STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675833	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center Oakwell Farms	8501 Laurens LN San Antonio, TX 78218

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health for 1 of 1 resident (Resident #48) reviewed for foot care, in that: The facility failed to thoroughly examine Resident #48's feet for injury and large nails on the left foot for a potential for an increased risk for infection to the feet due to diabetes mellitus. This failure could affect residents with diabetes mellitus by placing them at risk for poor foot health, infection, and a decline in health. The findings were: Record review of Resident #48's ace sheet, dated 4/25/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: diabetes mellitus, chronic kidney disease, heart failure, and palliative care (hospice). Further review revealed the resident was their own responsible party. Record review of Resident #48's quarterly MDS assessment, dated 3/15/24, revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact, the resident's range of motion was listed as impairment to lower extremity, and showering was listed as dependent. Record review of Resident #48's nurse progress notes from 3/8/24 to 4/25/24 revealed there was no nursing note that the resident refused a referral to a podiatrist. Further review revealed the resident had not seen a podiatrist. Record review of Resident #48's Care Plan, undated, revealed the goals and interventions included: Refusal of care; unstageable heel pressure ulcer (at admissions) with an intervention to do Full skin evaluation with bath/shower and assess skin daily with routine care. Further review revealed the resident's care plan did not have any goal or intervention for foot care for the resident's with diabetes mellitus. (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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/23/24 at 10:00 AM revealed Resident #48 was in bed alert and oriented to person, place and time. The resident had his left foot exposed which revealed signs of swelling, dryness, and nails were long. The resident stated that everything was fine except he wanted someone to cut his nails on the left foot. The resident stated he could not remember whether the nursing staff had asked about the trimming of his nails. During an observation and interview on 4/25/24 at 10:20 AM revealed Resident #48 was in bed watching TV; feet covered in a blanket. Resident agreed to remove the blanket to expose his left foot. The left foot had edema (swelling) and the nails were crusty and two nails were long (3rd and 4th toe). The resident removed the sock on the right leg and it revealed slight edema and the nails had received podiatry treatment in the past (nails were clipped.) The resident stated to the wound nurse, LVN C, present that he wanted his left foot nails clipped. The resident stated that the nurse should not touch his left foot. During an interview on 4/25/24 at 10:38 AM, LVN C stated Resident #48's left foot had been, that way since admission. The resident initially admitted for respite care and stayed longer; and LVN C had noticed the need for cutting the nails to the left foot but the resident refused. LVN C stated, I probably did not write the note of refusal in the chart. The LVN C's assessment on 4/25/24 was that resident had dried skin, edema, and an issue with the nails on the left foot. LVN C stated the nails needed to be cut because the nails could curve and cause problems with his toes. During an interview on 4/25/24 at 10:54 AM, the DON stated the policy for referring a resident to a podiatrist was for nursing staff to make an assessment and refer to the SW if there was a need for a podiatrist. Also, the DON stated that the nails of a diabetic resident needed cutting should be referred to podiatrist and not done by, in-house nursing services. The DON stated that the resident should have been referred to a podiatrist; and she was not aware of any referral made to the podiatrist. The DON stated the nails needed to be cut for comfort and dignity and providing care to the resident. During an interview on 4/25/24 at 10:20 AM, the SW stated the resident came to the facility for respite care on 3/8/24 under hospice care and had remained in the facility; there was no success in getting the resident placed at another facility. The SW stated she never inquired of the resident whether he wanted to see a podiatrist. The SW stated that the resident could self refer or nursing staff could request a referral to a podiatrist. The SW stated that as of 4/24/24 no referral was made to her by nursing staff to refer the resident. The SW stated, the resident had Medicaid to pay for podiatry services. The SW stated the resident was the RP. Record review of the facility's Care of Finger/Toenails revealed, Review the resident's care plan to assess for any special needs of the resident .do not trim nails of diabetic residents or residents with circulatory impairments.

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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** 45307 Based on observations, interviews, and record reviews the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys, for 1 of 3 medication carts (Medication Cart #3) reviewed for security and 1 of 24 residents (Resident #19) reviewed for medication storage. 1. Depakote sprinkles and Lexapro was left at the bedside of Resident #19. 2. Medication Cart #3 was repeatedly left unattended and unlocked. These deficient practices placed residents at risk for harm by misappropriation of property and not receiving the therapeutic effects of their medications. The findings included: 1. Record review of Resident #19's Quarterly MDS assessment, dated 03/30/2024, reflected an [AGE] year-old female most recently admitted on [DATE] with a primary diagnosis of Unspecified dementia, unspecified severity, with other behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and assessed to be severely cognitively impaired and totally dependent of medication administration. Observation on 04/23/2024 at 11:10 AM, a clear plastic cup with a brown smooth substance mixed with white particulate was revealed on the bedside in Resident #19's room. Interview was attempted on 04/23/2024 at 11:10 AM with Resident #19 but unsuccessful, due to Resident #19's confusion and disorientation. Interview on 04/23/2024 at 11:14 AM, LVN G confirmed she had just passed medications to Resident #19, and confirmed she generally administered Resident #19's Depakote (an anticonvulsant used to treat seizures and bipolar disorder) and Lexapro (an antidepressant used to treat depression and anxiety) together via a chocolate pudding mixture. LVN G confirmed she believed the entirety of the medication mixture was administered and only Resident #19's spittle remained. LVN G confirmed it was the expectation of the facility to not leave medications at bedside as other residents could enter the room and consume the residual medications. 2. Observation on 04/23/2024 at 10:08 AM, Medication Cart #3 was revealed to be unattended and unlocked. The medication cart was observed to have the lock button unengaged and unlocked while located in hall 300 between rooms [ROOM NUMBERS]. Interview and observation on 04/23/2024 at 10:11 AM, LVN G confirmed Medication Cart #3 was assigned to her. LVN G confirmed she left Medication Cart #3 to administer medications, however forgot to lock the cart prior to doing so. LVN G confirmed the potential risk could be unauthorized persons misappropriating medications from the cart or residents ingesting medications from the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/23/2024 at 12:11 PM, Medication Cart #3 was revealed to be unattended and unlocked. The medication cart was observed to have the lock button unengaged and unlocked while located in hall 300 between rooms [ROOM NUMBERS]. Observation and interview on 04/23/2024 at 2:05 PM, Medication Cart #3 was revealed to be unattended and unlocked in addition to keys observed inside of the push lock. RN H confirmed she had taken possession of Medication Cart #3 at 2:00 PM from LVN G who was still administering medications from the last medication pass of 1:30 PM. RN H confirmed LVN G was near the cart while documenting progress notes. RN H confirmed she did not regularly leave her cart unlocked or with the keys remaining inside of cart as that had the potential for misappropriation and accidents however, she only left it at LVN G's request while still passing her last remaining medications prior to her ending her shift. Interview on 04/23/2024 at 3:40 PM, the DON confirmed her expectations were for all nursing staff who have control of medications, was to secure the medications and to lock medication carts when left unattended. The DON confirmed the risk for harm to residents were varied and could include residents getting into the medication cart and taking medications out of it. Record review of LVN G's annual competency evaluation, dated 11/16/2023, reflected LVN G was hired on 11/15/2023 and was confirmed to have been competent in [ensuring] that only training and authorized personnel operate your unit/shift's equipment. Record review of the facility's undated, Storage of Medications, policy reflected, Procedure: . Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not left unattended. (Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.)

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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** 45307 Based on record review, interview, and observation, the facility failed to assure that menus are followed for 1 of 4 days reviewed for accuracy, in that: The facility failed to provide Resident #6 with the items specified on the menu. This deficient practice could place residents at risk for dissatisfaction, poor intake, and diminished quality of life. The findings included: Record review of the menu, dated 04/23/2024, reflected the lunch meal consisted of chicken parmesan, pasta noodles, cauliflower, garlic parmesan bread, and tiramisu dessert. Record review of Resident #6's meal ticket, dated 04/23/2024, reflected a meal texture of pureed with thin liquids. Under the meal, it reflected: Pureed chicken parmesan, pureed spaghetti noodles, pureed cauliflower, pureed garlic [NAME] biscuit pull-apart bread, and pureed thick cake tiramisu. Record review of Resident #6's Quarterly MDS assessment, dated 03/17/2024, reflected an [AGE] year-old female with an admitted [DATE] and a primary diagnosis of Senile degeneration of brain, not elsewhere classified (senile, or a decrease in the ability to think, concentrate, or remember), and assessed to be rarely or never understood in addition to be totally dependent for meal intake. Observation and interview on 04/23/2024 at 12:13 PM revealed Resident #6's meal tray to consist of a dark brown pureed-texture food, with a light [NAME] pureed-texture food, a deep forest green pureed-texture food, a golden colored pureed-texture food, and a chocolate pudding cup. Resident #6's family member confirmed she was not familiar with what the deep forest green food was supposed to be and was not certain which food the cauliflower was supposed to be on the tray. Resident #6's family member stated she regularly did not see her family member receive the correct meal ticket item but did not bring this concern to the nursing or dietary staff. Interview on 04/23/2024 at 12:31 PM, the DM confirmed the dietary department was to always follow the menu or would otherwise have to submit a substitution request to the RD to be accepted. The DM confirmed the kitchen did not have enough tiramisu for all residents to have been served it because they were ordered and received as a single-serving item. The DM confirmed when he made the order for the tiramisu, the census reflected a lower quantity of residents and thus only ordered as many as he had at the time compared to the current census now. The DM confirmed the residents who received pureed, thickened meals were to receive a chocolate pudding as opposed to the tiramisu on 04/23/2024 because of the available quantity of the actual tiramisu cups. The DM also confirmed the dark green pureed food was broccoli that was used instead of the cauliflower due to a supply shortage in the kitchen storage. The DM confirmed he did not communicate these substitutions to the residents prior to the lunch service. The DM confirmed the potential risk could be residents not eating the food due to being served foods they do not like and not being in control of what they eat. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/2024 at 11:40 PM, the RD confirmed she was the sole RD of the facility and began providing dietary consultation approximately one year ago and confirmed during her regular semimonthly visits she inspected the food storage and sanitary procedures of the kitchen. The RD confirmed she had never observed or reviewed a history of substitutions not communicated to residents but had observed instances when the DM had failed to order enough food and created an inevitability for a shortage causing some residents to receive one food item and other residents to receive a different item. The RD confirmed her expectation was to be informed of the substitutions to confirm they were nutritionally equivalent. The RD confirmed her expectation was for the menu to be perpetually followed and utilized the substitution form to confirm they were always followed in addition to her routine inspections. Record review of the kitchen's menu substitutions, dated April 2024, reflected no indication of a substitution for 04/23/2024 lunch service. Record review of facility policy, titled, Nutritional Policies and Procedures, dated, Completed Revision 8/1/2020, reflected, Make appropriate substitutions when items on the menu are not available. Record these substitutions and keep the records on file with the menus . No additional information related to informing residents about substitutions made or to following the menu was reflected within the policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45307 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 safely for 1 of 1 kitchen reviewed for kitchen sanitation, in that: 1. Three-compartment sink test strip logs incomplete for 7 of 24 days in April of 2024. 2. Walk-in refrigerator and freezer temperature logs incomplete for 2 of 24 days in April of 2024. 3. A unit of frozen stuffed green peppers encased in a half block of ice making it inaccessible observed in the walk-in freezer. 4. Unidentified yellow contaminant in the water a in clear tub containing bags of liquid eggs in walk-in refrigerator. 5. Dented can of mandarin oranges in main food storage. 6. Tomatoes with white, black, and green fuzzy substances in walk-in refrigerator. 7. Expired & undated food in nutrition rooms including a past dated pre-packaged deviled egg meal. 8. Black substance build-up inside of ice maker in nutrition room. 9. Dark brown substance on and around spout of coffee maker in nutrition room. 10. Unlabeled & Undated items in the activity pink room. These deficient practices could place residents at risk for cross-contamination and foodborne illness. The findings included: Observation on [DATE] beginning at 8:50 AM of the kitchen during initial inspection revealed the following: - The Test Strip Log For Three Compartment Sink, dated [DATE], reflected omissions for the water temperature and PPM (the concentration of a disinfectant chemical in a cleaner) on the dates: ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE]. - The Refrigerator and Freezer Temperature Log, dated [DATE], reflected omissions for both the refrigerator and freezer on the dates: ,d+[DATE] and ,d+[DATE]. - A clear, plastic container for food storage in the walk-in refrigerator holding sealed bags of liquid eggs sitting in a yellow-tinted liquid. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A size #1 dented can of mandarin oranges intermixed with the standard stock of cans, not included within the dented cans section. - A frozen food container made of aluminum holding stuffed green peppers stored underneath the walk-in freezer's condenser unit with a stream of ice connected to it and a layer of ice partially covering the food container. Interview on [DATE] at 9:05 AM, the DM confirmed the ultimate responsibility for food safety and any items in the kitchen ends with himself as the DM. The DM confirmed he completed audits of the temperature logs and 3-compartment sink logs but had not noticed the omissions. The DM confirmed the liquid in the container that held the liquid egg bags was an unknown substance but believed it to be water due to the reflection of the light on the eggs. The DM confirmed the dented can within the standard storage but confirmed he did not notice it when it was received and would have otherwise kept it separated. The DM confirmed the frozen stuffed green peppers had been in the freezer awhile but had not noticed the ice buildup on top of the food items and confirmed he completed audits of the walk-in freezer and refrigerator but did not notice the eggs or the stuffed green peppers. The DM confirmed the potential risk with the observations was that they could cause food to be contaminated or otherwise be served on un-sanitized kitchen equipment and cause foodborne illness. Observation and interview on [DATE] at 10:46 AM revealed three tomatoes in the walk-in refrigerator with an accumulation of white, black, and green fuzzy substance on them. The DM confirmed he had not observed that before and confirmed he believed it to be mold and confirmed his most recent audit was this morning but likely missed the tomatoes during his inspection. The DM confirmed the potential risk would be that the tomatoes be served and cause foodborne illness. Interview on [DATE] at 11:40 AM, the RD confirmed she is the sole RD of the facility and began providing dietary consultation approximately one year ago and confirmed during her regular semimonthly visits she inspected the food storage and sanitary procedures of the kitchen. The RD confirmed she had never observed or reviewed a history of dented cans in the main food stock, overly frozen over items in the walk-in freezer, or incomplete temperature or dishwashing logs. The RD confirmed the potential risk could be foodborne illness from either the food storage concerns or the 3-compartment sink log. Observation on [DATE] beginning at 9:10 AM of the facility nutrition rooms behind the nurse's station revealed the following: - 8 undated units of ice cream bars - 1 squeeze pouch of fruit sauce dated [,d+[DATE]] - A coffee machine with the drip spout encrusted with a dark, thick brown substance - An ice maker with several dark black substance inside of the ice maker unit contacting water dripping on the ice. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview on [DATE] at 9:23 AM revealed a pre-packaged deviled egg meal dated use by [DATE] within the locked unit refrigerator. LVN I confirmed the refrigerator contained food items for both residents as well as staff and confirmed the deviled egg meal was likely for a different staff member as the name on the bag did not match any current resident within the locked unit. LVN I confirmed residents in the locked unit were eligible to and would have family bring them food items to be stored in the memory care refrigerator. LVN I confirmed she was never instructed to keep staff food items separate from the resident food storage and confirmed the staff have their own refrigerators in the facility to use. Observation and interview on [DATE] at 9:31 AM revealed a refrigerator in the activity pink room that revealed a large quantity of undated/unlabeled items on the door of the refrigerator. Additionally, within the activity room revealed a case of 36 units of diet coke on the floor resting next to the refrigerator, along with a single potato on the counter next to the sink in the room. The AD confirmed this room was her own responsibility and was the primary room where residents will watch films or relax with a snack or a soda from the activity refrigerator. The AD confirmed she would keep her own personal food and snack items in the refrigerator and was never instructed to keep these items separate. The AD confirmed the 36 diet cokes were just delivered to her this morning and had intended to move them. The AD confirmed the potato was for her lunch and confirmed she only brought it for her lunch as she was instructed to not leave the facility at any time during the annual survey, even during her lunch, by her administration. Interview on [DATE] at 9:35 AM, the DON confirmed the AD reported to the ADM, but the condition of the nutrition rooms was the responsibility of nursing. The DON confirmed she was not aware of the past dated and unlabeled & undated items in the nutrition rooms or whether the locked unit refrigerator was being used as a mixed-use refrigerator for both residents and staff but confirmed that her expectation was to only use refrigerators exclusively for residents unless they were in the employee break room. The DON confirmed there were two total employee refrigerators in the facility to use, but confirmed the staff on the locked unit typically would not leave the locked unit during their lunches but did not conclude the locked unit staff stored their food items in that refrigerator. The DON confirmed the coffee machine in the nutrition room behind the nurse's station was primarily for residents, but the general inspection and maintenance was the responsibility of the dietary department. The DON confirmed the ice maker maintenance and cleanliness was the responsibility of the MS. The DON confirmed the potential risk with having mixed use refrigerators was that residents could have their food items misappropriated or be provided items inconsistent with their food plan, in addition to being fed items past dated and be exposed to foodborne illness. Interview on [DATE] at 9:45 AM, the ADM confirmed the AD reported to himself, and confirmed he was unaware of the activity room refrigerator having been utilized as a mixed-use refrigerator and confirmed his expectation was that any refrigerator in the facility be exclusively for either a resident or for staff but never both. The ADM confirmed the risk of such a practice could be misappropriation of resident food items and potentially foodborne illness. Interview on [DATE] at 9:53 AM, the MS confirmed his responsibility included routine maintenance of the ice makers in the facility and confirmed he had quarterly cleanings completed of the ice maker located behind the nurse's station. The MS confirmed these inspections and cleanings were documented and confirmed the last cleaning was completed on [DATE] and confirmed during his last cleaning, he did not observe the same black substance as was observed by the Surveyor earlier that morning. The MS confirmed the potential risk with contaminated ice could be a foul taste to residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 10:02 AM, the DM confirmed the dietary department was not responsible for the coffee machine behind the nurse's station but that was never identified to him before and confirmed generally food equipment such as coffee machines were already his responsibility but that this item likely was not noticed as a neglected issue prior to this inspection. The DM confirmed the potential risk to be foul tasting coffee to residents. Review of FDA Food Code 2022 Section ,d+[DATE].17 Ready to Eat/Temperature Control for Safety Food, Date Marking: (A) (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S ,d+[DATE].12, and except as specified in (E) and (F) of this section, refrigerated, 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, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Record review of policy titled, Dietary Services-Food Storage: Food Storage, dated revised ,d+[DATE] reflected: Food Services staff will store all foods or food items not requiring refrigeration at least (6) inches above the floor . and prepared food stored in the refrigerator until service shall be dated with an expiration date . and The Food Services manager, or his/her designee, will check refrigerators and freezers daily for proper temperatures. The Food Services Manager will maintain records of such information . and Food Services, or other designated staff, will maintain clean food storage areas at all times

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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** 34788 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 disease and infection for 4 of 9 residents (Residents #5, #16, #35 and, #46) reviewed for infection control, in that: 1. Medication Aide D did not sanitize the blood pressure cuff between Residents #5, #16, and #35. 2. While providing incontinent care for Resident #46, CNA E did not change her gloves or wash her hands after touching a trash can. These deficient practices could place residents at-risk for infection due to improper care practices. The findings include: 1. Record review of Resident #5's face sheet, dated 04/26/2024, revealed an admitted [DATE] with diagnoses which included: Dementia (decline in cognitive abilities), Chronic kidney disease (gradual loss of kidney function), Type 2 diabetes mellitus (high level of sugar in the blood), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood). Record review of Resident #5's physician orders for April 2024 revealed an order for. AMLODIPINE-BENAZEPRIL 5-20 MG 1 CAPSULE PO QD HOLD SBP<100 DBP<60 HR< 60. Record review of Resident #16's face sheet, dated 04/26/2024, revealed an admitted [DATE] with diagnoses which included: Osteoarthritis (type of degenerative bone disease), Cellulitis (skin infection), Cerebral infarction (Blood flow to the brain is blocked or reduced), Dysphagia (Difficulty in swallowing). Record review of Resident #16's physician orders for April 2024 revealed an order for, CARVEDILOL 25 MG TABLET 1 TAB(S) BY MOUTH 2 TIMES A DAY HOLD SBP <100 DBP <60 HR<60. Record review of Resident #35's face sheet, dated 04/26/2024, revealed an admitted [DATE] and, a readmitted [DATE], with diagnoses which included: Hypertension (High blood pressure), Type 2 diabetes mellitus (high level of sugar in the blood), Dysphagia (Difficulty swallowing), Aphasia (Language disorder cause by brain damage). Record review of Resident #35's physician orders for April 2024 revealed an order for. AMLODIPINE BESYLATE 2.5 MG TAB 1 TAB(S) BY MOUTH PM HOLD FOR SBP<100, DBP<60, OR HR<60. Observation on 04/25/24 at 8:50 a.m. revealed, while administering medications, Medication Aide D took the blood pressure and pulse of Residents #5, #16, and #35 Further observation revealed, Medication Aide D took the blood pressure and pulse of all 3 residents with the same blood pressure/pulse cuff. Medication Aide D did not sanitize the blood pressure/pulse cuff in between the residents. (continued on next page)

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	675833	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center Oakwell Farms	8501 Laurens LN San Antonio, TX 78218

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Medication Aide D on 04/25/2024 at 9:45 a.m., Medication Aide D confirmed she used the wrist cuff on all 3 residents to measure the blood pressure. Medication Aide D confirmed she forgot to use a disinfecting wipe to disinfect the wrist cuff in between resident but should have done it to avoid risk of cross contamination. Medication Aide D confirmed receiving infection control within the year. During an interview on 04/26/2024 at 11:15 a.m., the DON confirmed the medication aide should have sanitized the blood pressure/pulse cuff in between resident to avoid cross contamination. The DON revealed infection control training was provided to the staff multiple times a year. The DON revealed the staff's skills were checked annually. The DON further stated she would do spot check of the staff for skills and infection control knowledge. Further interview revealed the facility used the CDC guidelines as infection control policy. 2. Record review of Resident #46's face sheet, dated 04/26/2024, revealed an admitted [DATE] with diagnoses which included: Paraplegia (impairment in motor or sensory function of the lower extremities), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood) , Hypertension (High blood pressure), Retention of urine (inability to completely empty the bladder), Dysphagia (Difficulty swallowing). Record review of Resident #46's MDS Annual assessment, dated 04/20/2024, revealed the resident had a BIMS score of 15, indicating no impairment. Resident #46 required extensive assistance to total care and was always incontinent of bowel and bladder. Record review of Resident #46's care plan revealed a care plan initiated 03/22/2021 with a problem of Incontinent of bowel and bladder; wears incontinent briefs and require staff assistance for incontinent care and a goal of Incontinence will not create infection. Observation on 04/25/2024 at 1:35 p.m., revealed while providing incontinent care for Resident #46, CNA E touched the trash can with her gloved hands. She did not change her gloves or wash her hands, then, placed her hands on the hip of the resident to keep him in place. During an interview on 04/25/2024 at 1:55 p.m., CNA E confirmed she touched the trash after sanitizing her hands and putting her gloves one. CNA E stated she realized after the fact that she should have changed her gloves. CNA E confirmed receiving infection control training within the year. During an interview on 04/26/2024 at 11:15 a.m., the DON confirmed the environment around the residents was considered contaminated and the staff should have changed gloves and wash their hands after touching the trash can prior to touching the resident. The DON revealed infection control training was provided to the staff multiple times a year. The DON revealed the staff's skills were checked annually. The DON stated she would spot check the staff for skills and infection control knowledge. Record review of the facility's policy, titled, Hand washing/hand hygiene, dated December 2006, revealed, use an alcohol-based hand rub for all the following situations: [.] after handling used dressing, contaminated equipment etc .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 45307 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 dishwasher observed for safely functioning equipment, in that: The hybrid high temperature/chemical dishwasher was not operating at the manufacturer's minimum requirements for sanitization. This deficient practice could result in residents not having access to hygienically clean dishes and the potential for contracting food-borne illness because of improperly stored cold food items. The findings included: Observation and interview on 04/23/2024 at 9:10 AM, revealed the hybrid high temperature/chemical dishwasher was operating at 142 F wash temperature, 154 F rinse temperature, and 184 F sanitization temperature based on the manufacturers installed temperature gauges built into the dishwashing unit. The installed data plate by the manufacturer revealed the designed minimum wash temperature to be 150 F, the minimum rinse temperature to be 160 F, and the minimum sanitization temperature to be 180 F. The DM confirmed the unit was designed to be a high temperature dishwasher primarily but if it could be supplied, then the chemical would act as the secondary to ensure sanitization. The DM confirmed he was unaware whether the manufacturer's installed data plate was a strict minimum requirement at any time or only when the hot water demand was in place. The DM confirmed he was uncertain whether the system was currently operating on a high temperature setting or a chemical dishwasher setting. Interview on 04/23/2024 at 11:55 AM, the hybrid high temperature/chemical dishwasher contracted service technician confirmed he had serviced the unit for the last several months and confirmed it was a unique unit that utilized chemical primarily and utilized hot temperatures as secondary supply of sanitization but was unfamiliar with the intention of the minimum temperatures on the installed data plate. The technician confirmed he would research the purpose of the minimum temperatures and confirmed he was unaware if the dishwasher was running at the designed specifications to meet or exceed sanitization levels. The technician additionally confirmed he completed his own temperature tests of the following: 148 F wash temperature, 158 F rinse temperature, and 164 F sanitization temperature. The technician confirmed he was planning to complete maintenance to the unit today but denied that that unit was operating out of manufacturer's recommended minimum temperatures. Interview on 04/24/2024 at 11:40 AM, the RD confirmed she was the sole RD of the facility and began providing dietary consultation approximately one year ago and confirmed during her regular semimonthly visits she inspected the food storage and sanitary procedures of the kitchen. The RD confirmed the unit was a high temperature dishwasher primarily and utilized chemical sanitization as a secondary source. The RD confirmed she inspected the dishwasher during her semimonthly inspection visits and had no concerns in her recent visits with the dishwasher's effectiveness. The RD confirmed the data plate against the recorded temperatures and confirmed the data plate was intended to be followed to ensure adequate sanitization. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a provided email from the hybrid high temperature/chemical dishwasher contracted vendor, dated 04/24/2024, reflected, The ADC44 conveyer dish machine has been NSF-certified to kill germs with heat (high temp) or with chemicals (low temp), which is why the NSF data label on the machine has the temp and pressure specs for both methods. When the machine is installed, the installer should verify that the temperature and pressure requirements are met for either the heat sanitizing application or the chemical sanitizing application. The built-on booster will be adjusted to provide 180-degree final rinse water for a heat sanitizing application or a 120-degree water for a chemical sanitizing application. The system is not intended to automatically adjust between the two options. It must be setup at install for one or the other, it cannot do both. Record review of undated, untitled manufacturer's guidance for the dishwasher reflected, The ADC conveyors are rated in both methods of sanitizing, and NSF lists these dishmachines as dual sanitizers. This means the machine design can serve in both roles without modification. The final rinse manifold will accomplish the task of applying chemical sprays or high temperature sprays with the same water consumption rates and systems. The only difference is the type of chemical dispenser application (min. 50 ppm chlorine) or the boosted incoming hot water (min. 180-degree Fahrenheit) for final rinse. Record review of facility dietary policy titled, Dietary Manual, undated, reflected no significant policy in reference to the operation of the dishwasher apart from following the manufacturer's recommendations for operation.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 24 resident rooms (Resident #18's) reviewed for safe environment, in that: The facility failed to ensure Resident #18's bedroom door opened and closed smoothly. This failure could place residents at risk of a diminished quality of life and could trap residents in rooms during an emergency. The findings were: Record review of Resident #18's face sheet revealed the resident was readmitted on [DATE] with diagnoses that included: Alzheimer's disease, vomiting, and kidney failure. The resident was a male age 67. Record review of Resident #18's admission MDS assessment revealed the resident's BIMS' score was 12, which indicated the resident was moderately cognitively impaired. During an observation on 4/23/24 at 10:50 AM revealed the door to Resident #18's room did not open smoothly and would get stuck within one foot after opening. During an interview on 4/23/24 at 10:51 AM with Resident #18, the resident stated the door did not open smoothly and would get stuck. The resident stated he wanted the door fixed and had complained to staff; resident could not remember to whom he spoke about the door. During an interview on 4/23/24 at 10: 53 AM, RN A stated she had been employed two weeks and had noticed the problem with the door in Resident #18's room. RN A stated the door needed to open smoothly during an emergency which might require the staff to enter the room or the resident to leave the room un-impeded. RN A stated the resident did not complain to her about the door and she did not submit a work order. During an interview on 4/23/24 at 10:58 AM, the Maintenance Director stated, he had no orders for fixing the door; and would fix the problem which involved shifting screws on the door. The Maintenance Director stated the door needed to be fixed by the maintenance department to prevent the resident being trapped in the room during an emergency. Record review of facility's maintenance log revealed there was no work order present for the past six months for addressing the door issue in Resident #18's room. Record review of facility's Preventative Maintenance-log sheet dated 4-15-24 revealed all doors in the facility were checked by maintenance staff. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/24 at 4:26 PM, the Administrator stated he assumed the role of Administrator on 4/15/24 and became aware of the door issue in Resident #18's room involving the front door not opening smoothly today (4/23/24). The administrator was not aware of a work order nor a formal grievance. The administrator was not aware of a grievance filed by resident about the door not opening smoothly. The administrator added that the door needed to open smoothly in case of an emergency requiring a resident egress. Record review of facility's maintenance Service policy, date revised December 2004, reflected, Maintenance service shall be provided to all areas of the building grounds, and equipment.