

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675968	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2025
NAME OF PROVIDER OR SUPPLIER Stone Oak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 Madison Oak Dr San Antonio, TX 78258	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 (Resident #32) of twenty-eight residents reviewed for environment, in that: Resident #32's room air conditioning vents were visibly soiled. This deficient practice could result in residents living in an unclean and unpleasant environment. The findings were: Record review of Resident #32's face sheet, dated 07/25/2025, revealed the resident was an [AGE] year old male, originally admitted on [DATE], and re-admitted to the facility on [DATE] with the diagnoses of Alzheimer's disease (destroys memory and other important mental functions), heart failure (the heart does not pump blood enough), muscle weakness, muscle wasting and atrophy (loss of skeletal muscle mass), and dementia (loss of memory and thinking ability). Record review of Resident #32's quarterly MDS assessment, dated 07/02/2025, revealed the resident's BIMS score was 00 which indicated the resident was unable to complete the interview. Record review of Resident #32's comprehensive care plan, dated 07/12/2025, revealed the resident was at risk for infection or recurrent; chronic infection related to compromised medical condition. Observation on 07/22/2025 at 10:44 a.m. revealed Resident #32's room had one air conditioning vent in the ceiling. Further observation revealed the vent was soiled with a black substance and with rust. Further observation revealed the return vent was covered with dust. During an interview on 07/22/2025 at 11:39 a.m., the DON stated that Resident #32's room had one air conditioning vent, and it was rusty and soiled covered with dust. The DON said a dirty air conditioning vent might cause respiratory infection. During an interview on 07/22/2025 at 11:46 a.m., the District Manager for environment said Resident #32's room had one air conditioning vent, and it was dirty with dust, and the facility cleaned air vents once a month to prevent infection. Record review of the facility's July 2025 Deep Clean Schedule, dated 07/2025, revealed Resident #32's Room would be scheduled for deep clean on 07/18/2025. Record review of the facility policy, titled Physical Environment, revised 02/2017, revealed The community is designed, constructed, equipped, and maintained to protect the health and safety of resident, personnel, and the public.</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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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. (continued on next page)

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to encode and transmit required MDS information within 14 days after discharge for 2 of 32 residents reviewed for MDSs. 1. Resident #24 was discharged on 01/29/25 and as of 07/24/25 he did not have a discharge MDS assessment. 2. Resident #84 was discharged on 03/14/25 and as of 07/24/25 did not have a discharge MDS assessment. This deficient practice affects residents who receive care at the facility and could result in negative impacts on discharge planning. The findings included: 1. Record review of Resident #24's electronic face sheet dated 07/25/2025 reflected he was an [AGE] year-old male who was admitted to the facility on [DATE] and discharged on 01/25/2025 to the hospital. His diagnoses included: congestive heart failure (a long-term condition that happens when the heart cannot pump blood well enough to give the body a normal supply, resulting in shortness of breath), peripheral vascular disease (refers to any disease or disorder of the circulatory system outside of the brain and heart), and acute respiratory failure with hypoxia (a condition where the body does not get enough oxygen, leading to low blood levels of oxygen). Record review of Resident #24's admission MDS assessment dated [DATE] reflected he scored a nine out of fifteen on his BIMS which indicated he was moderately cognitively impaired. He usually understood and was understood. Record review of Resident #24's comprehensive care plan initiated on 01/23/2025 and cancelled on 07/25/2025 reflected Focus, Discharge Planning, interventions/Tasks included: coordinate safe discharge efforts as indicated by ensuring appropriate referrals have been made, DME has been ordered and home-based services have been arranged prior to discharge. Record review of Resident #24's IDT: Discharge Summary-Planning/Instructions/Recapitulation dated 01/22/2025 reflected Resident #24 was being discharged to home/assisted living/group home with Home Health., anticipated discharge date /actual discharge date was 02/02/2025. He was to be discharged home with family and provider services. 2. Record review of Resident #84's electronic face sheet dated 07/25/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE] and discharged to a private home or apartment with no home health or hospice. His admission diagnoses included: muscle weakness (lack of muscle strength), depression (a mental state of low mood and aversion to activity), and hypertension (high blood pressure). Record review of Resident #84's quarterly MDS assessment dated [DATE] reflected he could be understood, and he could understand. He scored a fifteen out of fifteen on his BIMS which indicated he was cognitively intact. Record review of Resident #84's comprehensive care plan revised 08/12/24 reflected Focus, wish to return home with supportive care and services family support, home health care. Record review of Resident #84's IDT: Discharge Summary-Planning/Instructions/Recapitulation dated 03/19/2025 reflected to return to prior home or community-based living, ALF/group home. During an interview on 07/25/2025 at 10:12 AM with the DOCR she acknowledged there was not a discharge MDS assessment for both Resident #24 and Resident #84 and did not know why and the person who should have completed one was no longer available. She stated that a discharge MDS signifies a resident's completion of a cycle of care and could negatively affect discharge planning. She stated the discharge assessment needed to be completed and sent in within fourteen days of the resident's discharge. During an interview on 07/25/2025 at 12:30 PM with the DON, she stated she did not realize the discharge MDS assessment was not completed for Residents #24 and #84, and it could negatively impact the discharge process, and tracking of care. During an interview on 07/25/25 at 12:35 PM with the ADM, she stated she needed to audit the MDSs to ensure they were completed, submitted timely and were accurate. She had no explanation as to why Resident #24's and #84's discharge MDSs were not completed. She stated the failure to complete and submit a discharge MDS could result in inaccurate quality measure, potential payment issues for the facility, and citations. She stated not completing a discharge MDS could result in inaccurate resident data and could hinder care planning for the residents. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, October 2023 reflected OBRA-Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include: Tracking records, Discharge (return not anticipated or return anticipated) Record Review of CMS Memorandum Summary dated August 25th, 2014, reflected discharge assessments are required assessments and are critical to ensuring the accuracy of Quality</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for three residents (Residents #2, #11 and #14) of thirty-two residents reviewed for MDS assessments. The Facility failed to note on Resident #2's admission MDS dated [DATE] he was taking a hypoglycemic medication. 2. The facility failed to ensure Resident #11's Quarterly MDS assessment was coded Not rated, resident had a catheter instead of Always incontinent for a resident identified to have a suprapubic catheter. 3. The facility failed to ensure Resident #14's quarterly MDS assessment was coded Yes regarding the resident was receiving antidepressant for his depression. These failures could place resident at risk for inadequate care due to inaccurate assessments. The findings included:</p> <p>1. Record review of Resident #2's electronic face sheet dated 07/23/2025 reflected he was a [AGE] year-old male who was admitted to the hospital facility on 05/28/2025. His diagnoses included: displaced fracture of the right femur (a broken thighbone where the broken pieces are out of alignment with each other), diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), post-traumatic stress disorder (a mental health condition that develops after experiencing or witnessing a traumatic event) and alcoholic cirrhosis (scarring) of liver with ascites (fluid) (a severe liver condition where excessive alcohol consumption leads to scarring of the liver, and the accumulation of fluid in the abdominal cavity).</p> <p>Record review of Resident #2's admission MDS assessment dated [DATE] reflected he could usually understand and usually be understood. He scored a six out of fifteen on his BIMS which indicated he was severely cognitively impaired. Resident #2 was noted on the assessment to have an active diagnosis of diabetes mellitus. He was noted to have received insulin injections for seven days. Under Section N0415 &quot;High-Risk Drug Classes: Use and Indication&quot;; he was not noted to be taking &quot;J. Hypoglycemic (lowers blood sugar) (including insulin)&quot;.</p> <p>Record review of Resident #2's Comprehensive Care Plan revised date 07/17/2025 reflected &quot;Focus, have diabetes, Interventions/Tasks, administer medications as ordered.&quot;;</p> <p>Record review of Resident #2's &quot;Active Orders as of: 07/24/2025&quot; reflected Lantus Subcutaneous (applied under the skin) Solution (Insulin) inject ten units subcutaneously one time a day for diabetes mellitus start date of 05/25/25.</p> <p>During an interview on 07/25/2025 at 10:12 AM with the DOCR she acknowledged the high-risk medication insulin which was a hypoglycemic should have been noted on Resident #2's admission MDS assessment. She stated it was important to have an accurate MDS assessment to ensure proper care is provided.</p> <p>During an interview on 07/25/2025 at 12:30 PM with the DON, she stated she did not realize the admission MDS assessment was not accurate for Resident #2. She stated the MDS assessments must accurately reflect the resident's status to meet their care needs, or they might be missed.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/25/25 at 12:35 PM with the ADM, she stated she needed to audit the MDSs to ensure they are completed, submitted timely and were accurate. She had no explanation as to why Resident #2's admission MDS assessment must be accurate to show the type of care he required, and he could miss needed care.</p> <p>2. Record review of Resident #11's face sheet dated 07/24/2025, revealed Resident #11 was admitted to the facility on [DATE] with a diagnosis that included: flaccid neuropathic bladder, not elsewhere classified (a condition where the bladder muscles are weak and cannot contract effectively to empty urine).</p> <p>Record review of Resident #11's physician order summary dated 07/24/2025, revealed order dated 06/17/2024, Suprapubic catheter change on the 15th of the month. 18FR/10CC every night shift starting on the 15th and ending on the 16th every month related to FLACCID NEUROPATHIC BLADDER, NOT ELSEWHERE CLASSIFIED.</p> <p>Record review of Resident #11's Quarterly MDS assessment, dated 07/02/2025, revealed a BIMS score of 01 which indicated severely impaired cognition. The Quarterly MDS Assessment further revealed in Section H (Bladder and Bowel), it was coded Resident #11 had a indwelling catheter, however Always incontinent was coded in Section H0300-Urinary Continence. In section H0300 of the Quarterly MDS assessment if the resident had a urinary catheter (indwelling condom), Not rated should have been coded.</p> <p>Record review of Resident #11's care plan, last care plan review completed date of 07/13/2025, revealed Resident #11 had a focus of I require a suprapubic catheter r/t DX of Urinary retention r/t Prostate condition.</p> <p>During an observation and interview on 07/25/2025 at 10:00 a.m. the DOCR after reviewing Resident #11's Quarterly MDS assessment stated the MDS should have been coded not rated and had been coded incorrectly. The DOCR further stated the MDS coordinator was responsible for the accuracy of the MDS assessment and the new MDS coordinator had completed Resident #11's Quarterly MDS assessment dated [DATE]. The DOCR stated inaccurately coding the MDS assessments could affect the overall care of the resident.</p> <p>During an observation and interview on 07/25/2025 at 10:54 a.m. the MDS coordinator stated after reviewing Resident #11's Quarterly MDS assessment it had been miscoded in error and should have been coded not rated. The MDS coordinator further stated miscoding the MDS assessments could cause billing issues and did not feel it could cause any patient care issue with it being incorrectly coded.</p> <p>During an interview on 07/25/2025 at 11:12 a.m. the DON stated MDS assessment accuracy was the responsibility of the MDS coordinator. The DON further stated that by not accurately completing the MDS assessment she would assume it could affect the type of care.</p> <p>During an interview on 07/25/2025 at 2:34 p.m. the Administrator stated the MDS coordinator was responsible for the MDS accuracy. The Administrator stated by the MDS assessment not being accurate it could provide incorrect information. The Administrator further stated he did not feel in Resident #11's case there would be a potentially negative outcome as they relied on the care plan for care.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Record review of Resident #14's face sheet, dated 07/25/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with the diagnoses of muscle wasting and atrophy (loss of skeletal muscle mass), dementia (loss of memory and thinking ability), hypothyroidism (thyroid gland does not produce enough thyroid hormone), and depression (lowering of a person's mood).</p> <p>Record review of Resident #14's quarterly MDS assessment, dated 04/29/2025, revealed the resident's BIMS score was 1 out of 15 indicating the resident had severe cognitive impairment and the resident required supervision or touching assistance (Helper provides verbal cues and/or touching assistance), such as sit to stand and chair to bed transfer. Further record review of the MDS assessment revealed regarding the question of "the resident was receiving antidepressant," the answer was coded "No."</p> <p>Record review of Resident #14's comprehensive care plan, dated 09/14/2024, revealed "I [Resident #14] require anti-depressant medication targeted behaviors is insomnia, crying, anger, and fatigue. For intervention, administer medication per medical doctor orders."</p> <p>Record review of Resident #14's physician orders, dated 03/12/2025, revealed the resident had the order of "Mirtazapine oral tablet 7.5 mg (mirtazapine) Give 0.5 tablet by mouth at bedtime for depression to equal 3.75 mg."</p> <p>Record review of Resident #14's medication administration record, from 07/01/2025 to 07/31/2025, revealed the resident was receiving "Mirtazapine oral tablet 7.5 mg (mirtazapine) Give 0.5 tablet by mouth at bedtime for depression to equal 3.75 mg; at bedtime as ordered."</p> <p>During an interview on 07/25/2025 at 9:49 a.m. the MDS coordinator stated after reviewing Resident #14's quarterly MDS assessment it had been miscoded in error and should have been coded "Yes" because Resident #14 was receiving Mirtazapine for depression, and it was an anti-depressant. The MDS coordinator further stated miscoding the MDS assessments could cause billing issues, and it might affect some patient care, and it was the MDS coordinator's responsibility for MDS accuracy.</p> <p>Record review of the CMS RAI Version MDS 3.0 Manual dated October 2024 revealed in part, "The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS . CH 3: MDS Items [H] H0300: Urinary Continence: Coding instructions: Code 9, not rated: if during the 7-day look-back period, the resident had an indwelling bladder catheter .</p> <p>Record review of the facility policy and procedure titled "Comprehensive Assessments" date revised March 2023 reflected "Accuracy of Assessment, each resident receives an accurate team member assessment of relevant care areas that provide team members with knowledge of each resident's status, needs, strengths, and areas of decline."</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the CMS RAI Version MDS 3.0 Manual dated October 2024 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS . CH 3: MDS Items [H] H0300: Urinary Continence: Coding instructions: Code 9, not rated: if during the 7-day look-back period, the resident had an indwelling bladder catheter .</p> <p>3. Record review of Resident #14's face sheet, dated 07/25/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with the diagnoses of muscle wasting and atrophy (loss of skeletal muscle mass), dementia (loss of memory and thinking ability), hypothyroidism (thyroid gland does not produce enough thyroid hormone), and depression (lowering of a person's mood).</p> <p>Record review of Resident #14's quarterly MDS assessment, dated 04/29/2025, revealed the resident's BIMS score was 1 out of 15 indicating the resident had severe cognitive impairment and the resident required supervision or touching assistance (Helper provides verbal cues and/or touching assistance), such as sit to stand and chair to bed transfer. Further record review of the MDS assessment revealed regarding the question of "the resident was receiving antidepressant," the answer was coded "No."</p> <p>Record review of Resident #14's comprehensive care plan, dated 09/14/2024, revealed " [Resident #14] require anti-depressant medication targeted behaviors is insomnia, crying, anger, and fatigue. For intervention, administer medication per medical doctor orders."</p> <p>Record review of Resident #14's physician orders, dated 03/12/2025, revealed the resident had the order of "Mirtazapine oral tablet 7.5 mg (mirtazapine) Give 0.5 tablet by mouth at bedtime for depression to equal 3.75 mg."</p> <p>Record review of Resident #14's medication administration record, from 07/01/2025 to 07/31/2025, revealed the resident was receiving "Mirtazapine oral tablet 7.5 mg (mirtazapine) Give 0.5 tablet by mouth at bedtime for depression to equal 3.75 mg" at bedtime as ordered.</p> <p>During an interview on 07/25/2025 at 9:49 a.m. the MDS coordinator stated after reviewing Resident #14's quarterly MDS assessment it had been miscoded in error and should have been coded "Yes" because Resident #14 was receiving Mirtazapine for depression, and it was an anti-depressant. The MDS coordinator further stated miscoding the MDS assessments could cause billing issues, and it might affect some patient care, and it was the MDS coordinator's responsibility for MDS accuracy.</p> <p>Record review of the CMS RAI Version MDS 3.0 Manual dated October 2024 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS . CH 3: MDS Items [H] H0300: Urinary Continence: Coding instructions: Code 9, not rated: if during the 7-day look-back period, the resident had an indwelling bladder catheter .</p> <p>(continued on next page)</p>		

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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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 (Residents #20 and #64) of ten residents reviewed for incontinence care. 1. When CNA-A and CNA-B were providing peri care to Resident #20, CNA-A cleaned the resident's genital area without separating the labia. 2. When CNA-C and CNA-D were providing peri care to Resident #64, CNA-C did not clean the resident's suprapubic area (below the umbilical region), left groin area, and left buttock area and cleaned the resident's genital area with multiple passes with one wipe. This failure could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: 1. Record review of Resident #20's face sheet, dated 07/25/2025, revealed the resident was an [AGE] year old female and admitted to the facility on [DATE] with the diagnoses of hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), muscle weakness, dementia (loss of memory and thinking ability), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), hypertension (high blood pressures), and muscle wasting and atrophy (loss of skeletal muscle mass). Record review of Resident #20's quarterly MDS assessment, dated 06/19/2025, revealed the resident's BIMS score was three out of fifteen indicating the resident had severe cognitive impairment, was dependent on the staff for chair to bed and toilet transfer, and was always incontinent of bladder and bowel. Record review of Resident #20's comprehensive care plan, dated 03/14/2025, revealed the resident episodes of bowel and bladder incontinence. For intervention - incontinent care assistance every shift and as needed and check and change on rounds and as needed. Observation on 07/24/2025 at 9:16 a. m. revealed CNA-A and CNA-B removed Resident #20's old and dirty brief, and CNA-A started cleaning the resident's suprapubic area, left groin, and right groin. When CNA-A cleaned the middle area of Resident #20's genitals, CNA-A did not separate the resident's labia. CNA-A cleaned the middle area of the resident's genitals without separating the labia, then rolled the resident to her left side and cleaned the resident's buttock area. During an interview on 07/24/2025 at 9:23 a.m. CNA-A stated when she cleaned the middle area of Resident #20's genitals, she did not separate the resident's labia, and she said she should have separated the resident's labia area when cleaning to prevent infection. CNA-A said she got checked-off regarding female peri care every other month. During an interview on 07/24/2025 at 2:45 p.m. the DON stated the facility did not have a specific policy regarding peri care. The DON said they used a skill check-off sheet for female peri care without catheter, and the sheet did not indicate separating female labia area when providing peri care, but the facility was following general professional guidelines. The surveyor tried to ask more questions, but the DON was unwilling to answer. Record review of professional guidelines (National Library of Medicine - Chapter 5: Provide for Personal Care Needs of Clients - Nursing Assistant - NCBI Bookshelf), titled Provide for Personal Care Needs of Client - perineal care for female, undated, revealed Expose their perineum only, Separate the labia, Use water and a soapy washcloth, Clean one side of the labia from top to bottom, and Using a clean portion of the first washcloth, clean the other side of the labia from top to bottom. 2. Record review of Resident #64's face sheet, dated 07/25/2025, revealed the resident was a [AGE] year old male and admitted to the facility on [DATE] with the diagnoses of cerebral infarction (blood supply to part of the brain is blocked or reduced), muscle weakness, type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), hypertension (high blood pressures), and hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body). Record review of Resident #64's admission MDS assessment, dated 04/23/2025, revealed the resident's BIMS score was 7 out of 15 indicating the resident had severe cognitive impairment, was dependent on the staff for sit to stand and chair to bed transfer, and was always incontinent of urinary bladder and frequently incontinent of bowel. Record review of Resident #64's comprehensive care plan, dated 04/09/2025, revealed the resident episodes of bowel and bladder incontinence. For intervention - incontinent care assistance every shift and as needed and check and change on rounds and as needed. Observation on 07/24/2025 at 11:47 a.m. revealed CNA-C and CNA-D removed Resident #64's old and dirty brief. CNA-C started cleaning the resident's right groin area, penis, and scrotum with multiple passes with one wipe, then rolled the resident to his left side without cleaning the resident's suprapubic area and left groin area. Further observation revealed CNA-C cleaned Resident #64's right buttock area and rectal area, then repositioned the resident to supine position</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs for 2 of 10 residents (Residents #20 and #64) by 2 of 4 CNAs (CNA-A and CNA-C) reviewed for competent staff, in that: 1. When CNA-A was providing peri care to Resident #20, CNA-A cleaned the resident's genital area without separating the labia. 2. When CNA-C was providing peri care to Resident #64, CNA-C did not clean the resident's suprapubic area (below the umbilical region), left groin area, and left buttock area and cleaned the resident's genital area with multiple passes with one wipe. The failure could place residents at risk for not receiving nursing services by adequately trained staff and could result in a decline in health and infection. Record review of Resident #20's face sheet, dated 07/25/2025, revealed the resident was an [AGE] year old female and admitted to the facility on [DATE] with the diagnoses of hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), muscle weakness, dementia (loss of memory and thinking ability), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), hypertension (high blood pressures), and muscle wasting and atrophy (loss of skeletal muscle mass). Record review of Resident #20's quarterly MDS assessment, dated 06/19/2025, revealed the resident's BIMS score was three out of fifteen indicating the resident had severe cognitive impairment, was dependent on the staff for chair to bed and toilet transfer, and was always incontinent of bladder and bowel. Record review of Resident #20's comprehensive care plan, dated 03/14/2025, revealed the resident episodes of bowel and bladder incontinence. For intervention - incontinent care assistance every shift and as needed and check and change on rounds and as needed. Observation on 07/24/2025 at 9:16 a.m. revealed CNA-A and CNA-B removed Resident #20's old and dirty brief, and CNA-A started cleaning the resident's suprapubic area, left groin, and right groin. When CNA-A cleaned the middle area of Resident #20's genitals, CNA-A did not separate the resident's labia. CNA-A cleaned the middle area of the resident's genitals without separating the labia, then rolled the resident to her left side and cleaned the resident's buttock area. During an interview on 07/24/2025 at 9:23 a.m. CNA-A stated when she cleaned the middle area of Resident #20's genitals, she did not separate the resident's labia, and she said she should have separated the resident's labia area when cleaning to prevent infection. CNA-A said she got checked-off regarding female peri care every other month. During an interview on 07/24/2025 at 2:45 p.m. the DON stated the facility did not have a specific policy regarding peri care. The DON said they used a skill check-off sheet for female peri care without catheter, and the sheet did not indicate separating female labia area when providing peri care, but the facility was following general professional guidelines. The surveyor tried to ask more questions, but the DON was unwilling to answer. Record review of professional guidelines (National Library of Medicine - Chapter 5: Provide for Personal Care Needs of Clients - Nursing Assistant - NCBI Bookshelf), titled Provide for Personal Care Needs of Client - perineal care for female, undated, revealed Expose their perineum only, Separate the labia, Use water and a soapy washcloth, Clean one side of the labia from top to bottom, and Using a clean portion of the first washcloth, clean the other side of the labia from top to bottom. 2. Record review of Resident #64's face sheet, dated 07/25/2025, revealed the resident was a [AGE] year old male and admitted to the facility on [DATE] with the diagnoses of cerebral infarction (blood supply to part of the brain is blocked or reduced), muscle weakness, type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), hypertension (high blood pressures), and hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body). Record review of Resident #64's admission MDS assessment, dated 04/23/2025, revealed the resident's BIMS score was 7 out of 15 indicating the resident had severe cognitive impairment, was dependent on the staff for sit to stand and chair to bed transfer, and was always incontinent of urinary bladder and frequently incontinent of bowel. Record review of Resident #64's comprehensive care plan, dated 04/09/2025, revealed the resident episodes of bowel and bladder incontinence. For intervention - incontinent care assistance every shift and as needed and check and change on rounds and as needed. Observation on 07/24/2025 at 11:47 a.m. revealed CNA-C and CNA-D removed Resident #64's old and dirty brief. CNA-C started cleaning the resident's right groin area, penis, and scrotum with multiple passes with one wipe, then rolled the resident to his left side without cleaning the resident's suprapubic area and left groin area. Further observation revealed CNA-C cleaned Resident #64's right buttock area and rectal area, then repositioned the resident to supine position (lying on the resident's</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Resident #98) of 28 residents, 1 of 1 medication rooms, and 1 (500-hall nursing cart) of 5 med carts reviewed for pharmacy services. 1. There were three antibiotic solutions (Imipenem and cilastatin) for Resident #98 to be given via intravenous route that expired 07/22/2025 found inside the facility medication room on 07/24/2025. 2. There was one super sani-cloth germicide disposable wipe that expired 05/2025 found inside the facility medication room on 07/24/2025. 3. There was one bottle of Senna-Plus 8.6 mg that expired 06/2025 found inside the 500-hall nurse cart on 07/24/2025. This failure could place residents at risk of not receiving appropriate therapeutic effects of medication. The findings included: Record review of Resident #98's face sheet, dated 07/25/2025, revealed the resident was an [AGE] year old female and admitted to the facility on [DATE] with diagnoses of sepsis (the body's extreme response to an infection), muscle weakness, type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), urinary tract infection (bladder infection), and hypertension (high blood pressure). Record review of Resident #98's admission MDS assessment, dated 04/03/2025, revealed the resident's BIMS score was two out of fifteen indicating the resident had severe cognitive impairment. Record review of Resident #98's physician order, dated from 07/17/2025 to 07/18/2025, revealed the resident had the order of Imipenem-Cilastatin Intravenous solution reconstituted 500 mg. Use 500 mg intravenously four times a day for ESBL (extended spectrum beta-lactamase) of the urine for 7 days. Record review of Resident #98's medication administration record, from 07/01/2025 to 07/31/2025, revealed the resident was receiving Imipenem-Cilastatin Intravenous solution reconstituted 500 mg via intravenous route from 07/17/2025 as ordered, and it was discontinued on 07/18/2025. Observation on 07/24/2025 at 1:53 p.m. revealed the facility had only one medication room, and inside the medication room there were Resident #98's three Imipenem-Cilastatin Intravenous solutions reconstituted 500 mg, and the three solutions were all expired on 07/22/2025. During an interview on 07/24/2025 at 2:03 p.m. RN-E stated there were Resident #98's three Imipenem-Cilastatin Intravenous solutions reconstituted 500 mg inside the facility medication room, and the three solutions were all expired on 07/22/2025. RN-E said facility nurses did not use this medication because it was discontinued on 07/18/2025, did not know the reason the medication was still in the medication room, and all expired medications should have been removed from the medication room. 2. Observation on 07/24/2025 at 1:53 p.m. revealed there was one Super Sani-Cloth Germicide disposable wipe that expired on 05/2025 inside the medication room. During an interview on 07/24/2025 at 2:03 p.m. RN-E stated there was one Super Sani-Cloth Germicide disposable wipe that expired on 05/2025 inside the medication room. RN-E said facility nurses did not use this wipe, and did not know the reason this one was still in the medication room. 3. Observation on 07/24/2025 at 2:34 p.m. revealed there was one bottle of Senna-Plus 8.6 mg that expired on 06/2025 inside the 500-hall nurse cart. During an interview on 07/24/2025 at 2:34 p.m. LVN-F stated there was one bottle of Senna-Plus 8.6 mg that expired on 06/2025 inside the 500-hall nurse cart. LVN-F said the nurse did not use it, did not know the reason this one was still in the nurse cart, and all expired medications should have been removed from the cart. During an interview on 07/24/2025 at 2:35 p.m. the DON stated all expired medications should have been removed from the medication room and carts, and expired medications might not reach therapeutic effects, and the facility did not have specific policy regarding expired medications and wipes. Record review of the facility policy, titled Medication Administration, revised 03/2019, revealed . two. Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to store plastic cups and bowls to allow for air-drying in the dish room.2. The facility failed to ensure all prepared items in the walk-in refrigerator was labeled and dated with use by date. These failures could place residents at risk for food borne illness. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. 1. The facility failed to store wet insulated plastic dome plate covers to allow for air-drying by the steam table.2. The facility failed to ensure all prepared items in the walk-in refrigerator were labeled and dated with the use by date. These failures could place residents at risk for food borne illness. The findings included: Observation of the facility's kitchen on 07/22/2025 at 9:03 AM revealed two stacks of wet insulated plastic dome plate covers, approximately fifteen in each stack, next to two stacks of dry insulated plastic dome plate covers by the steam table. The insulated plastic dome plate covers were stacked right side up on top of one another and did not allow airflow circulation. Observation of the facility's walk-in refrigerator on 07/23/2025 at 2 PM revealed three trays, each containing approximately thirty bowls of desserts, and four trays of prepared liquids were unlabeled. Observation of the facility's kitchen on 07/24/2025 at 11:00 AM revealed two stacks of wet insulated plastic dome plate covers, approximately fifteen in each stack, next to two stacks of dry insulated plastic dome plate covers by the steam table. The insulated plastic dome plate covers were stacked right side up on top of one another and did not allow airflow circulation. Interview with the Interim Dietary Manager on 07/25/2025 at 12:51 PM revealed he was filling in as the dietary manager since the previous manager quit and was learning this facility's kitchen and staff. The Interim Dietary Manager stated all open and prepared items being stored in the walk-in refrigerator needed to be labeled prior to being stored. The Interim Dietary manager stated it was the responsibility of all staff to ensure items in the walk-in refrigerator were labeled. The Interim Dietary Manager stated clean dishes were to be stored to allow air flow to allow drying. The Interim Dietary Manager stated all staff were responsible to ensure dishes were stored to allow proper air drying. The Interim Dietary Manager stated not properly drying and storing kitchen equipment and not labeling open or prepared items could cause food borne illness in the residents. During an interview with the Dietary Aide on 07/25/2025 at 1:54 PM she stated opened or prepared items in the walk-in refrigerator were to be labeled prior to being stored. The Dietary Aide stated dishes were to be stored to allow them to air dry. The Dietary Aide stated it was the responsibility of all staff to ensure opened or prepared items were labeled prior to being stored in the walk-in refrigerator. The Dietary Aide stated it was the responsibility of all staff to ensure dishes were stored to allow air flow to air dry. The Dietary Aide stated not labeling items stored in the walk-in refrigerator could cause staff to use old or expired foods and the residents could get sick. The Dietary Aide said if dishes were not dried before they were stored it could cause bacteria to grow causing residents to get sick. During an interview with the facility administrator on 07/25/2025 at 2:46 PM the Administrator stated all items opened or prepared being stored in the walk-in refrigerator were to be labeled with the use by date. The Administrator stated that it was the responsibility of all staff to ensure items were labeled. The Administrator stated by not labeling items in the walk-in refrigerator it could place the residents at risk of food borne illness. The Administrator stated clean dishes should be dried prior to being stored and by not doing so it could cause bacteria to grow on the dishes and potentially make the residents sick. The Administrator stated all staff were responsible to ensure dishes were dry before storing. Record review of facility policy named General Kitchen Sanitation, undated, revealed After cleaning and until use, store and manage all food-contact surfaces of equipment and multi-use utensils in a manner that protects the surfaces from manual contact, splash, dust, dirt, insects and other contaminants. Record review of facility policy named Food Storage, undated, revealed Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.(B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food Date Marking (B) Except as specified in (E) -(G) of this section refrigerated</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 (Resident #64) of twenty-eight residents reviewed for infection control practices. When CNA-C was providing peri care to Resident #64, CNA-C changed gloves without sanitizing or washing his hands. This deficient practice could place residents at risk for cross contamination and infections. The findings included: Record review of Resident #64's face sheet, dated 07/25/2025, revealed the resident was a [AGE] year old male and admitted to the facility on [DATE] with the diagnoses of cerebral infarction (blood supply to part of the brain is blocked or reduced), muscle weakness, type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), hypertension (high blood pressures), and hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body). Record review of Resident #64's admission MDS assessment, dated 04/23/2025, revealed the resident's BIMS score was 7 out of 15 indicating the resident had severe cognitive impairment, was dependent on the staff for sit to stand and chair to bed transfer, and was always incontinent of urinary bladder and frequently incontinent of bowel. Record review of Resident #64's comprehensive care plan, dated 04/09/2025, revealed the resident episodes of bowel and bladder incontinence. For intervention - incontinent care assistance every shift and as needed and check and change on rounds and as needed. Observation on 07/24/2025 at 11:47 a.m. revealed CNA-C and CNA-D removed Resident #64's old and dirty brief. CNA-C started cleaning the resident's right groin area, penis, and scrotum with multiple passes with one wipe, and then CNA-C changed gloves without sanitizing or washing hands. CNA-C rolled the resident to his left side and cleaned Resident #64's right buttock area and rectal area, and then changed gloves again without sanitizing or washing his hands. CNA-C put a new and clean brief under Resident #64 and closed it. In and interview on 07/24/2025 at 12:03 p.m. CNA-C stated he changed gloves without sanitizing or washing his hands. CNA-C said he should have sanitized or washed his hands before wearing new gloves to prevent infection. In an interview on 07/24/2025 at 2:45 p.m. the DON said CNA-C should have sanitized or washed his hands before wearing new gloves to prevent infection. Record review of the facility policy, titled Handwashing/Hand Hygiene, revised 01/2023, revealed . 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for situations such as this (including but not limited to): between gloves changes/ removing gloves.</p>		