STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676331	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Pond Rehabilitation and Healthcare	9903 Hunters Pond San Antonio, TX 78224

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 2 of 6 Residents (Resident #95 and Resident #104) whose MDS records were reviewed for accuracy. 1. The facility failed to ensure Resident #95's Quarterly MDS assessment dated [DATE] documented that Resident #95 received hospice services. 2. The facility failed to ensure Resident #104 Discharge MDS assessment dated [DATE] documented Resident #104 was discharged home. This failure could place residents at risk of improper or incorrect care or services necessary for their physical, mental, and psychosocial well-being due to inaccurate assessments. The findings included: 1. Record review of Resident #95's face sheet dated 07/10/24, revealed Resident #95 was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus with hyperglycemia (chronic health condition that affects how body turns food into energy), sepsis, unspecified organism, (body's extreme response to an infection), cardiac arrest (heart attack), ventricular fibrillation (a life-threatening heart rhythm that results in rapid, inadequate heartbeat), acute respiratory failure with hypoxia (lack of oxygen in the tissues in your body), tracheostomy status (an opening into the trachea (windpipe) from outside the neck to help air and oxygen reach the lungs) and gastrostomy status (surgical opening into the stomach for nutritional support). Record review of undated Care Plan indicated Resident #95 was on hospice services. Record review of hospice Physician Recertification dated 04/30/24 for Resident #95 indicated resident was admitted to hospice on 02/24/24 with a primary diagnosis of cardiac arrest and a secondary diagnosis of anoxic brain injury (condition where brain is completely deprived of oxygen). The physician wrote, The patient is a [AGE] year-old gentleman, admitted to hospice service with a terminal diagnosis of status post cardiac arrest and anoxic brain injury. The patient currently resides in a skilled nursing facility. The patient is nonverbal, in bed with eyes closed during evaluation. Unable to assess orientation. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #95's Quarterly MDS dated [DATE], Section O Section K1 indicated No under hospice services. During an interview on 07/11/24 at 2:00 pm with MDS Coord RN H, she acknowledged that hospice services should have been marked on the MDS under Special Treatments and Procedures for Resident #95 to ensure proper care planning. 2. Record review of Resident #104's face sheet dated 06/12/2024 revealed Resident #104 was admitted to the facility on [DATE] with diagnoses that included: Myocardial Infarction (heart attack), Hypothyroidism (low thyroid hormone), Hyperlipidemia (excess fats in the blood), and Congestive Heart Failure (heart doesn't pump enough blood). Record review of Resident #104's Discharge MDS assessment, dated 05/09/2024, revealed under section for identification, Discharge Status was coded as being discharged to Short-Term General Hospital. Record review of Resident #104's discharge progress note, dated 05/09/2024 3:55PM, showed Patient discharged home with daughter. During an interview with CLS facility staff, CLS verified that the resident was discharged home and not discharged to a Short-Term General Hospital. During an interview on 05/09/2024 at 12:01 pm with RN H, MDS Nurse - she verified the MDS discrepancy and that the MDS was coded incorrectly. She stated it should have reflected that the resident was discharged home. Record review of the CMS MDS 3.0 Manual dated October 2023 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 . 47611

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort for 1 of 8 residents reviewed for PASRR (Resident #24). The facility failed to ensure Resident #24 had an accurate PASRR Level 1 Screening indicating diagnoses of mental illness and refer the residents to the state designated authority. This failure could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings included: Record Review of Resident #24's Admission record, dated 7/11/24, revealed a [AGE] year-old male initially admitted [DATE] and with diagnoses including depression and insomnia. Record Review of Resident #24's quarterly MDS assessment, dated 5/16/24, reflected Resident #11 had intact cognition for daily decision making and had depression. Record review of Resident #24's a physician's order dated 7/11/24 indicated Resident #24 took venlafaxine for depression. Record review of Resident #24's PASRR Level 1 Screening completed on 6/20/24 indicated in section C0100 there was no evidence of this individual having mental illness. Record review of Resident #24's medical records from a hospital, dated 6/20/24, revealed active diagnosis of major depressive disorder (Mental health disorder having episodes of psychological depression. Major depressive disorder (MDD) is a type of depression. It can be more severe than some other types of depression and requires different treatments.). During an interview on 7/12/24 at 2:03 p.m. the MDS nurse stated the hospital completed the PASRR. The MDS nurse stated if she had noticed the resident had a diagnosis of MDD she would have contacted the hospital to correct the PASRR to indicate yes, he had a mental health illness. The MDS nurse stated he could have missed the opportunity to receive psychiatric services. During an interview on 7/12/24 at 1:48 p.m. the DON stated the MDS nurse was responsible for the PASRR. The DON was unsure of what could happen to the resident if his MDD diagnosis was not listed as an active diagnosis for the resident. The DON stated he had orders for medication to treat his depression. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled PASRR, dated 1/2022, stated Policy: The facility will designate an individual to follow up on ALL residents that have received a PASRR Level I screening. If the facility serves a resident with a positive PASRR Level I screening, the facility MUST have obtained A PASRR Level II evaluation from the Local Authority or have documented attempts to follow up with the Local Authority to obtain the PASRR Level II evaluation. Procedure: Nursing Individual MUST: A. Coordinate with referring entities to ensure that any person seeking admission to a Medicaid-Certified NF received a PASRR Level I screening for an intellectual disability (ID), related condition (DD) also known as developmental disability or mental illness (MI) prior to or upon admission .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to develop a comprehensive care plan for 1 (Resident #39) of 21 residents reviewed for comprehensive care plans, in that: Resident #39's care plan was missing diagnoses and treatment information. This deficient practice could place residents at risk of receiving inadequate care and could result in a decline in health. The findings were: Record review of Resident #39's face sheet, dated 07/12/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Paraplegia, complete; Hypotension; and Gastro-Esophageal Reflux Disease without Esophagitis. Record review of Resident #39's clinical record, as of 07/12/2024, revealed the resident was readmitted to the facility on [DATE]. Record review of Resident #39's Quarterly MDS Assessment, dated 06/30/2024, revealed a BIMS score of 15 which indicated intact cognition. Record review of Resident #39's care plan, revised 07/05/2024, revealed the care plan did not address the resident's diagnoses and health conditions: Nephrostomy Catheter, Urinary Catheter, Colostomy Status, Heart Failure, Acute Kidney Disease, Chronic Kidney Disease, Enhanced Barrier Precautions, need for pressure reducing bed and wheelchair, and use of Hydrocodone. During an interview with the MDS Coordinator on 07/12/2024 at 2:14 p.m., the MDS Coordinator confirmed Resident #39's care plan did not include: Nephrostomy Catheter, Urinary Catheter, Colostomy Status, Heart Failure, Acute Kidney Disease, Chronic Kidney Disease, Enhanced Barrier Precautions, need for pressure reducing bed and wheelchair, or use of Hydrocodone. The MDS Coordinator further stated that the resident had recently returned from the hospital and the care plan had not been fully updated since his re-admission. Record review of the facility policy and procedure titled Care Planning, revision date 5/2007 revealed .It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review the facility failed to ensure that it was free of medication error rate of 5 percent or greater. The facility had a medication error rate of 8% based on 2 out of 25 opportunities, which involved 2 of 4 Residents (Residents #52 and Resident #69) reviewed for medication administration, in that: 1. The facility failed to ensure CMA A administered Resident #52's isosorbide mononitrate (medication use to prevent chest pain (angina) in patients with certain heart conditions). 2. The facility failed to ensure LVN B administered Resident #69's insulin aspart (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) correctly. These failures could place residents at risk for not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions. The findings included: 1. Record review of Resident #52's face sheet, dated 7/12/24 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included chronic systolic (congestive) and diastolic (congestive) heart failure (is a syndrome caused by an impairment in the heart's ability to fill with and pump blood), presence of coronary angioplasty implant and graft (A procedure used to widen the coronary artery/ies that are blocked or narrowed), and hypertension (high blood pressure). Record review of Resident #52's order summary report, dated 7/12/24 revealed the following: - isosorbide mononitrate oral tablet extended release 24 Hour 30 MG, give 1 tablet by mouth one time a day for **DO NOT CRUSH** related to hypertension, with a start date of 6/21/24 with no end date. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/11/24 at 9:12 a.m. CMA A planned to administer medications to Resident #52. CMA A dispensed 5 medications (aspirin, carvedilol, dapagliflozin, furosemide, and losartan) into a medication cup at the medication cart. CMA A stated she needed to wait for one more medication, the apixaban, because they ran out of it in the medication cart. CMA A then clicked on 7 different medications (aspirin, carvedilol, dapagliflozin, furosemide, losartan, apixaban, and isosorbide mononitrate) in the electronic medication record to indicate she was going to administer them. After a few minutes CMA A stated they did not have any more of the apixaban so she would notify the nurse she would not administer it. This state surveyor asked CMA A to see the blister package of isosorbide mononitrate to write down the information because the CMA A never took it out of the cart but clicked the EMR to indicate she planned to administer it. CMA A removed it from her medication cart, this state surveyor wrote down the medication information, checked the pill against what was in the medication cup to see that it was not in the medication cup, and handed the package back to CMA A. CMA A then put it back into the medication cart. This state surveyor then asked CMA A how many medications she was going to administer to Resident #52. CMA A stated she had 5 medications in the medication cup that she would administer. CMA A then counted the medications she indicated she would give on the EMR and counted 6. CMA A stated she would not give the apixaban because they did not have it so that made it a total of 5 pills. CMA A missed counting one medication on the EMR. This state surveyor told CMA A that they counted 7 medications on the EMR, minus the 1 medication they would hold for a total of 6 pills and the medication cup only had 5 pills. CMA A then looked at the EMR and again pulled Resident #52's medications out of the cart. CMA A checked them all and compared what was in the medication cup. CMA A stated she forgot to dispense the isosorbide mononitrate. CMA A then dispensed the isosorbide mononitrate pill. CMA A stated she was distracted because they ran out of the apixaban, did not count the blister packs, and compare them to how many pills were in the medication cup. CMA A stated the resident could have an adverse reaction if she forgot to administer a medication but documented she gave it. 2. Record review of Resident #69's face sheet, dated 7/12/24, revealed a [AGE] year-old female resident admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infraction affecting left non dominate side (weakness of the left side after a stroke) and type 2 diabetes mellitus (a chronic condition that affects the way your body processes blood sugar). Record review of Resident #69's order summary report, dated 7/12/24 revealed the following: -insulin aspart inject solution 100 unit/ml, inject as per sliding scale, subcutaneously before meals and at bedtime, with an order date of 3/24/24 and no end date. During an observation on 7/11/24 at 11:01 a.m. LVN B planned to inject 6 units of insulin aspart to Resident #69. LVN B turned the pen to load 6 units of insulin, removed the cap of the pen, did not clean the rubber stopper with an alcohol pad, placed the needle on the pen, did not prime the pen, cleaned the residents left arm, and injected the insulin into the residents' right arm. During an interview on 7/11/24 at 11:10 a.m. LVN B stated he would only prime an insulin the first time it is opened and did not need to be primed after the first use. LVN B stated he was unsure if there would be air in the needle portion that needed to be dispensed prior to administration. LVN B stated he did not think it would affect the resident if the pen was primed prior to the first use. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/24 at 1:28 p.m. the DON stated staff should prime the insulin pen prior to each insulin administration to ensure there was no air bubbles. The DON stated if staff did not prime the insulin pen prior to administrator the dosage could be off, and the resident may not get the correct amount of insulin. The DON stated CMA A told her she had not gone into the room to administer the medication therefore she had not truly forgotten the medication. The DON stated the CMA A should have looked at the MAR found the medication, dispensed it, clicked yes on the EMR, and then returned later to save that she administered the medications. The DON stated if she did not verify the medications, she was giving she could miss a resident's dose. Record review of the facility's policy, titled, Medication Administration, no date, revealed, it is the policy of the facility that medications shall be administered as prescribed by the attending physician .2. Medications must be administered in accordance with the written orders of the attending physician .16. Prior to administering the residents medications, the nurse should compare the drug and the dosage schedule on the resident MAR with the drug label . Record review of the facility's policy, titled, Insulin Administration, dated 5/2007, revealed, Policy: it is the policy of this facility to ensure that insulin is utilized to control blood sugar levels in residence with diabetes mellitus procedures: .6. swab rubber stopper with alcohol swab and applying disposable needle onto pen 7. prime pen before injection (dial 2 units on the dose selector point needle up so that air bubbles are forced to top and firmly press plunger until drop of insulin appears, repeat if needed until drop of insulin appears) .

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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** 45857 Based on interviews and record reviews, the facility failed to maintain medical records on each resident that were-accurately documented for 1 of 8 residents (Resident #24) reviewed for accurate medical records in that: The facility failed to document Resident #24's medical diagnosis of Major Depressive Disorder (MDD) in his medical record. The deficient practices could affect residents who have medical records and could result in misinformation about professional care provided. The findings included: Record Review of Resident #24's Admission record, dated 7/11/24, revealed a [AGE] year-old male initially admitted [DATE] and with diagnoses including depression and insomnia. Record Review of Resident #24's quarterly MDS assessment, dated 5/16/24, reflected Resident #24 had intact cognition for daily decision making and had depression. Record review of Resident #24's a physician's order dated 7/11/24 indicated Resident #24 took venlafaxine for depression. Record review of Resident #24's medical records from a hospital, dated 6/20/24, revealed active diagnosis of major depressive disorder (Mental health disorder having episodes of psychological depression. Major depressive disorder (MDD) is a type of depression. It can be more severe than some other types of depression and requires different treatments.). [The resident's medical record indicated a diagnosis of depression and did not list his diagnosis of MDD.] During an interview on 7/12/24 at 2:03 p.m. the MDS nurse stated the charge nurses would enter in the resident's diagnosis information on admission. The MDS stated after she was responsible for checking the information was correct and would edit, update, or fix any errors. The MDS nurse stated she had looked at Resident #24's hospital paperwork with his active diagnosis information but did not recall MDD or she would have added it. The MDS nurse stated the resident could miss out of psychiatric services if his diagnosis were not entered correctly. During an interview on 7/12/24 at 1:48 p.m. the DON stated the charge nurse was responsible for entering medical information and the MDS nurse would have follow up after. The DON was unsure of what could happen to the resident if his MDD diagnosis was not listed as an active diagnosis for the resident. The DON stated he had orders for medication to treat his depression. Record review of the facility's policy titled Designated Record Set, no date, stated Policy: The facility shall maintain a health record for each resident, which shall include: . transfer record (admission and transfer), history and physical, current diagnosis .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections involving 2 of 6 staff (LVN) reviewed for infection control, in that: 1. The facility failed to ensure LVN B cleaned a rubber stopper on an insulin pen prior to insulin administration for Resident #69. 2. The facility failed to ensure LVN C changed gloves while providing nephrostomy care to Resident #39. These deficient practices could place residents at-risk for infections. The findings included: 1. Record review of Resident #69's face sheet, dated 7/12/24, revealed a [AGE] year-old female, admitted on [DATE] with diagnosis of type 2 diabetes and hemiplegia and hemiparesis following cerebral infarction affecting left non dominate side (Hemiparesis is a common after-effect of stroke that causes weakness on one side of the body). During an observation on 7/11/24 at 11:01 a.m. LVN B planned to inject 6 units of insulin aspart to Resident #69. LVN B turned the pen to load 6 units of insulin, removed the cap of the pen, did not clean the rubber stopper with an alcohol pad, placed the needle on the pen, did not prime the pen, cleaned Resident #69's arm and injected the insulin into the residents' right arm. During an interview on 7/11/24 at 11:10 a.m. LVN B stated he cleaned the pen at the cart prior but should have cleaned it in the room prior to placing the needle on the pen. LVN B stated he should clean the rubber stopper prior to placing the needle on in case there was dust or bacteria it could get infected. This state surveyor never observed LVN B cleaning the rubber stopper on the insulin pen. During an interview on 7/12/24 at 1:28 p.m. the DON stated the insulin pen should be cleaned before placing the needle on it to ensure it was cleaned and to prevent infection for the resident. 2. Record review of Resident #39's face sheet, dated 7/12/24, revealed a [AGE] year-old male, admitted on [DATE] and readmitted on [DATE] with diagnosis of genitourinary system, displacement of nephrostomy catheter (a tube your healthcare provider places to take pee directly from your kidney and channel it into a bag), urinary tract infection, type 2 diabetes, and hydronephrosis with renal and urethral calculous obstruction (A condition of excess urine accumulation in kidney(s) that causes swelling of kidneys. This causes pain during urination, nausea and vomiting.). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/12/24 at 9:47 a.m. LVN C provided nephrostomy care to Resident #39's right nephrostomy site. LVN C sanitized her hands, put on clean gloves, removed the old bandage covering the nephrostomy tube site, did not remove/change her gloves, grabbed regular gauze, cleansed the site with normal saline, and put on a new bandage. LVN C then removed her gloves, sanitized her hands, and put on new gloves. LVN C then provided care to Resident #39's left nephrostomy tube and again did not remove, clean her hands, and put on new gloves after removing the old bandage. During an interview on 7/12/24 at 10:58 a.m. LVN C stated she should have changed gloves between the dirty and clean bandage to prevent infection. LVN C stated the site could become contaminated when the dirty glove touched the clean bandage. During an interview on 7/12/24 at 1:42 p.m. the DON stated LVN C should have changed her gloves after removing the dirty bandage to prevent infection. The DON stated the facility did not have a specific policy for nephrostomy care. The DON stated they did not treat nephrostomy care as a sterile procedure and did not require sterile gauze or sterile gloves when changing the bandage. Record review of the facility's policy, titled, Insulin Administration, dated 5/2007, revealed, Policy: it is the policy of this facility to ensure that insulin is utilized to control blood sugar levels in residence with diabetes mellitus procedures: .6. swab rubber stopper with alcohol swab and applying disposable needle onto pen . Record review of a document titled Nephrostomy Tube Management- Skill Checklist, no date, stated Description: place the underpad beneath the resident, wash your hands and put on clean gloves, carefully remove the wet or soiled dressing, discard the dressing in the disposable waste bag, observe the dressing site for signs of skin breakdown, infection, or drainage, remove gloves and discard in the disposable waste bag, wash and dry your hands, DON (put on) gloves, with .(or 4x4 dipped NSS (normal saline)),cleanse the nephrostomy tube site in outward circles from the insertion site, discard soiled [gauze] in disposable waste bag, allow saline solution to dry, place one to two sterile drain dressings on the nephrostomy tube site, as indicated. Secure with adhesive tape .