5/25 at 1:30 p.m. the DON stated the staff had been trained and were very good and stated they were very nervous. The DON stated the catheter drainage bag should have been moved from the side of the bed with the resident and replaced with a new one once the system was disconnected. The DON stated the possible consequences of connecting the same catheter drainage tubing was it was a risk for infection. The DON stated there was no policy specific to the catheter becoming disconnected and supplied the guidance used by the facility titled Catheter Care Do's and Dont's by AHRQ dated March 2017 which references the CDC, NHSN (National Healthcare Safety Network).<br><br>Review of the guidance supplied by the facility titled Catheter Care Do's and Dont's by AHRQ dated March 2017 which references the CDC, NHSN (National Healthcare Safety Network) . Do keep the catheter system closed when using the urine collection or leg bags, Do replace catheters and urine collection bags that become disconnected. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the attending physician documented in the resident's medical record that the identified drug irregularity had been reviewed and what, if any, action had been taken to address it. If there was to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record for 1 of 1 Resident (Resident #18) whose psychotropic medications were reviewed.<br><br>Resident #18's attending physician failed to address the pharmacist's recommendation to consider a gradual dose reduction. Resident #18 had been receiving Prozac (antidepressant) 20 mg everyday since 6/4/24.<br><br>This deficient practice could contribute to Residents receiving a higher medication dose than necessary and result in adverse side effects.<br><br>The findings were:<br><br>Review of Resident #18's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnoses which included unspecified Dementia, Adjustment Disorder with Depressed Mood, Recurrent Depressive Disorders and Generalized Anxiety Disorder.<br><br>Review of Resident #18's quarterly MDS assessment, dated 5/10/25, revealed her BIMS score was 3 of 15 reflective of severe cognitive impairment. It was noted Resident #18 received an antidepressant, a high risk drug.<br><br>Review of Resident #18's Care Plan, dated 5/14/25, revealed she was receiving Psychotropic medications including an antidepressant medication. It was noted she had the potential for drug related complications, The targeted goal was that she remain free of drug related complications and receive the lowest therapeutic dose for control of symptoms through next review. One of the interventions was to consult with pharmacist and the MD was to consider dose reduction when clinically appropriate.<br><br>Review of Resident #18's consolidated physician orders for June 2025 revealed she was receiving Prozac 20 mg everyday with the start date of 6/4/24.<br><br>Review of Consultant Pharmacist review, dated 4/29/25, revealed Resident #18's MD was noted as the prescriber and the recommendation read This resident has been taking the antidepressant Prozac 20 mg po QD since 6/4/24. Please evaluate the current dose and consider a dose reduction. Further review revealed NP ? signed in lieu of Resident #18's MD.<br><br>Review of Resident #18's MD progress notes from May 2025 to June 2025 did not reveal documentation which addressed the Consultant Pharmacist review, dated 4/29/25.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 06/05/25 at 02:40 PM with the DON revealed psychotropic medications could have adverse side affects. She stated Resident #18 had been receiving Prozac since 6/4/24 and it was important the physician review and answer the Consultant Pharmacist recommendation, dated 4/29/25, related to a gradual dose reduction. The DON stated RN F was responsible for reviewing all Consultant Pharmacist reviews and ensure the MD received it for review for consideration of the Consultant Pharmacist's recommendation. The DON stated MD D should sign the Consultant Pharmacist's recommendation. She stated NP E, who signed the recommendation, worked for a psychiatric consulting agency and did not work under MD D.<br><br>Interview with RN F on 06/05/25 at 4:15 PM revealed she was responsible for reviewing the Consultant Pharmacy reviews. She stated she would contact a Resident's MD, in this case, Resident #18's prescribing MD was MD D and would review the recommendations with the MD. The MD would either agree or disagree based on their conversation. She stated she did not remember exactly when she contacted MD D and did not document their discussion anywhere in Resident #18's clinical record. RN F also stated she did not send Resident #18's Consultant Pharmacist's review to MD D for review. RN F stated NP E who signed the Consultant Pharmacist's review, dated 4/29/25, worked for a psychiatric consulting agency and was not MD D's extender (a healthcare professional who performed essential functions in patient care).<br><br>Review of facility policy, Tapering Medications and Gradual Drug Dose Reduction, undated, read in relevant part POLICY STATEMENT<br><br>1. After medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences.<br><br>2. All medications shall be considered for possible tapering. Tapering that is applicable for psychotropic medications are referred to as gradual dose reductions.<br><br>3. Resident who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated to discontinue these drugs.<br><br>POLICY INTERPRETATION AND IMPLEMENTATION<br><br>10. Residents who use psychotropic medications shall receive gradual dose reductions, unless clinically contraindicated, to discontinue the use of such drugs. Pertinent behavioral interventions will also be attempted. (Behavioral interventions refer to non-pharmacological attempts to influence an individual's behavior, including environmental alterations and staff approaches to care.)<br><br>11. Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner shall attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #16), reviewed for infection control.<br><br>Resident #16 was provided perineal and incontinent care with an indwelling foley catheter without the use of PPE.<br><br>This failure could result in pain and infection.<br><br>The findings were:<br><br>Record review of Resident #16's undated face sheet revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included flaccid neuropathic bladder(an underactive bladder doesn't contract enough leading to urinary retention or the inability to fully empty the bladder), muscle weakness, and other abnormalities of gait and mobility (abnormal walking pattern and the ability to move freely, coordination).<br><br>Record review of Resident #16's admission MDS dated [DATE] revealed the resident's speech was clear, she was able to understand and make herself understood. The resident had a BIMS of 15 indicating she was cognitively intact. The resident used a manual wheelchair and a walker and was dependent on staff for perineal hygiene and for rolling left and right. The resident had an indwelling foley catheter and was frequently incontinent of bowel and the resident had no infections including urinary tract infections.<br><br>Record review of Resident #16's undated care plan revealed a problem with a start date of 4/20/25 for risk of infection related to the foley catheter and the goal was MDRO transmission will be contained with proper EBP practices. Interventions included to ensure proper use of gloves and gowns for all high-contact care activities, and foley care to be performed using EBP with 100% compliance.<br><br>Record review of Resident #16's consolidated physician orders dated 6/5/25 revealed an order with a start date of 5/13/25 to maintain EBP during high-contact care activities (ie dressing, bathing/showering, transferring, providing hygiene, linen changes, pericare/changing briefs/toileting, wound care, and all indwelling devices care) every shift.<br><br>In an observation on 6/4/25 at 2:00 p.m. of perineal and incontinent care for Resident #16. An EBP sign was on the wall under the room number and resident name. There was an EBP cart with supplies in the resident's bathroom next to the handwashing sink. RNA A and RNA B washed their hands and proceeded to perform perineal and incontinent care for Resident #16 without the use of a gown for EBP. LVN C entered the room to assist with the foley catheter and held the drainage tubing port in her right gloved hand without utilizing a gown for EBP.<br><br>In an interview on 6/4/25 at 2:28 p.m. the ADON stated the EBP sign on the wall under the room number and resident's name was for Resident #16.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a joint interview on 6/4/25 at 2:50 p.m., RNA A and RNA B both stated they should have used the PPE and RNA B stated they washed their hands right next to the cart with PPE and they both stated they use the PPE every time they provide care for the resident and further stated they were really nervous and was why they did not utilize it. RNA A and RNA B both stated the possible risks or consequences of not wearing PPE was risk for bacteria or infection.<br><br>In an interview on 6/4/25 at 3:00 p.m. LVN C stated she had been trained on foley catheters and she should have utilized the PPE. LVN C stated the possible risks or consequences of not wearing PPE were possibly exposing the resident to bacteria and possible UTI.<br><br>In an interview on 6/5/25 at 1:30 p.m. the DON stated RNA A, RNA B, and LVN C should have worn PPE during perineal and catheter care. The DON stated the staff had been trained and stated they were very nervous. The DON stated the possible consequences of failing to wear PPE was a risk for infection.<br><br>Review of guidance provided by the DON for EBP dated 3/29/24 indicated Enhanced Barrier Precautions include use of PPE for residents with chronic wounds or indwelling medical devices during high-contact resident care, regardless of their multidrug-resistant organism status . don the gown and gloves . changing briefs . and device care use of urinary catheter . |