STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676136	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huebner Creek Health & Rehabilitation Center	8306 Huebner Rd San Antonio, TX 78240

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 1 of 8 residents (Residents #1) reviewed for reporting allegations of abuse, neglect, and exploitation. The facility failed to report an allegation of neglect to the state agency when on 02/24/2024 Resident #1 was assessed by RN A as lethargic and difficult to arouse with a Tylenol bottle at the bedside. RN A called 911 and EMS transported Resident #1 to the emergency room for evaluation and treatment. Resident #1 was assessed with a 12,000mg Tylenol overdose (the harm threshold is 4,000mg over 24-hours) and was treated with an antidote, stabilized, and discharged back to the facility 02/26/2024. This failure could place residents at risk for not having their allegations of abuse neglect and or exploitation reported. The findings included: A record review of Resident #1's admission record dated 12/11/2024 revealed an admitted [DATE] with diagnoses which included Alzheimer's disease (cause of dementia, causes brain cells to die over time and the brain to shrink), depression, and encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion). A record review of Resident #1's Quarterly MDS assessment dated [DATE], revealed Resident #1 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 13 out of a possible 15 which indicated no cognitive impairment. Further review revealed Resident #1 was assessed as independent - Resident completes the activity by themselves with no assistance from a helper. For the daily task of eating, The ability to use suitable utensils to bring food and / or liquid to the mouth and swallow food and / or liquid once the meal is placed before the Resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #1's physician orders dated 02/24/2024 revealed the physician prescribed Tylenol 325mg, give 2 tablets by mouth every 6 hours as needed for pain DNE (do not exceed) 3,000mg of APAP (Tylenol) per day. A record review of Resident #1's care plan dated 12/11/2024 revealed Resident #1 had, Suicidal ideation. Returned from hospital on 02/26/2024 after taking OTC Tylenol provided by family. Resident stated he swallowed the entire contents of the bottle. Sent to ER. staff to monitor Resident Q15 minutes. A record review of Resident #1's hospital stay summary dated 02/26/2024 revealed, . (Resident Representative and Family) present at bedside. Note that they had spent the day shopping and spending time with patient. Imagine that he felt more depressed after they brought him back to nursing home (first time they had visited in 3 weeks). Plan: as per initial consult note dated 02/25/2024. Agree with continuation of 1:1 given severity of recent suicide attempt. (Resident #1) is a [AGE] year-old male with PMH HTN, HLD, CAD with h/o stent placement x2, seizure disorder with prior unspecified brain surgery x 3. Hx of prior stroke of L posterior occipital, parietal, and temporal lobe, dementia / Alzheimer's disease, and severely hard of hearing who presented to the ED via EMS on 02/24/2024 for a chief complaint of acute acetaminophen (Tylenol) toxic ingestion. patient is currently a Resident of (the facility) since October 2023 after an admission for heat stroke. Per (Resident representative) patient is unable to take care of himself. (Resident representative) visits (Resident #1) as often including taking him out of the facility for meals and shopping as often as he can but reports that the patient frequently is unable to remember that he was visited. Last visit was 2 days ago (02/22/2024) and patient stated to (Resident representative) that he was lonely. Somehow the patient obtained a bottle of acetaminophen (Tylenol) and ingested 24 capsules of 500mg (12,000 mg) at approximately 1300 (1 PM) on 02/24/2024 before staff were able to halt the process. A record review of Resident #1's nursing progress notes revealed, Type: Nursing Progress Note Effective Date: 2/24/2024 19:10:00 (07:10 PM) Department: Nursing Position: Registered Nurse Created By: (RN A) Created Date: 2/24/2024 19:10:24 Note Text: on 2/24/2024 @ 1600 (4 PM) Resident (#1) noted, lethargic and difficult to arouse. Is A/O X 1 to self only, noted empty bottle of Tylenol extra strength on nightstand. Notified MD, DON, and Administrator, call made to (Resident representative). New orders: Transfer to ER for Eval & Tx. Emergency response made to 911, arrived @ 1700 (5 PM). Resident left facility 1708 (05:08 PM). (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Texas Unified Licensure Information Portal website https://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252F accessed 12/10/2024 revealed no evidence for a report to the state agency for Resident #1's allegation of neglect regarding Resident #1's suicide attempt on 02/24/2024. During an interview on 12/11/2024 at 10:59 AM the previous DON stated she was the DON for the facility in February 2024. The DON stated she remembered Resident #1 as a friendly outgoing fell ow who routinely was out of bed and participating in meals and activities. The DON stated she recalled Resident #1 was assessed with a Tylenol overdose incident sometime in late February 2024. The previous DON stated she recalled Resident #1 was treated at the hospital and returned to the facility. The previous DON stated although she did not have direct recollection from February 2024, she and the administrator would review all hospital transfers and admissions and was confident she and the previous administrator had reviewed Resident #1's hospital discharge and admission. The previous DON stated she did not recall if she or the Administrator had reported Resident #1's suicide attempt to the state agency. During an interview on 12/11/2024 at 02:56 PM RN A stated he was the RN for Resident #1 from December 2023 to April 2024 and usually worked Monday through Friday from 06:00 AM to 02:00 PM and Resident #1 was usually in a good mood and up out of bed and had meals in the dining room. RN A stated on 02/24/2024 Resident #1 stayed in bed and refused breakfast and lunch as well as his medications. RN A stated he had documented at 4pm that around 3pm res was found lethargic and hard to arouse, I found a bottle of empty Tylenol and called 911, I continued to provide support with positioning and assisted Resident #1 with 911. I documented and reported to (the MD), and the (Residents' Representative). RN A Stated he did not assess peer residents for safety with a sweep for medications at the bedside, nor did he witness other staff assess other residents for safety. RN A stated he recalled the DON was notified of Resident #1's suicide attempt and 911 transfer to the hospital. RN A stated he had no knowledge of how Resident #1 came to possess the Tylenol bottle. RN A stated he was not aware if the facility had reported Resident #1's suicide attempt or the Tylenol bottle at his bedside. During a joint interview on 12/10/2024 at 4:00 PM the Administrator and the DON stated they were not the leadership for the facility in February 2024. The Administrator and the DON stated they began their service in April 2024. The Administrator and the DON stated they had minimal knowledge of Resident #1's suicide attempt on 02/24/2024 and were not aware if the previous Administrator nor the previous DON had reported to the state agency specific to medications at the bedside and Resident #1's suicide attempt. The Administrator and the DON stated after Resident #1's suicide attempt the facility should have reported the incident to the state agency. The Administrator and the DON stated they would research the incident and provide documentation to support the facility's actions surrounding Resident #1's suicide attempt. On 12/11/2024 the administrator and the DON provided in-service records for the date of 02/27/2024 titled Documentation for Change of Condition, Completing Incident Report. No further documentation was provided for evidence of reporting to the state agency regarding medications at the bedside nor Resident #1's suicide attempt. A record review of the facility's in-service was titled, Documentation for Change of Condition, Completing Incident Report dated 02/27/2024 revealed the previous DON provided the in-service to 26 employees. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's policy titled Abuse / Neglect dated 03/29/2018, revealed, . It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations they may constitute abuse or neglect to any resident in the facility. Definitions: . Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Prevention: the facility will provide the residents, families, hands down and environment free from abuse and neglect. all reports of abuse or suspicion of abuse / neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and or abuse preventionist within 24 hours of complaint. Reporting: any person having reasonable cause to believe an elderly or incapacitated the dog is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state, and adult Protective Services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the abuse preventionist or designee. The administrator or designee will report to HHSC all incidents that meet the criteria of provider letter 19-17 dated July 10th, 2019, if the allegations involve abuse or result in serious out of the injury the report is to be made within 24 hours of the allegation

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to ensure allegations of abuse, neglect, exploitation, or mistreatment have evidence that all alleged violations were thoroughly investigated and prevented further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress and reported the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action were taken, for 1 of 8 residents (Residents #1) reviewed for allegations of abuse, neglect, and exploitation. The facility failed to investigate and report an allegation of neglect when on 02/24/2024 Resident #1 was assessed by RN A as lethargic and difficult to arouse with a Tylenol bottle at the bedside. RN A called 911 and EMS transported Resident #1 to the emergency room for evaluation and treatment. Resident #1 was assessed with a 12,000mg Tylenol overdose (the harm threshold is 4,000mg over 24-hours) and was treated with an antidote, stabilized, and discharged back to the facility 02/26/2024. This failure could place residents at risk for not having their allegations of abuse neglect and or exploitation investigated and reported. The findings included: A record review of Resident #1's admission record dated 12/11/2024 revealed an admitted [DATE] with diagnoses which included Alzheimer's disease (cause of dementia, causes brain cells to die over time and the brain to shrink), depression, and encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion). A record review of Resident #1's Quarterly MDS assessment dated [DATE], revealed Resident #1 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 13 out of a possible 15 which indicated no cognitive impairment. Further review revealed Resident #1 was assessed as independent - Resident completes the activity by themselves with no assistance from a helper. For the daily task of eating, The ability to use suitable utensils to bring food and / or liquid to the mouth and swallow food and / or liquid once the meal is placed before the resident. A record review of Resident #1's physician orders dated 02/24/2024 revealed the physician prescribed Tylenol 325mg, give 2 tablets by mouth every 6 hours as needed for pain DNE (do not exceed) 3,000mg of APAP (Tylenol) per day. A record review of Resident #1's care plan dated 12/11/2024 revealed Resident #1 had, Suicidal ideation. Returned from hospital on 02/26/2024 after taking OTC Tylenol provided by family. Resident stated he swallowed the entire contents of the bottle. Sent to ER. staff to monitor Resident Q15 minutes. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident #1's hospital stay summary dated 02/26/2024 revealed, . (Resident Representative and Family) present at bedside. Note that they had spent the day shopping and spending time with patient. Imagine that he felt more depressed after they brought him back to nursing home (first time they had visited in 3 weeks). Plan: as per initial consult note dated 02/25/2024. Agree with continuation of 1:1 given severity of recent suicide attempt. (Resident #1) is a [AGE] year-old male with PMH HTN, HLD, CAD with h/o stent placement x2, seizure disorder with prior unspecified brain surgery x 3. Hx of prior stroke of L posterior occipital, parietal, and temporal lobe, dementia / Alzheimer's disease, and severely hard of hearing who presented to the ED via EMS on 02/24/2024 for a chief complaint of acute acetaminophen (Tylenol) toxic ingestion. patient is currently a Resident of (the facility) since October 2023 after an admission for heat stroke. Per (Resident representative) patient is unable to take care of himself. (Resident representative) visits (Resident #1) as often including taking him out of the facility for meals and shopping as often as he can but reports that the patient frequently is unable to remember that he was visited. Last visit was 2 days ago (02/22/2024) and patient stated to (Resident representative) that he was lonely. Somehow the patient obtained a bottle of acetaminophen (Tylenol) and ingested 24 capsules of 500mg (12,000 mg) at approximately 1300 (1 PM) on 02/24/2024 before staff were able to halt the process. A record review of Resident #1's nursing progress notes revealed, Type: Nursing Progress Note Effective Date: 2/24/2024 19:10:00 (07:10 PM) Department: Nursing Position: Registered Nurse Created By: (RN A) Created Date: 2/24/2024 19:10:24 Note Text: on 2/24/2024 @ 1600 (4 PM) Resident (#1) noted, lethargic and difficult to arouse. Is A/O X 1 to self only, noted empty bottle of Tylenol extra strength on nightstand. Notified MD, DON, and Administrator, call made to (Resident representative). New orders: Transfer to ER for Eval & Tx. Emergency response made to 911, arrived @ 1700 (5 PM). Resident left facility 1708 (05:08 PM). A record review of the Texas Unified Licensure Information Portal website https://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252F accessed 12/10/2024 revealed no evidence for an initial report nor a post incident 5-day report to the state agency for Resident #1's allegation of neglect regarding Resident #1's suicide attempt on 02/24/2024. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 10:59 AM the previous DON stated she was the DON for the facility in February 2024. The DON stated she remembered Resident #1 as a friendly outgoing fell ow who routinely was out of bed and participating in meals and activities. The DON stated she recalled Resident #1 was assessed with a Tylenol overdose incident sometime in late February 2024. The previous DON stated she recalled Resident #1 was treated at the hospital and returned to the facility. The previous DON stated although she did not have direct recollection from February 2024, she and the administrator would review all hospital transfers and admissions and was confident she and the previous administrator had reviewed Resident #1's hospital discharge and admission. The previous DON stated she did not recall if she or the Administrator had investigated and reported Resident #1's suicide attempt to the state agency. During an interview on 12/11/2024 at 02:56 PM RN A stated he was the RN for Resident #1 from December 2023 to April 2024 and usually worked Monday through Friday from 06:00 AM to 02:00 PM and Resident #1 was usually in a good mood and up out of bed and had meals in the dining room. RN A stated on 02/24/2024 Resident #1 stayed in bed and refused breakfast and lunch as well as his medications. RN A stated he had documented at 4pm that around 3pm res was found lethargic and hard to arouse, I found a bottle of empty Tylenol and called 911, I continued to provide support with positioning and assisted Resident #1 with 911. I documented and reported to (the MD), and the (Residents' Representative). RN A Stated he did not assess peer residents for safety with a sweep for medications at the bedside, nor did he witness other staff assess other residents for safety. RN A stated he recalled the DON was notified of Resident #1's suicide attempt and 911 transfer to the hospital. RN A stated he had no knowledge of how Resident #1 came to possess the Tylenol bottle. RN A stated he was not aware if the facility had investigated or reported Resident #1's suicide attempt or the Tylenol bottle at his bedside. During a joint interview on 12/10/2024 at 4:00 PM the Administrator and the DON stated they were not the leadership for the facility in February 2024. The Administrator and the DON stated they began their service in April 2024. The Administrator and the DON stated they had minimal knowledge of Resident #1's suicide attempt on 02/24/2024 and were not aware if the previous Administrator nor the previous DON had reported to the state agency specific to medications at the bedside and Resident #1's suicide attempt. The Administrator and the DON stated after Resident #1's suicide attempt the facility should have been investigated and reported to the state agency. The Administrator and the DON stated they would research the incident and provide documentation to support the facility's actions surrounding Resident #1's suicide attempt. On 12/11/2024 the administrator and the DON provided in-service records for the date of 02/27/2024 titled Documentation for Change of Condition, Completing Incident Report. No further documentation was provided for evidence of reporting to the state agency regarding medications at the bedside nor Resident #1's suicide attempt. A record review of the facility's in-service was titled, Documentation for Change of Condition, Completing Incident Report dated 02/27/2024 revealed the previous DON provided the in-service to 26 employees. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's policy titled Abuse / Neglect dated 03/29/2018, revealed, . It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations they may constitute abuse or neglect to any resident in the facility. Definitions: . Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Prevention: the facility will provide the residents, families, hands down and environment free from abuse and neglect. all reports of abuse or suspicion of abuse / neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and or abuse preventionist within 24 hours of complaint. Reporting: any person having reasonable cause to believe an elderly or incapacitated the dog is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state, and adult Protective Services. State law mandates that citizens report all suspected cases of abuse, neglect, or financial exploitation of the elderly and incapacitated persons. When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the abuse preventionist or designee. The administrator or designee will report to HHSC all incidents that meet the criteria of provider letter 19-17 dated July 10th, 2019, if the allegations involve abuse or result in serious out of the injury the report is to be made within 24 hours of the allegation

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 10 residents (Resident #1) reviewed for medications at the bedside. The facility failed to monitor residents for medications at the bedside when on 02/24/2024 Resident #1 was assessed by RN A as lethargic and difficult to arouse with a Tylenol bottle at the bedside. RN A called 911 and EMS transported Resident #1 to the emergency room for evaluation and treatment. Resident #1 was assessed at with a 12,000mg Tylenol overdose (the harm threshold is 4,000mg over 24-hours) and was treated with an antidote, stabilized, and discharged back to the facility 02/26/2024 without assessing other residents for safety nor educating staff with an in-service for the incident. An IJ was identified on 12/12/2024. The IJ template was provided to the facility on [DATE] at 03:50 PM. While the IJ was removed on 12/13/2024, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. This failure could place residents who needed safety monitoring for medications at the bedside, at risk for harm by neglect to include serious injury, or death. The findings included: A record review of Resident #1's admission record dated 12/11/2024 revealed an admitted [DATE] with diagnoses which included Alzheimer's disease (cause of dementia, causes brain cells to die over time and the brain to shrink), depression, and encephalopathy (A medical term used to describe a disease that affects brain structure or function. It causes altered mental state and confusion). A record review of Resident #1's Quarterly MDS assessment dated [DATE], revealed Resident #1 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 13 out of a possible 15 which indicated no cognitive impairment. further review revealed Resident #1 was assessed as independent - Resident completes the activity by themselves with no assistance from a helper. For the daily task of eating, The ability to use suitable utensils to bring food and / or liquid to the mouth and swallow food and / or liquid once the meal is placed before the resident. A record review of Resident #1's physician orders dated 02/24/2024 revealed the physician prescribed Tylenol 325mg, give 2 tablets by mouth every 6 hours as needed for pain DNE (do not exceed) 3,000mg of APAP (Tylenol) per day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident #1's care plan dated 12/11/2024 revealed Resident #1 had, Suicidal ideation. Returned from hospital on 02/26/2024 after taking OTC Tylenol provided by family. Resident stated he swallowed the entire contents of the bottle. Sent to ER. staff to monitor Resident Q15 minutes. A record review of Resident #1's hospital stay summary dated 02/26/2024 revealed, . (Resident Representative and Family) present at bedside. Note that they had spent the day shopping and spending time with patient. Imagine that he felt more depressed after they brought him back to nursing home (first time they had visited in 3 weeks). Plan: as per initial consult note dated 02/25/2024. Agree with continuation of 1:1 given severity of recent suicide attempt. (Resident #1) is a [AGE] year-old male with PMH HTN, HLD, CAD with h/o stent placement x2, seizure disorder with prior unspecified brain surgery x 3. Hx of prior stroke of L posterior occipital, parietal, and temporal lobe, dementia / Alzheimer's disease, and severely hard of hearing who presented to the ED via EMS on 02/24/2024 for a chief complaint of acute acetaminophen (Tylenol) toxic ingestion. patient is currently a Resident of (the facility) since October 2023 after an admission for heat stroke. Per (Resident representative) patient is unable to take care of himself. (Resident representative) visits (Resident #1) as often including taking him out of the facility for meals and shopping as often as he can but reports that the patient frequently is unable to remember that he was visited. Last visit was 2 days ago (02/22/2024) and patient stated to (Resident representative) that he was lonely. Somehow the patient obtained a bottle of acetaminophen (Tylenol) and ingested 24 capsules of 500mg (12,000 mg) at approximately 1300 (1 PM) on 02/24/2024 before staff were able to halt the process. A record review of Resident #1's nursing progress notes revealed, Type: Nursing Progress Note Effective Date: 2/24/2024 19:10:00 (07:10 PM) Department: Nursing Position: Registered Nurse Created By: (RN A) Created Date: 2/24/2024 19:10:24 Note Text: on 2/24/2024 @ 1600 (4 PM) Resident (#1) noted, lethargic and difficult to arouse. Is A/O X 1 to self only, noted empty bottle of Tylenol extra strength on nightstand. Notified MD, DON, and Administrator, call made to (Resident representative). New orders: Transfer to ER for Eval & Tx. Emergency response made to 911, arrived @ 1700 (5 PM). Resident left facility 1708 (05:08 PM). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huebner Creek Health & Rehabilitation Center	8306 Huebner Rd San Antonio, TX 78240

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/11/2024 at 10:59 AM the previous DON stated she was the DON for the facility in February 2024. The DON stated she remembered Resident #1 as a friendly outgoing fell ow who routinely was out of bed and participating in meals and activities. The DON stated she recalled Resident #1 was assessed with a Tylenol overdose incident sometime in late February 2024. The previous DON stated she recalled Resident #1 was treated at the hospital and returned to the facility. The previous DON stated although she did not have direct recollection from February 2024, she and the administrator would review all hospital transfers and admissions and was confident she and the previous administrator had reviewed Resident #1's hospital discharge and admission. the previous DON stated she did not recall if she had provided an in-service for the staff specific to Resident #1's suicide attempt. The previous DON stated she could not recall if the facility had assessed peer residents for safety to include reviews for medications at the bedsides. During an interview on 12/11/2024 at 02:56 PM RN A stated he was the RN for Resident #1 from December 2023 to April 2024 and usually worked Monday through Friday from 06:00 AM to 02:00 PM and Resident #1 was usually in a good mood and up out of bed and had meals in the dining room. RN A stated on 02/24/2024 Resident #1 stayed in bed and refused breakfast and lunch as well as his medications. RN A stated he had documented at 4pm that around 3pm resident was found lethargic and hard to arouse, I found a bottle of empty Tylenol and called 911, I continued to provide support with positioning and assisted Resident #1 with 911. I documented and reported to (the MD), and the (Residents' Representative). RN A stated he did not assess peer residents for safety with a sweep for medications at the bedside, nor did he witness other staff assess other residents for safety. RN A stated he recalled the DON was notified of Resident #1's suicide attempt and 911 transfer to the hospital. RN A stated he had no knowledge of how Resident #1 came to possess the Tylenol bottle. RN A stated he had not received an in-service specific to medications at the bedside after resident #1's suicide attempt. During a joint interview on 12/10/2024 at 4:00 PM the Administrator and the DON stated they were not the leadership for the facility in February 2024. The Administrator and the DON stated they began their service in April 2024 . The Administrator and the DON stated they had minimal knowledge of Resident #1's suicide attempt on 02/24/2024 and were not aware if the previous Administrator nor the previous DON had provided an in-service to the staff specific to medications at the bedside and or provided a safety assessment of peer residents for medications at the bedside. The Administrator and the DON stated after Resident #1's suicide attempt the staff should have been in-serviced and peer residents should have been assessed for safety. The Administrator and the DON stated they would research the incident and provide documentation to support the facility's actions surrounding Resident #1's suicide attempt. On 12/11/2024 the administrator and the DON provided in-service records for the date of 02/27/2024 titled Documentation for Change of Condition, Completing Incident Report. No further documentation was provided for evidence of Resident assessments for safety regarding medications at the bedside nor in-services for medications at the bedside. A record review of the facility's in-service was titled, Documentation for Change of Condition, Completing Incident Report dated 02/27/2024 revealed the previous DON provided the in-service to 26 employees. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the facility's undated policy titled Nursing Home List of Items Not Allowed in Residents Room revealed, Medications: (includes all Prescription and Over-the-Counter drugs, except emergency items like nitroglycerin, which must be ordered by the doctor through the Nursing Home.) and in certain situations where the resident is allowed to self-administer as per care plan. NOTE: A good rule of thumb has been established by the Food and Drug Administration whereby any products labeled Keep out of reach of children or carries any type of caution label is merchandise that contains ingredients which are harmful if taken without supervision or used in a way not designated. Many of our residents, due to mental impairments or poor eyesight might inadvertently drink or eat some of the above items causing irreparable harm. A record review of the Tylenol manufactures website TYLENOL(R) Easy to Swallow Caplets for Fast Pain Relief | TYLENOL(R) accessed 12/16/2024 revealed, Warnings: Liver warning: This product contains acetaminophen. Severe liver damage may occur if you take more than 4,000 mg of acetaminophen in 24 hours. Keep out of reach of children. Overdose warning: In case of overdose, get medical help or contact a Poison Control Center right away. (1-800-222-1222) Quick medical attention is critical for adults as well as for children even if you do not notice any signs or symptoms. The Administrator was notified on 12/12/24 at 03:50 PM, an IJ situation had been identified due to the above failures. The IJ template was given to the administrator on 12/12/24 at 03:50, PM and a POR was requested. The POR was accepted on 12/12/2024 at 08:01 PM and indicated the following: (the Facility) 12/12/2024 Plan of Removal Problem: IJ F689 Free of Accidents/Hazards/Supervision/Devices called on 12/12/24. Interventions: Facility staff searched through all items in residents' rooms to check for any items not allowed on 12/12/2024. All items identified as not allowed in residents rooms were removed from their rooms on 12/12/2024. On 12/12/2024, in-service initiated for all staff if you see medications at bedside or any other items not allowed in resident rooms, they should notify charge nurse, DON, and Administrator. Administrative staff will keep a log of any medications found at bedside. This log will include the residents name, date, what item was found, and action taken and that resident will be assessed to ensure they are free from harm by the item not allowed in the room. RP will be contacted to discuss facility policy for Items not Allowed in Rooms. On 12/12/2024, the Regional Compliance Nurse In-serviced the DON and administrator on resident overdoses. If a resident overdoses they should search that residents to look for additional items that residents can harm themselves with and remove any items identified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/2024, Regional Compliance Nurse in-serviced DON and Administrator to search all other residents' rooms to ensure they don't have any items not allowed in their room / items that they harm themselves with when an incident of an overdose occurs. On 12/12/2024, Regional Compliance Nurse in-serviced DON and Administrator to add incidents that are accidents, hazards, and/or require supervision occur in the facility that they should add to the monthly QAPI Committee meeting for review. On 12/12/2024 nursing staff in-serviced to ask residents that return from being out on pass if they returned with any items that are not allowed in resident's rooms and if they do identify, they will not let resident take to his/her room and notify the DON and/or administrator. Resident out on pass log will be reviewed 5 x a week by DON and/or designee, and DON / designee will confirm the confirm with the nurse that the residents were screen when they returned from out on pass. On 12/12/2024, Facility to provide education/notification in form of an email to all RPs of residents with a list of the items not allowed in residents rooms. E-mails will be sent with a read receipt to ensure they have been reviewed. An audit list will be kept to verify that all current residents RP's read the email. A physical copy of the items not allowed in residents rooms will be mailed out to resident RP's on 12/13/2024. For all future residents, list will be provided upon admission as part of the admission packet. On 12/12/2024, education/in-service to be provided to all staff to reiterate the policy of items not allowed in residents rooms, by phone, COVR (scheduling portal/message board) and in person. Staff will not be able to return to work until education has been provided. In-service will be completed by 12/12/24. Signature or acknowledgement of this in-service will be confirmed by an audit list. On 12/12/2024 Facility will provide a copy of list of items not allowed to residents and keep a signed copy. Resident that are alert but unable to physically sign will be confirmed by two witnesses. On 12/12/2024, a sign was placed at the front door of the facility with the items not allowed in residents rooms. On 12/12/2024 all residents assessed to ensure that no residents voiced any suicidal Ideations On 12/12/2024 MD was notified of IJ F689 Free of Accidents/Hazards/Supervision/Devices On 12/12/2024 Facility to provide care for affected resident as per plan of care. Monitoring: Facility staff will conduct champion rounds 5x a week indefinitely in every resident room and look for items not allowed in residents. They will remove items not allowed if they identify any. Monitoring will start 12/12/2024. Regional Administrator and Regional Compliance Nurse will monitor during weekly visits and ask DON and Administrator what items are not allowed in residents room and what to do if any are identified. Monitoring will start 12/12/2024 and will continue x 8 weeks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administrator / DON will monitor 5 residents' rooms daily, 5 days a week to ensure residents do not have any items not allowed in room. Regional Administrator and Regional Compliance Nurse will check 5 rooms each once a week to ensure that staff are conducting their champion rounds 5 x week and look for items not allowed in residents rooms. Monitoring will start 12/12/2024 and will continue x 8 weeks. Plan of Removal Verification Facility staff searched through all items in residents' rooms to check for any items not allowed on 12/12/2024. All items identified as not allowed in residents rooms were removed from their rooms on 12/12/2024. o During facility observation on 12/13/24 at 11:00 a.m., observed multiple bagged items in Administrator's office that staff identified as unauthorized items, removed from room, and bagged individually. Interview with the Administrator on 12/13/24 at 1:24 p.m. revealed that responsible parties have already been contacted, and they were picking up unauthorized items. o During facility observation on 12/13/24 at 12:15 p.m., observed Hospitality Aide / Receptionist B greeted a visitor arriving at the facility and provided him with the list of unauthorized items. o During facility observation on 12/13/2024 at 12:45 p.m. Hospitality Aide B monitored a bag a visitor entered the facility with and told the visitor to ensure the resident was safe to have the shakes in the bag. o During facility observation on 12/13/24 at 1:28 p.m., surveyor observed Hospitality aide / Receptionist B on phone with family member explaining the list of unauthorized items. On 12/12/2024, in-service initiated for all staff if you see medications at bedside or any other items not allowed in resident rooms, they should notify charge nurse, DON, and Administrator. Administrative staff will keep a log of any medications found at bedside. This log will include the residents name, date, what item was found, and action taken and that resident will be assessed to ensure they are free from harm by the item not allowed in the room. RP will be contacted to discuss facility policy for Items not Allowed in Rooms. During facility observation of in-service log on 12/13/24 at 1:38 p.m., observed in-service log (on-going) for all staff. In-service reflected medications at bedside or any other items not allowed in resident rooms, notification of charge nurse, DON, and Administrator. On 12/12/2024, the Regional Compliance Nurse In-serviced the DON and administrator on resident overdoses. If a resident overdoses they should search that residents to look for additional items that residents can harm themselves with and remove any items identified. o During facility observation on 12/13/24 at 1:38 p.m., observed in-service given by Regional Compliance Nurse completed 12/12/24 to DON & Administrator. In-service reflected resident overdoses, searching residents' rooms and removing items. In-service was signed by DON and Administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/2024, Regional Compliance Nurse in-serviced DON and Administrator to search all other residents' rooms to ensure they don't have any items not allowed in their room / items that they harm themselves with when an incident of an overdose occurs. o During facility observation on 12/13/24 at 11:00 a.m., observed multiple bagged items in Administrator's office that staff identified as unauthorized items, removed from room, and bagged individually. Interview with the Administrator on 12/13/24 at 1:24 p.m. revealed that responsible parties have already been contacted, and they were picking up unauthorized items. o Interview with ADON C [shift M-F, days, on-call] on 12/13/24 at 11:11 a.m. revealed she received an in-service from the DON, and she has also been providing the in-service to staff members regarding personal items that residents may not have in their rooms. ADON C stated she has been handing out the lists to staff members and explaining purpose of list and items on the list. She stated she assisted in room check and removing unauthorized items from the rooms, explaining to residents, and calling family members. o Interview with ADON D [M-F, on-call] on 12/13/24 at 12:12 p.m. revealed that she received in-service from DON and has also been giving in-service to facility staff regarding items not allowed in residents' rooms. She stated she assisted in identifying and removing unauthorized items from residents' rooms and educating residents and family members. She stated she will continue to educate staff, residents, and visitors about unauthorized items. She stated she was aware at times that residents could request self-administer medications and if this occurred, she would review with DON to complete self-administration assessments as needed. On 12/12/2024, Regional Compliance Nurse in-serviced DON and Administrator to add incidents that were accidents, hazards, and/or require supervision occur in the facility that they should add to the monthly QAPI Committee meeting for review. o Record review of the POR binder revealed that Regional Compliance Nurse had completed the in-service on 12/12/24 with DON and Administrator to add incidents that are accidents, hazards, and/or require supervision to the QAPI Committee meeting for review. On 12/12/2024 nursing staff in-serviced to ask residents that return from being out on pass if they returned with any items that were not allowed in resident's rooms and if they do identify, they will not let resident take to his/her room and notify the DON and/or administrator. Resident out on pass log will be reviewed 5 x a week by DON and/or designee, and DON / designee will confirm the confirm with the nurse that the residents were screen when they returned from out on pass. o A record review of the facility's Out on Pass Log revealed residents will be screened upon return to the facility. On 12/12/2024, Facility to provide education/notification in form of an email to all RP's of residents with a list of the items not allowed in residents rooms. E-mails will be sent with a read receipt to ensure they have been reviewed. An audit list will be kept to verify that all current residents RP's read the email. A physical copy of the items not allowed in residents rooms will be mailed out to resident RP's on 12/13/2024. For all future residents, list will be provided upon admission as part of the admission packet. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Interview with Admissions Coordinator/Marketing G [1st shift, M-F and varying weekends] on 12/13/24 at 8:14 a.m. revealed that he received in-service from Administrator regarding items residents may not have in their rooms. He stated he has a copy of the list and has incorporated the list with the Admission Packet to provide to new admissions/family members. He stated since his office in in the front of the facility, he will watch out for residents and visitors coming in with shopping bags and remind them of the unauthorized list of items. o Interview with BOM on 12/13/24 at 2:45 p.m. revealed that BOM sent email notification to family members who have provided email on 12/12/24 at 5:35 p.m. Email included delivered and read notification. o Interview with BOM on 12/13/24 at 2:45 p.m. revealed the responsible parties who have not provided an email were mailed a letter explaining the List of Items not allowed in facility. BOM stated letters were mailed on 12/13/24. On 12/12/2024, education/in-service to be provided to all staff to reiterate the policy of items not allowed in residents rooms, by phone, COVR (scheduling portal/message board) and in person. Staff will not be able to return to work until education has been provided. In-service will be completed by 12/12/24. Signature or acknowledgement of this in-service will be confirmed by an audit list. o Total staff 117. Review of POR binder revealed 114 out of 117 staff members have been contacted. Nurses: 11 out of 27 nurses interviewed with sample from all three shifts. CNA/MA 7 out of 25 nurse aides interviewed. 16 non-nursing / non-direct care staff interview. o Interview with MA E on 12/13/24 at 8:10 a.m. [1st shift, M-F] revealed that she received in-service from DON regarding items that residents may not have in their rooms. She stated she was provided a list of items to follow. She stated if she found unauthorized items, she would notify the charge nurse or her DON to let them know. o Interview with CNA F on 12/13/24 at 8:12 a.m. [1st shift, M-F] revealed that she received in-service from DON regarding items that residents may not have in their rooms. She stated she was provided a list of items to follow. She stated if she found unauthorized items, she would notify the charge nurse or her DON to let them know. o Interview with Admissions Coordinator/Marketing G [1st shift, M-F and varying weekends] on 12/13/24 at 8:14 a.m. revealed that he received in-service from Administrator regarding items residents may not have in their rooms. He stated he has a copy of the list and has incorporated the list with the Admission Packet to provide to new admissions/family members. He stated since his office in in the front of the facility, he will watch out for residents and visitors coming in with shopping bags and remind them of the unauthorized list of items. o Interview with LVN H [PRN Nurse, varying shifts] on 12/13/24 at 8:18 a.m. revealed that she received in-service from DON regarding items that residents may not have in their rooms. She stated she was provided a list of items to follow. She stated if she found unauthorized items, she would inform residents and remove them from the room for safekeeping and notify family members to pick them up. She stated she would notify DON of unauthorized items. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Interview with Housekeeper I on 12/13/24 [1st shift, rotating schedule] at 8:32 a.m. revealed that she received in-service from DON regarding items that residents may not have in their rooms. She stated she was provided a list of items to follow and look for. She stated she would notify her supervisor or the Administrator if she identified unauthorized items. o Interview with Hospitality Aide/Receptionist B [1st Shift M-F] on 12/13/24 at 10:15 a.m. revealed that she received in-service from Administrator about items residents may not have in their rooms. She stated she was provided a copy for herself and has copies available at the receptionist deck to hand out to residents and/or family members. She stated she would watch for residents returning from pass or visitors entering the facility with items and provide them with a list of authorized items and remind them that they need to follow the posted guidelines. She stated she was comfortable asking residents and visitors to follow guidelines. o Interview with RN J, Charge Nurse [1st Shift M-F] on 12/13/24 at 10:40 a.m. revealed that she received in-service on items residents may not have in their rooms and has been provided a list of items to keep for reference. She stated that if she identifies unauthorized items or is told by her aides or other staff members about unauthorized items, she will speak to resident and/or R/P and remove them from the room. She would educate residents and/or R/P and notify DON or Administrator at time of occurrence. o Interview with PT K [1st Shift M-F] on 12/13/24 at 10:48 a.m. revealed that he has received in-service from DON regarding items residents may not have in their rooms. He stated he was given a personal copy of the list. He stated that if he noticed any items in the rooms, he would remove them and notify the DON or Administrator as well as let the resident know why they were not safe to keep in the room. o Interview with COTA L [1st shift M-F] on 12/13/24 at 11:00 a.m. revealed that she received in-service regarding unauthorized items that residents may not have in their rooms. She stated she had a copy of the list of items and if she notices items, she will let the resident know why they cannot have it/them and remove the item(s). She stated she would let the charge nurse know. o Interview with PT M [1st shift M-F] on 12/13/24 at 11:03 a.m. revealed that she received in-service from DON on items not allowed to be in resident's rooms. She stated she would remove unauthorized items and let the resident know why she had to take the items. She stated she would notify the Charge Nurse or DON of found items and give the item to them for safekeeping. o Interview with the SW [1st shift M-F] on 12/13/24 at 11:05 a.m. revealed that she received in-service from DON regarding personal items that residents may not keep in their rooms. She stated she will remove unauthorized items from the room, educate residents and/or family members/visitors as well as keep an eye out for people coming in facility with shopping bags. She stated she will continue to educate. o Interview with the BOM [1st shift M-F] on 12/13/24 at 11:07 a.m. revealed that she received in-service from DON on items that residents may not keep in their rooms. She stated she had a list of the items and if she were to see residents with unauthorized items, she would notify the DON or Administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Interview with LVN/MDS N Coordinator [1st shift M-F] on 12/13/24 at 11:09 a.m. revealed that she received in-service from DON on unauthorized items. She stated she had the list of items and was aware of what to look for in the residents' rooms. She stated she will remove identified items and notify Charge Nurse and DON of identified items. o Interview with ADON C [1st shift M-F and on-call] on 12/13/24 at 11:11 a.m. revealed she received in-service from DON and has also been providing the in-service to staff members regarding personal items that residents may not have in their rooms. She stated she had been handing out the lists to staff members and explaining purpose of list and items on the list. She stated she assisted in room checks and removing unauthorized items from the rooms, explaining to residents, and calling family members. o Interview with LVN O (PRN shifts) on 12/13/24 at 11:22 a.m. revealed she received in-service from DON on items residents are not allowed to keep in their rooms. She stated she would remove identified items, explain to resident and/or family why they cannot have these items and let the DON know. She stated as charge nurse, she would assist her aides with removing items and education. o Interview with CNA P [1st shift, M-F and PRN] on 12/13/24 at 11:32 a.m. revealed that she received in-service from DON about items not allowed to be in residents' rooms. She stated that she would let her resident know that she would have to remove unauthorized items and notify Charge Nurse and/or DON. o Interview with Medical Records / Central Supply Q [1st shift M-F] on 12/13/24 at 11:34 a.m. revealed that she received in-service from DON on items that residents may not have in their rooms. She stated she was in residents' rooms almost daily for stocking supplies and was aware of being on the lookout for unauthorized items. She stated she would remove the items, let the resident know why he/she cannot have the items and notify the Charge Nurse and/or DON. o Interview with the Activity Director [1st shift / some evenings, M-F] on 12/13/24 at 11:36 a.m. revealed that she received in-service from DON regarding items residents may not have in their rooms. The Activity Director stated she did a lot of resident shopping and followed this list prior to in-service. The Activity Director stated she would review it with the resident council and keep a copy of the list for reference. o Interview with CNA R [1st shift & prn, M-F] on 12/13/24 at 11:36 a.m. revealed she received in-service on authorized and unauthorized items that residents may have in their room. She stated she had been a nurse aide for more than [AGE] years and was very aware of these items. She stated she would let her resident know why he/she cannot have the items and remove items from room and let the Charge Nurse know. o Interview with Laundry Staff S [1st shift wknd] on 12/13/24 at 11:42 a.m. revealed that she received in-service by DON about unauthorized items in resident's rooms. She stated she would let the charge nurse, or the DON know if she saw items in the room. o Interview with Laundry Staff T [1st shift wknds] on 12/13/24 at 11:42 a.m. revealed that she received in-service by DON about unauthorized items in resident's rooms. She stated she would let the charge nurse, or the DON know if she saw items in the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676136	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huebner Creek Health & Rehabilitation Center	8306 Huebner Rd San Antonio, TX 78240

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Interview with SLP U [1st shift M-F] on 12/13/24 at 11:45 a.m. revealed that she received the in-service on unauthorized items and feels comfortable removing the items, letting Charge Nurse and DON know and educating resident on the list of unauthorized items. She stated she had daily contact with residents regarding food items / non-compliance and items that they may / may not keep in their rooms. o Interview with Housekeeper V [1st shift, M-F] on 12/13/24 at 11:47 a.m. revealed that she received in-service from DON. She reviewed provided list and stated that she had been taught to let the Charge Nurse, DON or her supervisor know if a resident has these items. She stated she was not comfortable removing items hersel [TRUNCATED]

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to record in residents' medical records sufficient information to identify the Resident and services provided, for 1 of 8 residents (Residents #2) reviewed for services provided with documentation of nursing services. LVN LL failed to document her skin assessment, report to the physician and Resident's Representative, and detailed physicians order when on 10/23/2024 LVN LL assessed Resident #2 with a rash, communicated with the physician, and the physician prescribed Resident #2 a steroid skin cream. This failure could place residents at risk for inaccurate medical records. The findings included: A record review of Resident #2's admission record revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction, restlessness and agitation, and cognitive communication deficit. A record review of Resident #2's quarterly MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 08 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #2's care plan dated 12/12/2024 revealed, The Resident requires ant-psychotic medications for behavior management related to agitation s/p CVA. administer medications as orders. Monitor / document for side effects and effectiveness. discuss with MD, family re([NAME]) [sic] ongoing need for use of medication. Educate the Resident and family about risks, benefits, and side effects. A record review of Resident #2's physicians" order dated 10/23/2024 revealed LVN LL documented a topical skin cream the MD prescribed for Resident #2. The order did not reveal where Resident #1's skin rash was and or directions as to where on Resident #2's body to apply the medication. The order read, Order Summary: hydrocortisone external cream 1% (hydrocortisone topical) Apply to rash on body topically two times a day for rash for 14 days. A record review of Resident #1's medical record revealed no evidence of any documentation regarding Resident #2's rash (location, size, description), report to the physician for the rash, report to Resident #2's Representative regarding the rash and the treatment prescribed. During an interview on 12/12/2024 at PM LVN LL stated she had assessed Resident #2 with a rash to his bilateral forearms due to his behaviors and anxiety when he would rub his forearms, He had thin skin and would rub his forearms and irritate his skin. LVN LL stated she had a lot going on that day, and I did not document my assessment of his rash. LVN LL stated she had not documented the location and quality of Resident #2's forearm rash nor the communication with the physician nor document on the order where the rash was. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 01:10 PM the DON stated the training and expectation was for all nursing staff to accurately document their assessments and communications with physicians, residents, and their Representatives. A record review of the facility's Documentation dated May 2015 revealed, Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident. involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility, and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software (electronic medical record). All documentation and clinical records are confidential and can be released only with signed permission of the resident or legal representative. Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets. 2. The facility will ensure that information is comprehensive and timely and properly signed.