STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER CITY CARE CENTER	**921 NOLAN ST SAN ANTONIO, TX 78202**

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 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interviews and record reviews the facility failed to immediately consult with the resident's physician; and notify consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications for 4 of 6 residents (Resident #1, #2, #3, and #4) reviewed for change of status, in that: 1. LVN K and LVN L did not call the physician or nurse practitioner when Resident #1 had a change in condition and was placed on 6 liters - of oxygen via non-rebreather mask for an oxygen saturation of 80% on room air. 2. a. Resident #2 presented with a decline in health and charge nurse RN H and LVN I did not report the finding to the physician, their supervisor, or family resulting in resident #2 sent to hospital via 911 emergency services. b. LVN M did not notify physician or the nurse practitioner when Resident #2 had blood pressure dropped to ,[DATE] mmHg and pulse 59 beat per minutes on [DATE] during 6 AM - 2 PM Shift. c. LVN L did not notify the physician or the nurse practitioner when Resident #2 had blood pressure dropped to ,[DATE] mmHg and pulse 56 beat per minutes on [DATE] during 2 PM - 10 PM shift and ,[DATE] mmHg and 54 beat per minutes on [DATE] during 10 PM - 6 AM shift. 3. RN J did not notify physician after Resident #3 had low blood sugar on [DATE]. 4. Resident #4 presented with a decline in health and the charge nurse RN H did not report the finding to the physician, her supervisor, or family thereby denying supervisors and medical prctioners the opportunity to intervene for the resident. This deficient practice caused residents harm and placed residents at risk for harm by not providing the physician the opportunity for interventions and resident families for opportunities to advocate for the residents. These failures resulted in identification of Immediate Jeopardy (IJ) on [DATE]. While the IJ was removed [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place to ensure residents were being assessed for a change in condition and physician was being notified. The findings were: 1. Record review of Resident #1's admission record dated [DATE] revealed an admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's order summary report dated [DATE] revealed an order of [MEDICATION NAME] tablet 325 MG give 2 tablets by mouth every 6 hours as needed for elevated temperature; moderate pain. Start date: [DATE]. Record review of Resident #1's Treatment Administration Record schedule for ,[DATE] dated [DATE] - [DATE] revealed [MEDICATION NAME] tablet 325 mg give 2 tablets by mouth every 6 hours as needed for elevated temperature; moderate pain was documented as administering to Resident #1 at 7:39 PM. Record review of Resident #1's documentation on oxygen saturation dated [DATE] revealed oxygen saturation at 1:41 AM was 97 % room air, at 9:09 AM was 95% room air, at 6:23 PM 94% room air, at 8:36 PM was 93% high flow oxygen, at 8:46 PM was 97% high flow oxygen. Record review of Resident #1's progress noted dated [DATE] at 8:49 PM written by LVN K revealed Resident presented with a 100.4 fever, this nurse and other nurse helped resident, this nurse gave him Tylenol 650mg by mouth, and other nurse gave Tylenol suppository to help bring down the fever, also placed resident on oxygen 6Liters via non-rebreather mask. Rechecked temperature of patient and it was 99.5, resident o2 sat was at 97% on 6Liters via non-rebreather, resident appeared stable and resting. This nurse and other nurse left room for ,[DATE] minutes to attend to other resident's needs, did not call family prior because patient appeared stable. This nurse and other nurse went to check again on the patient and patient was gasping for air and not responding to stimuli, verbal or physical. Other nurse immediately started CPR on resident, CNA went to grab crash cart and brought it to the patient's room. This nurse put AED pads on resident, turned on AED, AED said no shockable rhythm noted, other nurse continued CPR, this nurse came and called emergency responders, emergency responders came and relieved nurse of CPR duties, this nurse came to nurse's station and called responsible party of situation. Resident is currently on stretcher with EMS, providing emergency care, will monitor resident. Record review of Resident #1's the SBAR - 8hr. - V2 with effective date [DATE] 20:35 revealed date and time MD or NP notified was on [DATE] at 8:30 PM. Record review of EMS Patient Care Report dated [DATE] revealed EMS was notified on [DATE] at 8:20 PM. Review EMS's assessment at 8:36 PM revealed breathing absent, pulse carotid absent; mental status: unresponsive. Interview on [DATE] at 4:14 PM with LVN K she confirmed LVN L was making round shortly after dinner and saw Resident #1 was gasping for air. LVN K stated she checked Resident #1's vital signs which revealed oxygen saturation was at 80% on room air, and temperature 100.4 F. LVN K confirmed she administered Tylenol by mouth and suppository and administered 6 liters of oxygen via non-rebreather for Resident #1. LVN K stated she rechecked Resident #1's temperature and oxygen saturation which revealed 99.5 F and 97% on 6 liters of oxygen via non-rebreather mask. LVN K confirmed Resident #1 appear resting and stable, so LVN K and LVN L left Resident #1 room and went check other residents for 5 - 10 minutes. LVN K confirmed when LVN K and LVN returned and checked on Resident #1, they noticed Resident #1 was gasping for air, and Resident #1 did not respond to verbal command and sternal rub. LVN K confirmed LVN L initiated CPR, and LVN K brought crash cart. Interview on [DATE] at 4:28 PM with LVN K confirmed she initiated SBAR after calling 911, and then she notified the nurse practitioner and family. Interview on [DATE] at 5:00 PM with LVN L confirmed LVN K asked LVN L to check on Resident #1 toward the end of shift. LVN L confirmed she found out Resident #1 had elevated temperatures approximately 102-degree Fahrenheit and oxygen saturation was low at 88% on room air. LVN L confirmed she administered Tylenol 650 suppository and administered 6 liters of oxygen via non-rebreather mask. LVN L confirmed she sat with Resident #1 for 20 minutes. Then, she checked Resident #1's temperature and oxygen saturation again revealed temperature was at 99-degree Fahrenheit and oxygen saturation was 98% on 6 liters of oxygen via non-rebreather mask. LVN L stated she went out to change her PPE because her PPE was torn, and LVN K stayed with Resident #1. LVN L further confirmed she then left the unit for break and did not know if LVN K remained to stay with Resident #1 or not. LVN L stated after she went on break for about 20 minutes, and while she was talking with the receptionist, LVN K asked LVN L to come back the unit and told LVN L that I think he passed away. LVN L said she put on PPE and rushed Resident #1's room. LVN L stated she checked Resident #1 revealed no pulse and no breathing, and then she started CPR. LVN L stated Maintenance brought the crash cart, LVN K called EMS. Then, EMS came and took over the CPR. EMS tried to resuscitate Resident #1 for 45 minutes. LVN L stated LVN K had nurse practitioner and family on the phone. Interview on [DATE] at 4:50 PM with the DON confirmed according to the SBAR note revealed the nurse had notified the doctor when she noticed the resident elevated temperature and got order from the physician for Tylenol 650 mg by mouth and suppository. Interview on [DATE] at 4:55 PM with DON confirmed it was ok for the nurse to step out Resident #1's room after stabilizing Resident #1. Interview on [DATE] at approximately 8:49 AM with Nurse Practitioner R confirmed the nurse should have been notified the physician or the nurse practitioner after stabilizing Resident #1 with Tylenol and oxygen. Nurse Practitioner R confirmed if Resident #1 was on room air or was on oxygen via nasal canula and later Resident #1 need to be on 6 liters of oxygen via non-rebreather mask, then Resident #1 had change of condition. The Nurse Practitioner R confirmed he did not know about the situation of Resident #1 was on 6 liters of oxygen via non-rebreather mask. Nurse Practitioner R

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

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.

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F 0580

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 1)

further confirmed the nurse at the facility communicated with him after Resident #1 expired. 2. a. Record review of Resident #2's admission record revealed an admission date of [DATE] with a discharge date of [DATE] and [DIAGNOSES REDACTED]. Record review of Resident #2's nursing progress notes revealed a nurse note dated [DATE] at 8:20 AM, Authored by RN H stated, Pt continues with grimacing and increased irritability; difficult to redirect and provide care/assessment. Noted febrile. Record review of Resident #2's nursing progress notes revealed a nurse note dated [DATE] at 8:22 AM, Authored by RN H stated, Increased agitation/hallucinating attempting to get out of bed. Record review of Resident #2's nursing progress notes revealed a nurse note dated [DATE] at 7:33 AM, Authored by RN H stated, grimacing. Record review of Resident #2's nursing progress notes revealed a nurse note dated [DATE] at 7:34 AM, Authored by RN H stated, pt febrile 101.7 axillary. Record review of Resident #2's nursing progress notes revealed a nurse note dated [DATE] at 9:48 authored by LVN I stated, refused, spitting meds out. Record review of Resident #2's nursing progress notes revealed a nurse note Authored by LVN N, dated [DATE] at 10:24 AM stated, Resident #2 was transferred to a Hospital on [DATE] 11:00 AM related to Altered mental status. This is intended to serve as notice of an emergency transfer. Interview on [DATE] at 2:14 PM with RN H confirmed she worked on [DATE] and [DATE] from 6:00 AM to 10:00 PM, on each day and was the charge nurse responsible for resident #2. She confirmed Resident #2 was refusing some medications and fluids, refusing wound care, presenting with mental confusion and aggression on [DATE] and [DATE]. RN H confirmed the air condition in the facility was not cooling the facility well and was very uncomfortable for resident #2 on [DATE] and [DATE]. RN H confirmed she attempted to perform nursing interventions by offering Resident #2 anti-psychotics and pain relievers as needed. RN H confirmed she did not report to the physician or document any nursing interventions related to Resident #2's medication and meal / fluid intake refusals, fever occurrences, and the residents increasing altered mental status and aggression. RN H confirmed she moved resident #2 and his roommate Resident #4 from room [ROOM NUMBER] to room [ROOM NUMBER] on [DATE], related to room [ROOM NUMBER] was cooler than room [ROOM NUMBER]; RN H confirmed she did not report any findings to the physician or family. Interview on [DATE] at 11:24 AM with LVN I confirmed she was the LVN responsible for Resident #2 on [DATE] and [DATE] from 2:00 PM to 6:00 am. She confirmed Resident #2 was refusing medications and care on both days. LVN I confirmed she reported the refusals to her supervisor RN H. LVN I confirmed she did not report the findings to the physician or the family. Interview on [DATE] at 3:30 PM with the facility's DON confirmed she had no report from RN H or LVN I related to Resident #2's medication refusals, wound care refusals, and meal and fluids refusals on [DATE] and [DATE]. Interview on [DATE] at 2:08 PM with the facility's APRN FNP R confirmed he had no report from anyone at the facility related to Resident #2's refusals of wound care, meals, fluids, or room change on [DATE] and [DATE]. b. Record review of Resident #2's Order Summary Report dated [DATE] revealed order of [MEDICATION NAME] tablet 2.5 mg give 1 tablet by mouth one time a day for hypertension, [MEDICATION NAME] capsule 0.4 mg (tamsulosin HCl) give 1 capsule by mouth at bed time for enlarged prostate, [MEDICATION NAME] tablet 20 mg ([MEDICATION NAME]) give 1 tablet by mouth one time a day for blood thinner, Tylenol tablet 325 mg ([MEDICATION NAME]) give 2 tablets by mouth every 6 hours as needed for pain. Record review of Resident #2's Blood Pressure Summary dated [DATE] revealed Resident#2 had systolic blood pressure (the first number - indicated how much pressure of blood is exerting against artery walls when heart beat) from [DATE] to [DATE] was equal or greater than 90 mmHg. Record review of Resident #2's pulse summary dated [DATE] revealed Resident #2 had heart rate (pulse) from [DATE] to [DATE] was greater than 60 beat per minutes. Record review of Resident #2's vital sign was documented by LVN M on [DATE] at 9:45 AM revealed blood pressure was ,[DATE] mmHg and pulse was 59 beat per minute. Record review of Resident #2 Medication Administration Record [REDACTED]#2 on [DATE] for the morning dose. Further review revealed [MEDICATION NAME] tablet 20 mg give 1 tablet by mouth one time a day for blood thinner was documented as administered to Resident #2 on [DATE] for the morning dose. Interview on [DATE] at 11:05 AM with LVN M confirmed she documented on [DATE] at 9:45 AM blood pressure ,[DATE] mmHg and pulse 59 beat per minute. LVN M confirmed she took Resident #2's vital signs, wrote them down, and moved on to another resident. LVN M confirmed she did not recheck Resident #2's blood pressure and pulse because there was no significant going on with Resident #2. LVN M confirmed blood pressure and pulse did not give her any alarm concern because Resident #2 just woke up and responded, therefore, LVN M did not check his blood pressure again and did not notify the physician or nurse practitioner. c. Record review of Resident #2's vital sign documented by LVN L on [DATE] at 10:01 PM revealed blood pressure was ,[DATE] mmHg and pulse was 56 beat per minute. Further review Resident #2's vital signs documented by LVN L on [DATE] at 5:41 AM revealed blood pressure was ,[DATE] mmHg and pulse was 54 beat per minute. Interview on [DATE] at 5:22 PM with LVN L confirmed she documented Resident #2's blood pressure [DATE] at 10:01 PM was ,[DATE] mmHg and blood pressure on [DATE] at 5:41 AM was ,[DATE] mmHg. LVN further confirmed on [DATE] at 5:24 PM she believed Resident #2's blood pressure - ,[DATE] mmHg and ,[DATE] mmHg was his baseline and his response was normal, so LVN L did not notify the physician or nurse practitioner. Interview on [DATE] at 3:34 PM with LVN L confirmed Resident #2's blood pressure of ,[DATE] mmHg and pulse was 56 beat per minutes and blood pressure ,[DATE] mmHg and pulse was 54, she did not check the blood pressure and the pulse again, did not review resident's trending of blood pressure and pulse, and she did not notify the physician or nurse practitioner because she was being told by LVN K that Resident #2's blood pressure and heart rate run low. Interview on [DATE] at 5:38 PM with the DON confirmed Resident #2's blood pressure look lower on [DATE] at 9:45 AM was ,[DATE] mmHg, [DATE] at 10:01 PM was ,[DATE] mmHg, and [DATE] at 5:41 AM was ,[DATE] mmHg. Interview on [DATE] at 5:42 PM with the DON confirmed Resident #2's pulse look lower on [DATE] at 9:45 AM was 59 beat per minute, [DATE] at 10:01 PM was 56 beat per minute, and [DATE] at 5:41 AM was 54 beat per minute. Interview on [DATE] at 5:52 PM with the DON confirmed the nurse should have called the physician or nurse practitioner on Resident #2's low blood pressure and pulse. 3. Record review of Resident #3's admission record dated [DATE] with admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's order summary order dated [DATE] revealed orders of Accucheck blood sugar three times per day for [MEDICAL TREATMENT]/sliding scale, monitor vital sign every shift report any abnormal result to MD, insulin [MEDICATION NAME] solution 100 unit/mL inject 8 unit subcutaneously one time a day for diabetes. Further review revealed there was order created on [DATE] and ended [DATE] read [MEDICATION NAME] Hypokit Solution Reconstituted 1 MG inject 1 mg subcutaneously one time only for Resident blood sugar at 43 during last round for 1 day. Record review of Resident #3's progress note documented by RN J dated [DATE] at 5:08 AM revealed Resident more effort to arouse on second rounds. Vital sign taken. Resident on [MEDICAL TREATMENT] blood sugar taken to be @ 43mg/dl. [MEDICATION NAME] given. Sugar dissolved in H2O rubbed around in her gums. 30 minutes later resident more easily follows commands. Pending blood sugar value post [MEDICATION NAME] 1mg administration and added sugar to resident's gums. Further review Resident #3's progress note dated [DATE] at 5:56 AM revealed Resident able to follow commands more readily. Able to stick out tongue when giving carbohydrate source. Able to move arms on command to wipe face. B/S currently 60mg/dl 1hr post Glugacon 1mg. Interview on [DATE] at 10:40 AM RN J confirmed while he was documenting at nursing station and an aide informed him that Resident #3 was acting differently. He went to Resident #3's room and assessed her. RN J said Resident #3 was slow to answer the question, Resident #3 know her name, but did not know where she was at. RN J stated he checked her blood sugar and found out it was low, then he gave her [MEDICATION NAME] and supplemental carbohydrate because she was able to take thing by mouth. RN J confirmed the whole facility had standing order for [MEDICATION NAME] and carbohydrate supplemental if resident had low blood sugar and change level of consciousness, he stated, because you don't have time to call the provider. RN J confirmed after giving Resident #3 was given [MEDICATION NAME] and carbohydrate supplemental, she was able to response and answer question appropriately and back to her baseline. Interview on [DATE] at 10:43 AM with RN J confirmed he did not notify the physician or nurse practitioner regarding Resident #3's low blood sugar and needed [MEDICATION NAME] injection. RN J further confirmed he did not document on SBAR report, but he confirmed he document on progress note because of standing order. Interview on [DATE] at 6:11 PM with the DON confirmed the RN J should have notified the physician or nurse practitioner, and RN J should have done the SBAR because Resident #3 had change of condition due to low blood sugar. Interview on [DATE] at 6:16 PM with RN F - Regional Compliance Nurse and the DON confirmed they did not see the SBAR for the incident of Resident #3's low blood sugar on [DATE]. Interview on [DATE] at 8:59 AM with NP R confirmed for resident had low blood sugar the nurse should have used clinical judgment to assess the patient whether the patient was alert, coherent, or having [MEDICAL CONDITION] or respiratory status was stable or not. If resident need oxygen, diaphoretic, non-response, and elevated heart rate the patient can treat with [MEDICATION NAME] and watch them come out of hypoglycemic safely and the vital sign was stable. The nurse should report to the physician about resident's low blood sugar, and there would be a review of medication why patient blood sugar went so low, was it the compliance issue or diet issue, how many times happened before or resident acutely ill. If patient went to situation of blood sugar was low and being corrected with [MEDICATION NAME], once the patient stable the nurse should have check resident blood sugar every hour or at least couple hours to make sure resident eating and go back to check blood sugar as routine schedule. Interview on [DATE] at 9:03 AM NP

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F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) R confirmed resident #3 had change of condition because she had symptomatic of low blood sugar and need [MEDICATION NAME], therefore, the nurse should have notified the NP or physician and complete SBAR report. Interview on [DATE] at 10:06 AM with the Medical Director confirmed depend on resident condition, if patient conscious, the nurse should administer orange juice or glucose tablet. The Medical Director further confirmed the nurse could administer [MEDICATION NAME] if there was an order was available. The Medical Director stated usually after the nurse stabilized resident with [MEDICATION NAME], the nurse should check blood sugar every 2 hours and if the blood sugar was back to normal they should check resident blood sugar on their regular schedule such as AC&HS - before meal and at bed time or every 6 hours. 4. Record review of Resident #4's admission record revealed an admitted [DATE] and a discharge date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's progress notes revealed no nursing documentation on [DATE] through [DATE]. Record review of Resident #4's progress notes revealed a nursing note on [DATE] at 6:00 PM, authored by RN H stating Pt in respiratory distress/ unresponsive. 911 called and transferred to downtown (wrote name of hospital). (family) notified. Interview on [DATE] at 2:14 PM with RN H confirmed she worked on [DATE] and [DATE] from 6:00 AM to 10:00 PM, on each day and was the charge nurse responsible for resident #4. She confirmed Resident #4 refused some medications and fluids as well as presented with mental confusion and developed a fever on [DATE] and [DATE]. RN H confirmed the air conditioning in the facility was not cooling the facility well and was very uncomfortable for resident #4 on [DATE] and [DATE]. RN H confirmed she did not report to the physician or document any nursing interventions related to Resident #4's medication and meal / fluid intake refusals or Resident #4's fever. RN H confirmed she did not report to the resident's family or her supervisor. RN H confirmed she attempted to perform nursing interventions and offered Resident #4 water and applyed wet towels to his person. RN H confirmed she moved Resident #4 and his roommate Resident #2 on [DATE] to another room that was not as warm. RN H confirmed she did not report the room change or the rationale for the room change to her supervisor, the physician or family, when asked why she did not report her findings to anyone, she did not provide a rationale. Interview on [DATE] at 3:30 PM with the facility's DON confirmed she had no report from RN H related to Resident #4's medication, meal and fluids refusals on [DATE] and [DATE], or room change on [DATE]. Interview on [DATE] at 11:30 AM with Resident #4's family representative confirmed the family did not receive any status update from the facility prior to the report of Resident #4 being sent out via 911 to the hospital on [DATE]. Interview on [DATE] at 2:08 PM with the facility's NP R confirmed he had no report from anyone at the facility related to Resident #4's refusals of medications, meals, fluids, or room change on [DATE] and [DATE]. Record review of the facility's Notifying the Physician of Change of Status, dated [DATE], revealed bullet #1 the nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time and date of call to physician, and interventions that were implemented in the resident's clinical record.; and bullet #2 stating .the nurse is responsible .for responding to a change of condition in a timely and effective manner. The nurse will document the time of the call to the physician in the clinical record. The Administrator was notified on IJ on [DATE] at 10:42 PM and was given a copy of the IJ templated and a Plan of Removal was requested. The Plan of Removal accepted on [DATE] at 11:50 AM. On [DATE] at 5:47 PM Plan of Removal received from the DON. The facility's Plan of Removal included the following steps to be taken by the facility: ALLEGED ALLEGATIONS: Documentation / Neglect: Staff facility failed to assess residents' vital signs and signs and symptoms of COVID residents. Interventions: The following in-services were initiated by the DON, ADON and regional nurse on [DATE]: Any staff member not present or in-serviced on [DATE], will not be allowed to assume their duties until in-serviced. Licensed Nurses will be In Service on the following: In- Service on Documentation in PCC In-Service on COVID Assessment q shift - completing COVID Assessment Q shift In Service on obtaining Vital Signs - Inservice on Obtaining Vital Signs each shift and as needed. Inservice on Change of Condition which includes a specific change and Physician/NP notification, and any interventions or orders. In service on Abuse/Neglect The medical director was notified of the immediate jeopardy situation on 11:39pm Monitoring The DON / designee will monitor scheduled assessments 7 days a week to ensure all assessments were completed. The DON/designee will ask 10 nurses randomly on various shifts per week for 6 weeks What they would do and document if a resident had a change of condition. The DON/designee will review the 24-hour report 7 days a week to ensure COVID assessments are done each shift and vital signs are taken as ordered. The QA committee will review findings and makes changes as needed. The surveyor verification of the Plan of Removal on [DATE] was as follows: Interview on [DATE] at 2:22 PM with LVN W confirmed he received in-service/training on completing COVID assessments every shift, checked resident vital sign every 4 hour, call physician and document on Resident change of change of condition under SBAR form because COVID patient changed drastically. LVN W further confirmed resident change of condition could be resident become confused, decrease in urine output, or vital sign was out of range. Interview on [DATE] at 3:53 PM with agency staff - LVN Z and EMT AA confirmed they received training on all the documentation on PCC such as SBAR and incident report. LVN Z and EMT AA confirmed COVID assessment need to complete every shift and vital sign every 4 hour for COVID residents. LVN Z and EMT AA also confirmed receiving training on abuse and neglect. Interview on [DATE] at 4:50 PM with RN BB confirmed he received training on documentation in PCC regarding completing COVID assessment, document vital sign, and documentation on notify physician when resident had change of condition. RN BB further confirmed received training on abuse and neglect. Interview on [DATE] at 4:57 PM with RN B confirmed she received training on documentation of COVID Assessment, vital sign, notifying physician and document on resident's change of condition. Interview on [DATE] at 5:11 PM with LVN CC confirmed she received training during mandatory meeting about documentation. LVN CC confirmed documentation on COVID assessment, vital signs. LVN CC confirmed she need to inform the physician when resident had any change such as vital sign off baseline and residents not their normal self. LVN CC confirmed she need to document on intervention, notifying physician and imitated SBAR form. LVN CC confirmed she received training on abuse and neglect. Interview on [DATE] at 7:21 PM with LVN I confirmed she received in-service training on documentation on PCC such as SBAR form for resident change of condition, vital sign and COVID assessment. Record review of the facility in-service training attendance roster titled Completing COVID Assessment - Nurse will complete COVID Assessment on Resident Q shift. Each shift will obtain new set up vital signs and assess resident and complete COVID assessment dated [DATE] revealed 14 of 14 Licensed staff signed the in-service roster; 7 of 7 licensed agency nurses signed the in-service roster Record review of facility in-service training attendance roster titled Notifying the physician of change in status dated [DATE] revealed 14 of 14 Licensed staff signed the in-service roster; 7 of 7 licensed agency nurses signed the in-service roster. Verified on [DATE] revealed DON documented monitor schedule assessment in PCC from [DATE] - [DATE] Verified on [DATE]/2020 revealed DON asked 3 LVN on ,[DATE]; 2 LVNs on ,[DATE]; 1 LVN on ,[DATE]; and 3 LVNs on ,[DATE] on change of condition. Verified on [DATE] revealed DON monitored 24-hour report from [DATE] - [DATE] On [DATE] at 4:41 PM, the Area Director of Operations, Regional Compliance Nurse - RN F, Assistant Administrator, Director of Nursing, and LVN G - Assistant Director of Nursing were informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm with a scope identified as a pattern due to residents on-going need for assessments for signs and symptoms of COVID-19.
F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to protect the residents right to personal privacy and confidentiality of his or her personal and medical records, for 1 of 1 Resident (Resident #2) reviewed for HIPPA violations, in that: RN H made available Resident #2's chest x-ray to the Activities Director S, a non-licensed unauthrorized employee of the facility. This deficient practice places all residents at risk for harm by having their confidential medical documents given to unauthorized individuals. The findings: Record review of Resident #2's admission record revealed an admission date of [DATE] with a discharge date of [DATE] and [DIAGNOSES REDACTED]. Interview on 7/9/2020 at 11:22 AM with Resident #2's legal representative confirmed she was asking of the nurses at the facility for her husband's status. The residents' legal representative states there is only one good nurse there and she is Activity Director S, she reports to me about my husband. Resident #2's legal representative states another family member asked Activity Director S for her husband's chest x-ray and Activities Director S emailed it to them. Interview on 7/9/2020 at 11:45 AM with the facility's DON confirmed Activities Director S emailed a picture of Resident #2's chest x-ray report to the family of Resident #2 on 7/5/2020, using the facility's iPad. Interview on 7/9/2020 at 2:14 PM with RN H confirmed she worked on 7/4/2020 and 7/5/2020 from 6:00 AM to 10:00 PM, on each day and was the charge nurse responsible for Resident #2. RN H confirmed Activity Director S had presented herself as a nurse to the spouse of Resident #2. RN H confirms she was informed by Activity Director S of the family's request for the results of his chest x-ray. RN H confirmed she called the x-ray lab and asked for the chest x-ray results for Resident #2 to be faxed to the facility. RN H confirmed upon receipt of

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	675896	A. BUILDING _____ B. WING _____	**07/24/2020**

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RIVER CITY CARE CENTER	**921 NOLAN ST SAN ANTONIO, TX 78202**

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 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) the fax she provided the document to Activity Director S on 7/5/2020. Interview on 7/11/2020 at 1:08 PM with Activities Director S confirmed she presented herself to Resident #2's family as a nurse. Activities Director S confirmed she asked RN H for Resident #2's chest x-ray. Activities Director S confirmed she received the chest x-ray from RN H and then used the facility's iPad to take a picture and email it to Resident #2's family. Record review of the facility's policy titled Health Information Requests, Release and Production Fee Guidelines and subtitled Request for copies of health information: dated 11/2017, revealed when someone outside of the facility requests copies of information from a residents chart it is first necessary to determine their identity and if they have legal authority to receive any information. Once rights to the health information has been established an authorization to release health information form must be completed and sent to the director of health information management to be reviewed and approved.

F 0584

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

. Based on observations, interviews and record reviews the facility failed to provide residents safe, comfortable and homelike environment for 3 of 50 residents (Resident #4, #6 and #7) whose room review for comfortable and safe temperature level and for 4 of 63 Residents (Resident #12, #13, #25, and #26) whose room review for clean bed and bath linens, in that: 1. Resident #4 was hospitalized and deceased complicated by the heat in his room. 2. a. The air temperature in Resident #6's room was not maintained between ,[DATE]-degree Fahrenheit. 2. b. The air temperature in Resident #7's room was not maintained between ,[DATE]-degree Fahrenheit. 3. HVAC condensers / compressors were dirty, struggling with the heat, and not insulated and were leaking and had condensation. 4a. Resident #12's bed did not have any sheets. b. Resident #13's bed did not have any sheets. c. Resident #25's bed did not have any sheets. d. Resident #26's bed did not have any sheets. These deficient practices could place residents who were lying bed without sheets at risk for diminish quality of life, and residents whose room temperature fall outside ,[DATE]-degree Fahrenheit could adversely affect their health and safety. The findings were: 1. Record review of Resident #4's admission record revealed an admitted [DATE] and a discharge date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's census report revealed he was moved from room [ROOM NUMBER] to room [ROOM NUMBER] on [DATE]. Record review of Resident #4's progress notes revealed an entry on [DATE] at 6:00 PM, authored by RN H stating Pt in respiratory distress/ unresponsive. 911 called and transferred to (local hospital.) (Family member) notified. Observation on [DATE] at 5:20 PM of the east wing of the facility revealed no hallway heating ventilation air-conditioning vent between rooms 40 to 51. Air temperature measurements of the single HVAC vents in room [ROOM NUMBER] was 84-degree Fahrenheit. Interview on [DATE] at 10:20 AM with Resident#4's family confirmed resident #4 was admitted to the hospital on [DATE] with the [DIAGNOSES REDACTED]. Interview on [DATE] at 2:14 PM with RN H confirmed she worked on [DATE] and [DATE] from 6:00 AM to 10:00 PM, on each day and was the charge nurse responsible for resident #4. She confirmed Resident #4 refused some medications and fluids and presented with mental confusion and developed a fever on [DATE] and [DATE]. RN H confirmed the air condition in the facility did not cool the facility well and was very uncomfortable for resident #4 on [DATE] and [DATE]. RN H confirmed she attempted to perform nursing interventions and offered Resident #4 water and applyed wet towels to his person. RN H confirmed she moved resident #4 from room [ROOM NUMBER] to room [ROOM NUMBER] on [DATE], related to room [ROOM NUMBER] was cooler than room [ROOM NUMBER]. RN H confirmed on [DATE] she called emergency services 911 and sent Resident #4 to the hospital related to heat induced convulsions. 2a. Record review of Resident #6's admission record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's census record, dated [DATE], revealed him to reside in room [ROOM NUMBER]. Observation on [DATE] at 5:20 PM of the east wing of the facility revealed no hallway heating ventilation air-conditioning vent between rooms 40 to 51. Air temperature measurements of the single HVAC vent in room [ROOM NUMBER] was 83-degeree Fahrenheit. Interview on [DATE] at 5:30 PM with Resident #6 confirmed he resides in room [ROOM NUMBER], he stated he was hot and suffered on the weekend of [DATE]. Resident #6 stated the room feels cooler now, but he is still uncomfortable even with a portable temporary fan in the room. 2b. Record review of Resident #7's admission record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's census record, dated [DATE], revealed him to reside in room [ROOM NUMBER]. Observation on [DATE] at 5:20 PM of the east wing of the facility revealed no hallway heating ventilation air-conditioning vent between rooms 40 to 51. Air temperature measurements of the single HVAC vent in room [ROOM NUMBER] was 84-degree Fahrenheit. Interview on [DATE] at 5:30 PM with Resident #7 confirmed he resides in room [ROOM NUMBER], he stated he was hot and suffered on the weekend of [DATE]. Resident #7 stated the room feels cooler now, but he is still uncomfortable even with a portable temporary fan in the room. 3) Observation on [DATE] at 5:00 PM of the facility's outdoor HVAC system compressors and condensers revealed them lacking insulation on the return cold gas [MEDICATION NAME] piping leading into the building with condensation. Observation on [DATE] at 5:20 PM of the east wing of the facility revealed no hallway heating ventilation air-conditioning vent between rooms 40 to 51. Air temperature measurement of the single HVAC vent in rooms #41 was 84' Fahrenheit, room [ROOM NUMBER] 83' Fahrenheit, and room [ROOM NUMBER] was 84' Fahrenheit; Air temperature measurement of the single HVAC vent in room [ROOM NUMBER] was 68' Fahrenheit. Interview on [DATE] at 3:30 PM with the facility Administrator confirmed he learned on [DATE] of the warm temperatures in the facility. The Administrator stated he contacted the facility's Maintenance Director whom contacted the Regional Maintenance Supervisor and the three coordinated with Cold Air and Heat contractor to assess the failure of their HVAC system. On [DATE] in the afternoon the facility bought temporary air conditioners and fans and deployed them throughout the home and in residents' rooms. Beginning on [DATE] in the afternoon the HVAC contractor worked on site with the facility's maintenance staff to repair and replace HVAC systems. The facility purchased a new outdoor 5-ton compressor-condenser and the contractor installed it on [DATE] at 2:00 PM. Interview on [DATE] at 3:50 PM with the Cold Air & Heat contractor confirmed he was contracted by the facility for HVAC failure evaluation and repair, stating the facility's outdoor HVAC compressor / condensers were dirty, lacking refrigerant, and lacking insulation, causing them to struggle with the heat. Interview on [DATE] at 4:00 PM with the facility's maintenance director confirmed the facility's HVAC system failed on the weekend of ,[DATE] to [DATE], stating he and his staff contacted the HVAC contractor and facilitated the repair and replacement to the HVAC system with the installation of a new outdoor air conditioning compressor-condenser unit and deploying temporary fans and water coolers down the hallways. The maintenance director confirmed the Cold Air & Heat contractor T cleaned and recharged several other condensers / compressors. Interview on [DATE] at 5:00 PM with the maintenance director confirmed the east wing hallway has no HVAC vent between rooms 40 to 51 and air temperature measurement of the single HVAC vent in rooms #41 was 84' Fahrenheit, room [ROOM NUMBER] 83' Fahrenheit, and room [ROOM NUMBER] was 84' Fahrenheit. The maintenance director confirmed several condensers / compressor units were lacking insulation and would replace the insulation on the piping. Record review of the facility's HVAC contractor receipts for the period ,[DATE] to [DATE] revealed a receipt dated [DATE] from HVAC contractor T from Cold Air & Heat stating was out on both [DATE]th and 5th at night during day. Found unit G, H, I, and J struggling thru heat unit H lost compressor. Record review of the facility's HVAC contractor receipts for the period ,[DATE] to [DATE] revealed a letter from Reynolds Heating and Air a HVAC contractor, dated [DATE], stating Over the weekend of 4th & 5th July we discussed at various times differential temperatures in the building and solutions. I recommended several checks to ensure correct head temperatures, cleanliness of coils and temperatures in the attic .several options to increase air flow, these being the installation of additional roof top units, mini split systems and additional vents in the halls where needed. 4. a. Record review of Resident #12's admission record dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:23 PM revealed Resident #12 was lying in bed without bed sheet. b. Record review of Resident # 13's admisison record dated [DATE] revealed an admision date of [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:23 PM revealed Resident #13 was lying in bed without bed sheet. c. Record review of Resident #25's admission record dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:23 PM revealed Resident #25 was lying in bed without bed sheet. d. Record review of Resident #26's admission record dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:23 PM revealed Resident #25 was lying in bed without bed sheet. During an interview on [DATE] at 5:27 PM with RN B confirmed she informed the DON that they could not find the linen. Observation of a linen cart in the west wing of COVID posittive unit on [DATE] at 5:27 PM revealed there was blankets, flat sheets and fitted sheets. Interview on [DATE] at 6:55

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) PM with Administrator confirmed he had been rounding on the residents and they stated they were comfortable. Record review of the facility policy titled Resident Rights undated revealed Safe environment - the resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.
F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interviews and record reviews, the facility failed to ensure residents were free from neglect for 8 of 30 residents (Residents #1, #2, #3, #9, #27, #28, #29, and #30) whose care was reviewed for neglect, in that: 1. The facility failed to ensure processes were developed and implemented to ensure staff communicated with physician when Residents (#1, #2 and #3) had a change of condition. a. LVN K and LVN L did not call the physician or nurse practitioner when Resident #1 had a change in condition and was placed on 6 liters - of oxygen via non-rebreather mask for an oxygen saturation of 80% on room air. b. LVN M did not notify physician or the nurse practitioner when Resident #2's blood pressure dropped to ,[DATE] mmHg and pulse 59 beat per minutes on [DATE] during 6 AM - 2 PM Shift. c. LVN L did not notify the physician or the nurse practitioner when Resident #2 had blood pressure of ,[DATE] mmHg and pulse 56 beat per minutes on [DATE] during 2 PM - 10 PM shift and ,[DATE] mmHg and 54 beat per minutes on [DATE] during 10 PM - 6 AM shift. d. RN J did not notify physician after Resident #3's had a low blood sugar on [DATE]. 2. The facility failed to implement a process to ensure staff completed a COVID Assessment resulting in Resident #1, #2, and #3 not being assessed for COVID 19 sign and symptoms every shift. a. Resident #1 did not have COVID assessment on [DATE] during 6AM - 2 PM shift and 2 PM - 10 PM Shift. b. Resident #2 did not have COVID assessment on [DATE] during 2PM - 10 PM shift and on [DATE] and [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. c. Resident #3 did not have COVID assessment on [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. 3. The facility failed to have a structure to ensure staff wear proper PPE when they worked in the positive COVID unit. a. RN B did not wear eye protection when she performed blood sugar checks for COVID positive Residents. b. Housekeeper A came out of a COVID positive residents' rooms went with a surgical mask instead of a N95 mask. c. Housekeeper A walked out of the back door at end of hall and walked back in with a surgical mask instead of N95 mask. d. CNA C did not wear gloves when delivering meal tray to Resident #29 and did not sanitize or wash her hands after delivering meal tray. e. CNA D did not wear gloves and did not sanitize or wash her hands after touching the light switch and delivery of a meal tray to Resident #9. f. RN E did not wear a face shield or goggles when she entered to Resident #30's room to deliver a meal tray. g. LVN K did not wear a face shield or googles when she performed swab test for Resident #27 and Resident #28. h. Medication Aide O entered positive COVID unit without PPE and did not put on PPE until she entered the medication room inside the COVIVD positive unit. These deficient practices could affect COVID positive Residents who had change of condition were not being assessed and identified, could place them at risk of infection from transmission of communicable disease and could result in worsening health status, hospitalization , and death. These failures resulted in identification of Immediate Jeopardy (IJ) on [DATE]. The immediacy was lifted on [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place for all COVID Residents. The findings were: 1a. Record review of Resident #1's admission record dated [DATE] revealed an admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's order summary report dated [DATE] revealed an order of [MEDICATION NAME] tablet 325 MG give 2 tablets by mouth every 6 hours as needed for elevated temperature; moderate pain. Start date: [DATE]. Record review of Resident #1's Treatment Administration Record schedule for ,[DATE] dated [DATE] - [DATE] revealed [MEDICATION NAME] tablet 325 mg give 2 tablets by mouth every 6 hours as needed for elevated temperature; moderate pain was documented as administering to Resident #1 at 7:39 PM. Record review of Resident #1's documentation on oxygen saturation dated [DATE] revealed oxygen saturation at 1:41 AM was 97 % room air, at 9:09 AM was 95% room air, at 6:23 PM 94% room air, at 8:36 PM was 93% high flow oxygen, at 8:46 PM was 97% high flow oxygen. Record review of Resident #1's progress noted dated [DATE] at 8:49 PM written by LVN K revealed Resident presented with a 100.4 fever, this nurse and other nurse helped resident, this nurse gave him tylenol 650mg by mouth, and other nurse gave tylenol suppository to help bring down the fever, also placed resident on oxygen 6L via non-rebreather mask. Rechecked temperature of patient and it was 99.5, resident O2 sat was at 97% on 6L via non-rebreather, resident appeared stable and resting. This nurse and other nurse left room for ,[DATE] minutes to attend to other resident's needs, did not call family prior because patient appeared stable. This nurse and other nurse went to check again on the patient and patient was gasping for air and not responding to stimuli, verbal or physical. Other nurse immediately started CPR on resident, CNA went to grab crash cart and brought it to the patient's room. This nurse put AED pads on resident, turned on AED, AED said no shockable rhythm noted, other nurse continued CPR, this nurse came and called emergency responders, emergency responders came and relieved nurse of CPR duties, this nurse came to nurses' station and called responsible party of situation. Resident is currently on stretcher with EMS, providing emergency care, will monitor resident. Record review of Resident #1's SBAR - 8hr. - V2 with effective date [DATE] 20:35 revealed date and time MD or NP notified was on [DATE] at 8:30 PM Record review of EMS Patient Care Report dated [DATE] revealed EMS was notified on [DATE] at 8:20 PM. Review EMS's assessment at 8:36 PM revealed breathing absent, pulse carotid absent; mental status: unresponsive. Interview on [DATE] at 4:14 PM with LVN K she confirmed LVN L was making round shortly after dinner and saw Resident #1 was gasping for air. LVN K stated she checked Resident #1's vital signs which revealed oxygen saturation was at 80% on room air, and temperature 100.4 F. LVN K confirmed she administered Tylenol by mouth and suppository and administered 6 liters of oxygen via non-rebreather for Resident #1. LVN K stated she rechecked Resident #1's temperature and oxygen saturation which revealed 99.5 F and 97% on 6 liters of oxygen via non-rebreather mask. LVN K confirmed Resident #1 appear resting and stable, so LVN K and LVN L left Resident #1 room and went check other residents for 5 - 10 minutes. LVN K confirmed when LVN K and LVN returned and checked on Resident #1, they noticed Resident #1 was gasping for air, and Resident #1 did not respond to verbal command and sternal rub. LVN K confirmed LVN L initiated CPR, and LVN K brought crash cart. Interview on [DATE] at 4:28 PM with LVN K confirmed she initiated SBAR after calling 911, and then she notified the nurse practitioner and family. Interview on [DATE] at 5:00 PM with LVN L confirmed LVN K asked LVN L to check on Resident #1 toward the end of shift. LVN L confirmed she found out Resident #1 had elevated temperatures approximately 102-degree Fahrenheit and oxygen saturation was low at 88% on room air. LVN L confirmed she administered Tylenol 650 suppository and administered 6 liters of oxygen via non-rebreather mask. LVN L confirmed she sat with Resident #1 for 20 minutes. Then, she checked Resident #1's temperature and oxygen saturation again revealed temperature was at 99-degree Fahrenheit and oxygen saturation was 98% on 6 liters of oxygen via non-rebreather mask. LVN L stated she went out to change her PPE because her PPE was torn, and LVN K stayed with Resident #1. LVN L further confirmed she then left the unit for break and did not know if LVN K remained to stay with Resident #1 or not. LVN L stated after she went on break for about 20 minutes, and while she was talking with the receptionist, LVN K asked LVN L to come back the unit and told LVN L that I think he passed away. LVN L said she put on PPE and rushed Resident #1's room. LVN L stated she checked Resident #1 revealed no pulse and no breathing, and then she started CPR. LVN L stated Maintenance brought the crash cart, LVN K called EMS. Then, EMS came and took over the CPR. EMS tried to resuscitate Resident #1 for 45 minutes. LVN L stated LVN K had nurse practitioner and family on the phone. Interview on [DATE] at 4:50 PM with the DON confirmed according to the SBAR note the nurse had notified the doctor when she noticed Resident #1's elevated temperature and got order from the physician for Tylenol 650 mg by mouth and suppository. Interview on [DATE] at 4:55 PM with DON stated it was ok for the nurse to step out Resident #1's room after stabilizing Resident #1. Interview on [DATE] at approximately 8:49 AM with Nurse Practitioner R confirmed the nurse should have notified the physician or the nurse practitioner after stabilizing Resident #1 with Tylenol and oxygen. Nurse Practitioner R confirmed if Resident #1 was on room air or was on oxygen via nasal canula and later Resident #1 need to be on 6 liters of oxygen via non-rebreather mask, then Resident #1 had a change in condition. Nurse Practitioner R stated he did not know about Resident #1 was on 6 litters of oxygen via non-rebreather mask. Nurse Practitioner R stated the nurse at the facility communicated with him after Resident #1 expired. b. Record review of Resident #2's face sheet date [DATE] revealed an admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Order Summary Report dated [DATE] revealed order of [MEDICATION NAME] tablet 2.5 mg give 1 tablet by mouth one time a day for hypertension, [MEDICATION NAME] capsule 0.4 mg (tamsulosin HCl) give 1 capsule by mouth at bed time for enlarged prostate, [MEDICATION NAME] tablet 20 mg ([MEDICATION NAME]) give 1 tablet by mouth one time a day for blood thinner, Tylenol tablet 325 mg ([MEDICATION NAME]) give 2 tablets by mouth every 6 hours as needed for pain. Record

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F 0600

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 5)
review of Resident #2's Blood Pressure Summary dated [DATE] revealed Resident#2 had systolic blood pressure (the first number - indicated how much pressure of blood is exerting against artery walls when heart beat) from [DATE] to [DATE] was equal or greater than 90 mmHg. Record review of Resident #2's pulse summary dated [DATE] revealed Resident #2 had heart rate (pulse) from [DATE] to [DATE] was greater than 60 beat per minutes. Record review of Resident #2's vital signs was documented by LVN M on [DATE] at 9:45 AM revealed blood pressure was ,[DATE] mmHg and pulse was 59 beat per minute. Record
review of Resident #2 Medication Administration Record [REDACTED]#2 on [DATE] for the morning dose. Further review revealed [MEDICATION NAME] tablet 20 mg give 1 tablet by mouth one time a day for blood thinner was documented as administered to
Resident #2 on [DATE] for the morning dose. Interview on [DATE] at 11:05 AM with LVN M confirmed she documented on [DATE]
at 9:45 AM bp ,[DATE] mmHg and pulse 59 beat per minute. LVN M confirmed she took Resident #2's vital signs, write them down, and moved on to another resident. LVN M confirmed she did not recheck Resident #2's blood pressure and pulse because there was nothing significant going on with Resident #2. LVN M confirmed blood pressure and pulse did not give her any alarm concern because Resident #2 just woke up and responded, therefore, LVN M did not check his blood pressure again and did not notify the physician or nurse practitioner. c. Record review of Resident #2's vital sign documented by LVN L on [DATE] at 10:01 PM revealed blood pressure was ,[DATE] mmHg and pulse was 56 beat per minute. Further review Resident #2's vital signs documented by LVN L on [DATE] at 5:41 AM revealed blood pressure was ,[DATE] mmHg and pulse was 54 beat per minute. Interview on [DATE] at 5:22 PM with LVN L confirmed she documented Resident #2's blood pressure [DATE] at 10:01 PM was ,[DATE] mmHg and blood pressure on [DATE] at 5:41 AM was ,[DATE] mmHg. LVN further confirmed on [DATE] at 5:24 PM she
believed Resident #2's blood pressure - ,[DATE] mmHg and ,[DATE] mmHg was his baseline and his response was normal, so LVN L did not notify the physician or nurse practitioner. Interview on [DATE] at 3:34 PM with LVN L confirmed Resident #2's blood pressure of ,[DATE] mmHg and pulse was 56 beat per minutes and blood pressure ,[DATE] mmHg and pulse was 54, she did not check the blood pressure and the pulse again, did not review resident trending blood pressure and pulse, and she did not notify the physician or nurse practitioner because she was being told by LVN K that Resident #2's blood pressure and heart rate run low. Interview on [DATE] at 5:38 PM with the DON confirmed Resident #2's blood pressure look lower on [DATE] at 9:45 AM was ,[DATE] mmHg, [DATE] at 10:01 PM was ,[DATE] mmHg, and [DATE] at 5:41 AM was ,[DATE] mmHg. Interview on
[DATE] at 5:42 PM with the DON confirmed Resident #2's pulse look lower on [DATE] at 9:45 AM was 59 beat per minute, [DATE] at 10:01 PM was 56 beat per minute, and [DATE] at 5:41 AM was 54 beat per minute. Interview on [DATE] at 5:52 PM with the
DON confirmed the nurse should have called the physician or nurse practitioner on Resident #2's low blood pressure and pulse. d. Record review of Resident #3's admission record dated [DATE] with admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's order summary order dated [DATE] revealed orders of Accucheck blood sugar three times per
day for [MEDICAL TREATMENT]/sliding scale, monitor vital sign every shift report any abnormal result to MD, insulin [MEDICATION NAME] solution 100 unit/mL inject 8 unit subcutaneously one time a day for diabetes. Further review revealed there was order created on [DATE] and ended [DATE] read [MEDICATION NAME] Hypokit Solution Reconstituted 1 MG inject 1 mg
subcutaneously one time only for Resident blood sugar at 43 during last round for 1 day. Record review of Resident #3's progress note documented by RN J dated [DATE] at 5:08 AM revealed Resident more effort to arouse on second rounds. Vital sign taken. Resident on [MEDICAL TREATMENT] blood sugar taken to be @ 43mg/dl. [MEDICATION NAME] given. Sugar dissolved in
H2O rubbed around in her gums. 30 minutes later resident more easily follows commands. Pending blood sugar value post [MEDICATION NAME] 1mg administration and added sugar to resident's gums. Further review Resident #3's progress note dated [DATE] at 5:56 AM revealed Resident able to follow commands more readily. Able to stick out tongue when giving carbohydrate source. Able to move arms on command to wipe face. B/S currently 60mg/dl 1hr post Glugacon 1mg. Interview on [DATE] at 10:40 AM RN J confirmed while he was documenting at nursing station and an aide informed him that Resident #3 was acting differently. He went to Resident #3's room and assessed her. RN J said Resident #3 was slow to answer the question, Resident #3 know her name, but did not know where she was at. RN J stated he checked her blood sugar and found out it was low, then he gave her [MEDICATION NAME] and supplemental carbohydrate because she was able to take thing by mouth. RN J confirmed the whole facility had standing order for [MEDICATION NAME] and carbohydrate supplemental if resident had low blood sugar and change level of consciousness, he stated, because you don't have time to call the provider. RN J confirmed after giving Resident #3 was given [MEDICATION NAME] and carbohydrate supplemental, she was able to response and answer question appropriately and back to her baseline. Interview on [DATE] at 10:43 AM with RN J confirmed he did not notify the physician or nurse practitioner regarding Resident #3's low blood sugar and needed [MEDICATION NAME] injection. RN J further confirmed he did not document on SBAR report, but he confirmed he document on progress note because of standing order. Interview on [DATE] at 6:11 PM with the DON confirmed the RN J should have notified the physician or nurse practitioner, and RN J should have done the SBAR because Resident #3 had change of condition due to low blood sugar. Interview on [DATE] at 6:16 PM with RN F - Regional Compliance Nurse and the DON confirmed they did not see the SBAR for the incident of Resident #3's low blood sugar on [DATE]. Interview on [DATE] at 8:59 AM with NP R confirmed for resident had low blood sugar the nurse should have used clinical judgment to assess the patient whether the patient was alert, coherent, or having [MEDICAL CONDITION] or respiratory status was stable or not. If resident need oxygen, diaphoretic, non-response, and elevated heart rate the patient can treat with [MEDICATION NAME] and watch them come out of hypoglycemic safely and the vital sign was stable. The nurse should report to the physician about resident's low blood sugar, and there would be a review of medication why patient blood sugar went so low, was it the compliance issue or diet issue, how many times happened before or resident acutely ill. If patient went to situation of blood sugar was low and being corrected with [MEDICATION NAME], once the patient stable the nurse should have check resident blood sugar every hour or at least couple hours to make sure resident eating and go back to check blood sugar as routine schedule. Interview on [DATE] at 9:03 AM NP R confirmed resident #3 had change of condition because she had symptomatic of low blood sugar and need [MEDICATION NAME],
therefore, the nurse should have notified the NP or physician and complete SBAR report. Interview on [DATE] at 10:06 AM with the Medical Director confirmed depend on resident condition, if patient conscious, the nurse should administer orange juice or glucose tablet. The Medical Director further confirmed the nurse could administer [MEDICATION NAME] if there was an order was available. The Medical Director stated usually after the nurse stabilized resident with [MEDICATION NAME], the nurse should check blood sugar every 2 hours and if the blood sugar was back to normal they should check resident blood sugar on their regular schedule such as AC&HS - before meal and at bed time or every 6 hours. 2a. Record review of Resident #1's Assessments revealed the last assessment before [DATE] (6 AM - 2 PM shift) was COVID assessment dated [DATE] at 3:58 PM and the next assessment after [DATE] (2 PM -10 PM shift) was COVID assessment dated [DATE] at 00:58 AM. Further review revealed there was no COVID Assessment on [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. Interview on [DATE] at 9:21 AM with LVN I confirmed there was no COVID assessment for Resident #1 on [DATE] during 6 AM -2 PM and 2 PM -10 PM. she stated it was busy during day shift, but night shift had more time to do assessment. Interview on [DATE] at 5:27 PM with the DON confirmed she did not see the COVID Assessment for Resident #1 on [DATE] during 6AM - 2 PM shift and 2PM - 10 PM. She further confirmed she only saw other assessments documented in progress note and vital sign during 6AM - 2PM shift and 2PM - 10 PM shift. b. Record review of Resident #2's Assessments dated on [DATE] revealed Weekly Nursing summary dated [DATE] at 5:54 PM and COVID assessment dated [DATE] at 1:52 PM. Further review revealed there was no documentation on COVID Assessment on [DATE] during 2 PM - 10 PM shift. Interview on [DATE] at 3:24 PM with LVN K confirmed she worked on [DATE]
during 2 PM - 10 PM shift on East Wing. LVN K further confirmed there was no COVID assessment for Resident #2 on her shift on [DATE]. LVN K explained she had 5 admissions on that day and another nurse who worked with her on that day should have done COVID assessment for Resident #2. Record review of Resident #2's Assessments revealed the last assessment before [DATE] (6AM - 2PM shift) was COVID assessment dated [DATE] at 1:52 PM and the next assessment after [DATE] (2 PM - 10 PM shift) was COVID assessment dated [DATE] at 4:22 AM. Further review revealed there was no documentation on [DATE] and [DATE] during 6 AM - 2 PM and 2 PM - 10 PM shift. Interview on [DATE] at 7:57 PM with RN H confirmed she did not have time do COVID assessment for Resident #2 on [DATE] and [DATE] during her shift 6AM - 2PM. RN H further confirmed she expected LVN I came in during 2 PM -10 PM shift to help her to complete the COVID Assessment. Interview on [DATE] at 9:16 AM with LVN I confirmed there was no COVID assessment for Resident #2 on [DATE] and [DATE] during 6 AM - 2 PM and 2 PM-10 because
it was busy during the morning shift, so night shift had more time to do assessment. c. Record review of Resident #3's Assessments revealed there was no COVID Assessment on [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. Further review revealed the assessment before [DATE] (6 AM - 2 PM shift) was Skilled Nurses Notes dated [DATE] at 01:35 AM, and the assessment after [DATE] (2 PM - 10 PM shift) was Skilled Nurse Notes dated [DATE] at 04:27 AM. Interview on [DATE] at 4:35 PM with the DON confirmed there was no COVID Assessment for Resident #3 on [DATE] during 6 AM - 2 PM and 2 PM - 10 PM shift. Interview on [DATE] at 4:38 PM with the DON confirmed the license nurse could complete COVID Assessment, Respiratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER CITY CARE CENTER	921 NOLAN ST SAN ANTONIO, TX 78202

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

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) Screen, or Skilled Nurse Note to consider as assessed Resident with COVID every 12 hours. The DON further confirmed when any resident admitted to the facility, the computer would automatically generate assessment to complete every 12 hours. The DON confirmed the facility updated to assess COVID resident every 8 hours. Interview on [DATE] at 4:43 PM with the DON confirmed vital sign should be done every shift. Interview on [DATE] at 4:44 PM with the DON confirmed she monitored documentation for assessment and vital signs. The DON said if there was documentation missing, she would talk to the nurse. The DON further confirmed the licensed nurses received orientation up on hire and ongoing in-service training on what they are supposed to document on their assessment and vital sign. The DON confirmed weekly monitoring and now daily monitoring even on weekend on chart auditing on major change of condition, vital sign, and assessments. Interview on [DATE] at 4:48 PM the DON confirmed if the license nurse noticed a change of condition, he or she should stabilize the resident first, and call physician to let them know what going with resident. The DON said if the physician had new order for resident, the nurse should initiate the new order, and the nurse need to documentation the communication with doctor and family. Interview on [DATE] at 4:53 PM the DON confirmed there was ongoing in-service with license staff on Resident's change of condition by going over scenarios and getting feedback from staff. Interview on [DATE] at 4:55 PM with the DON confirmed run report see who had change of condition, anything change in weekend and follow up with individual resident to find out why they transfer out. The DON further confirmed if there was no documentation, she would follow up with the nurse. Interview on [DATE] at 6:55 PM with the Administrator confirmed he had been rounding on the residents and they stated they were comfortable. Administrator sated they have more than an adequate supply of eye protection (face shields, goggles) available for staff. He further stated staff should be wearing eye protection when providing direct contact care. Administrator stated he was surprised they have not had positive staff in the building as he thought some of the infection control issues were due to staff becoming complacent. He sated he thought staff were being in-serviced on COVID and infection control process by agency. Interview on [DATE] at 10:03 AM with Medical Director confirmed he managed patient at the facility. He confirmed he utilized tele-monitoring to see resident at the facility. The nurse assessed the patient and if there was any issue would reported to the nurse practitioner. Then, the nurse practitioner and the doctor would have conversation online about the patient's situation. The Medical Director confirmed the facility had their own protocol on the assessment and frequency of assessing COVID residents. When the resident had change of condition the nurse should notify the nurse practitioner, then the nurse practitioner provide any necessary order and then the nurse practitioner communicated with the medical director and make change in resident plan of care as needed. Record review of the facility's policy titled Abuse/Neglect dated [DATE] revealed the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart . 7. Neglect: is the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record review of COVID 19 plan dated [DATE] revealed .Resident Screening . Resident will be screened during their stay according to the following: at least daily for the following symptoms: fever, new or worse cough, new or worse shortness of breath, chills, repeated shaking with chills, new muscle pain or aches, headache, sore throat, new loss of taste or smell, new or worse dizziness, nausea/vomiting/diarrhea. If any of the above symptoms are assessed, the resident will be placed on contact/droplet precaution until further evaluation for COVID 19 . This facility will also review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019. Record review of Responding to Coronavirus (COVID-19) in Nursing Homes Responding to COVID-19 dated [DATE] revealed Resident with new-onset suspected or confirmed COVID-19: Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms. retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding on [DATE]. Record review of Notifying the Physician of Change in Status dated [DATE] revealed the nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for medicate medical attention. This facility utilizes the INTERAC tool, Change in Condition - When to Notify the MD/NP/PA to review resident condition and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition require immediate notification of the physician and non-immediate/report on next work day notification of the physician. 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in resident's clinical record . 6. The nurse will monitor and reassess the resident's status and response to interventions. Physician should develop a working [DIAGNOSES REDACTED]. 7. The nurse ill document all attempts to contact the physician, all attempt to notify the family and or legal representative, the physician's response, the physician orders [REDACTED]. 3. a. Observation on [DATE] at 5:00 PM revealed RN B walked in residents' rooms to conduct blood glucose without wearing a face shield or goggles. During an interview on [DATE] at 5:08 PM with RN B confirmed she did not wear face shield or goggle because the facility had a limited supply of eye protection available. Interview on [DATE] at 6:55 PM with the Administrator he confirmed the facility had more than an adequate supply of eye protection (face shields, goggles) available for staff. He further stated staff should be wearing eye protection when providing direct contact care. The Administrator stated he was surprised they have not had positive staff in the building as he thought some of the infection control issues were due to staff becoming complacent. The Administrator stated he thought nursing agency staff were being in-serviced on COVID and infection control process by agency. b. Observation on [DATE] at 5:10 PM revealed Housekeeper A came out of a COVID positive residents' room with a surgical mask on instead of a N95 mask. c. Observation on [DATE] at 5:10 PM revealed Housekeeper A walked out of the back door at end of hall and walked back in with just a surgical mask. Interview on [DATE] at 5:12 PM with RN B confirmed Housekeeper A was wearing surgical mask while he was working in the positive COVID Residents' rooms. RN B further confirmed Housekeeper A should have worn N95 mask while working in COVID positive unit. d. Record review of Resident #29's admission record dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:42 PM revealed CNA C did not wear gloves when she placed meal tray on a bedside table of Resident #29. Further observation revealed CNA C did not sanitize or wash her hands after exiting Resident #29's room. CNA C continue getting another meal tray at the nursing station to deliver to another resident. During an interview on [DATE] at 5:45 PM with CNA C she did not wear gloves when she took the tray into Resident #29's room. She also confirmed she did not wash or sanitize her hands after delivering the tray to Resident #29's room. CNA C further stated she had not had in-service training on caring for COVID positive residents. e. Record review of Resident #9's admission record date [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:42 PM revealed CNA D did not wear gloves when she delivered meal tray to Resident #9's room. Further observation revealed CNA D turned the light switch on in Resident #9's room and placed the meal tray on a bedside table with her bare hands. Without sanitizing or washing her hands, CNA D continued to pass out a meal tray to another resident. Interview on [DATE] at 5:47 PM with CNA D confirmed she turned the light switch on and placed the meal tray on bedside table for Resident #9 without wearing gloves. CNA D further confirmed she did not sanitize or wash her hands after exiting Resident #9's room. f. Record review of Resident #30's admission record date [DATE] revealed an admitted on [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:45 PM revealed RN E brought a meal tray into Resident #30's room and assisted Resident #30 to sit up. Further observation revealed RN E did not wear face shield or googles. RN E wore regular eyeglasses. Interview on [DATE] at 5:59 PM RN E confirmed she did not wear goggles or face shield because it was her first day of work, and
F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interviews and record reviews, the facility failed implement written policies and procedures that ensure residents were free from neglect for 8 of 30 residents (Residents #1, #2, #3, #9, #27, #28, #29, and #30) whose care was reviewed for neglect, in that: 1. The facility failed to ensure processes were developed and implemented to ensure staff communicated with physician when Residents (#1, #2 and #3) had a change of condition. a. LVN K and LVN L did not call the physician or nurse practitioner when Resident #1 had a change in condition and was placed on 6 liters - of oxygen via non-rebreather mask for an oxygen saturation of 80% on room air. b. LVN M did not notify physician or the nurse practitioner when Resident #2's blood pressure dropped to ,[DATE] mmHg and pulse 59 beat per minutes on [DATE] during 6 AM - 2 PM Shift. c. LVN L did not notify the physician or the nurse practitioner when Resident #2 had blood pressure of ,[DATE] mmHg and pulse 56 beat per minutes on [DATE] during 2 PM - 10 PM shift and ,[DATE] mmHg and 54 beat per minutes on [DATE] during 10 PM - 6 AM shift. d. RN J did not notify physician after Resident #3's had a low blood sugar on [DATE]. 2.

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) The facility failed to implement a process to ensure staff completed a COVID Assessment resulting in Resident #1, #2, and #3 not being assessed for COVID 19 sign and symptoms every shift. a. Resident #1 did not have COVID assessment on [DATE] during 6AM - 2 PM shift and 2 PM - 10 PM Shift. b. Resident #2 did not have COVID assessment on [DATE] during 2PM - 10 PM shift and on [DATE] and [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. c. Resident #3 did not have COVID assessment on [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. 3. The facility failed to have a structure to ensure staff wear proper PPE when they care for Residents (#9, #27, #28, #29, and #30) in the positive COVID unit. a. RN B did not wear eye protection when she performed blood sugar checks for COVID positive Residents. b. Housekeeper A came out of a COVID positive residents' rooms went with a surgical mask instead of a N95 mask. c. Housekeeper A walked out of the back door at end of hall and walked back in with a surgical mask instead of N95 mask. d. CNA C did not wear gloves when delivering meal tray to Resident #29 and did not sanitize or wash her hands after delivering meal tray. e. CNA D did not wear gloves and did not sanitize or wash her hands after touching the light switch and delivery of a meal tray to Resident #9. f. RN E did not wear a face shield or goggles when she entered to Resident #30's room to deliver a meal tray. g. LVN K did not wear a face shield or googles when she performed swab test for Resident #27 and Resident #28. h. Medication Aide O entered positive COVID unit without PPE and did not put on PPE until she entered the medication room inside the COVIVD positive unit. These deficient practices could affect COVID positive Residents who had change of condition were not being assessed and identified, could place them at risk of infection from transmission of communicable disease and could result in worsening health status, hospitalization , and death. These failures resulted in identification of Immediate Jeopardy (IJ) on [DATE]. The immediacy was lifted on [DATE], the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place for all COVID Residents. The findings were: Record review of the facility's policy titled Abuse/Neglect dated [DATE] revealed the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart . 7. Neglect: is the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 1a. Record review of Resident #1's admission record dated [DATE] revealed an admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's order summary report dated [DATE] revealed an order of [MEDICATION NAME] tablet 325 MG give 2 tablets by mouth every 6 hours as needed for elevated temperature; moderate pain. Start date: [DATE]. Record review of Resident #1's Treatment Administration Record schedule for ,[DATE] dated [DATE] - [DATE] revealed [MEDICATION NAME] tablet 325 mg give 2 tablets by mouth every 6 hours as needed for elevated temperature; moderate pain was documented as administering to Resident #1 at 7:39 PM. Record review of Resident #1's documentation on oxygen saturation dated [DATE] revealed oxygen saturation at 1:41 AM was 97 % room air, at 9:09 AM was 95% room air, at 6:23 PM 94% room air, at 8:36 PM was 93% high flow oxygen, at 8:46 PM was 97% high flow oxygen. Record review of Resident #1's progress noted dated [DATE] at 8:49 PM written by LVN K revealed Resident presented with a 100.4 fever, this nurse and other nurse helped resident, this nurse gave him tylenol 650mg by mouth, and other nurse gave tylenol suppository to help bring down the fever, also placed resident on oxygen 6L via non-rebreather mask. Rechecked temperature of patient and it was 99.5, resident O2 sat was at 97% on 6L via non-rebreather, resident appeared stable and resting. This nurse and other nurse left room for ,[DATE] minutes to attend to other resident's needs, did not call family prior because patient appeared stable. This nurse and other nurse went to check again on the patient and patient was gasping for air and not responding to stimuli, verbal or physical. Other nurse immediately started CPR on resident, CNA went to grab crash cart and brought it to the patient's room. This nurse put AED pads on resident, turned on AED, AED said no shockable rhythm noted, other nurse continued CPR, this nurse came and called emergency responders, emergency responders came and relieved nurse of CPR duties, this nurse came to nurses' station and called responsible party of situation. Resident is currently on stretcher with EMS, providing emergency care, will monitor resident. Record review of Resident #1's SBAR - 8hr. - V2 with effective date [DATE] 20:35 revealed date and time MD or NP notified was on [DATE] at 8:30 PM Record review of EMS Patient Care Report dated [DATE] revealed EMS was notified on [DATE] at 8:20 PM. Review EMS's assessment at 8:36 PM revealed breathing absent, pulse carotid absent; mental status: unresponsive. Interview on [DATE] at 4:14 PM with LVN K she confirmed LVN L was making round shortly after dinner and saw Resident #1 was gasping for air. LVN K stated she checked Resident #1's vital signs which revealed oxygen saturation was at 80% on room air, and temperature 100.4 F. LVN K confirmed she administered Tylenol by mouth and suppository and administered 6 liters of oxygen via non-rebreather for Resident #1. LVN K stated she rechecked Resident #1's temperature and oxygen saturation which revealed 99.5 F and 97% on 6 liters of oxygen via non-rebreather mask. LVN K confirmed Resident #1 appear resting and stable, so LVN K and LVN L left Resident #1 room and went check other residents for 5 - 10 minutes. LVN K confirmed when LVN K and LVN returned and checked on Resident #1, they noticed Resident #1 was gasping for air, and Resident #1 did not respond to verbal command and sternal rub. LVN K confirmed LVN L initiated CPR, and LVN K brought crash cart. Interview on [DATE] at 4:28 PM with LVN K confirmed she initiated SBAR after calling 911, and then she notified the nurse practitioner and family. Interview on [DATE] at 5:00 PM with LVN L confirmed LVN K asked LVN L to check on Resident #1 toward the end of shift. LVN L confirmed she found out Resident #1 had elevated temperatures approximately 102-degree Fahrenheit and oxygen saturation was low at 88% on room air. LVN L confirmed she administered Tylenol 650 suppository and administered 6 liters of oxygen via non-rebreather mask. LVN L confirmed she sat with Resident #1 for 20 minutes. Then, she checked Resident #1's temperature and oxygen saturation again revealed temperature was at 99-degree Fahrenheit and oxygen saturation was 98% on 6 liters of oxygen via non-rebreather mask. LVN L stated she went out to change her PPE because her PPE was torn, and LVN K stayed with Resident #1. LVN L further confirmed she then left the unit for break and did not know if LVN K remained to stay with Resident #1 or not. LVN L stated after she went on break for about 20 minutes, and while she was talking with the receptionist, LVN K asked LVN L to come back the unit and told LVN L that I think he passed away. LVN L said she put on PPE and rushed Resident #1's room. LVN L stated she checked Resident #1 revealed no pulse and no breathing, and then she started CPR. LVN L stated Maintenance brought the crash cart, LVN K called EMS. Then, EMS came and took over the CPR. EMS tried to resuscitate Resident #1 for 45 minutes. LVN L stated LVN K had nurse practitioner and family on the phone. Interview on [DATE] at 4:50 PM with the DON confirmed according to the SBAR note the nurse had notified the doctor when she noticed Resident #1's elevated temperature and got order from the physician for Tylenol 650 mg by mouth and suppository. Interview on [DATE] at 4:55 PM with DON stated it was ok for the nurse to step out Resident #1's room after stabilizing Resident #1. Interview on [DATE] at approximately 8:49 AM with Nurse Practitioner R confirmed the nurse should have notified the physician or the nurse practitioner after stabilizing Resident #1 with Tylenol and oxygen. Nurse Practitioner R confirmed if Resident #1 was on room air or was on oxygen via nasal canula and later Resident #1 need to be on 6 liters of oxygen via non-rebreather mask, then Resident #1 had a change in condition. Nurse Practitioner R stated he did not know about Resident #1 was on 6 litters of oxygen via non-rebreather mask. Nurse Practitioner R stated the nurse at the facility communicated with him after Resident #1 expired. b. Record review of Resident #2's face sheet date [DATE] revealed an admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Order Summary Report dated [DATE] revealed order of [MEDICATION NAME] tablet 2.5 mg give 1 tablet by mouth one time a day for hypertension, [MEDICATION NAME] capsule 0.4 mg (tamsulosin HCl) give 1 capsule by mouth at bed time for enlarged prostate, [MEDICATION NAME] tablet 20 mg ([MEDICATION NAME]) give 1 tablet by mouth one time a day for blood thinner, Tylenol tablet 325 mg ([MEDICATION NAME]) give 2 tablets by mouth every 6 hours as needed for pain. Record review of Resident #2's Blood Pressure Summary dated [DATE] revealed Resident#2 had systolic blood pressure (the first number - indicated how much pressure of blood is exerting against artery walls when heart beat) from [DATE] to [DATE] was equal or greater than 90 mmHg. Record review of Resident #2's pulse summary dated [DATE] revealed Resident #2 had heart rate (pulse) from [DATE] to [DATE] was greater than 60 beat per minutes. Record review of Resident #2's vital signs was documented by LVN M on [DATE] at 9:45 AM revealed blood pressure was ,[DATE] mmHg and pulse was 59 beat per minute. Record review of Resident #2 Medication Administration Record [REDACTED]#2 on [DATE] for the morning dose. Further review revealed [MEDICATION NAME] tablet 20 mg give 1 tablet by mouth one time a day for blood thinner was documented as administered to Resident #2 on [DATE] for the morning dose. Interview on [DATE] at 11:05 AM with LVN M confirmed she documented on [DATE] at 9:45 AM bp ,[DATE] mmHg and pulse 59 beat per minute. LVN M confirmed she took Resident #2's vital signs, write them down, and moved on to another resident. LVN M confirmed she did not recheck Resident #2's blood pressure and pulse because there was nothing significant going on with Resident #2. LVN M confirmed blood pressure and pulse did not give her any alarm concern because Resident #2 just woke up and responded, therefore, LVN M did not check his blood pressure again and did not notify the physician or nurse practitioner. c. Record review of Resident #2's vital sign documented by LVN L on [DATE] at 10:01 PM revealed blood pressure was ,[DATE] mmHg and pulse was 56 beat per minute. Further review Resident #2's vital sign documented by LVN L on

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F 0607

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 8)

[DATE] at 5:41 AM revealed blood pressure was ,[DATE] mmHg and pulse was 54 beat per minute. Interview on [DATE] at 5:22 PM with LVN L confirmed she documented Resident #2's blood pressure [DATE] at 10:01 PM was ,[DATE] mmHg and blood pressure on [DATE] at 5:41 AM was ,[DATE] mmHg. LVN further confirmed on [DATE] at 5:24 PM she believed Resident #2's blood pressure - ,[DATE] mmHg and ,[DATE] mmHg was his baseline and his response was normal, so LVN L did not notify the physician or nurse practitioner. Interview on [DATE] at 3:34 PM with LVN L confirmed Resident #2's blood pressure of ,[DATE] mmHg and pulse was 56 beat per minutes and blood pressure ,[DATE] mmHg and pulse was 54, she did not check the blood pressure and the pulse again, did not review resident trending blood pressure and pulse, and she did not notify the physician or nurse practitioner because she was being told by LVN K that Resident #2's blood pressure and heart rate run low. Interview on [DATE] at 5:38 PM with the DON confirmed Resident #2's blood pressure look lower on [DATE] at 9:45 AM was ,[DATE] mmHg, [DATE] at 10:01 PM was ,[DATE] mmHg, and [DATE] at 5:41 AM was ,[DATE] mmHg. Interview on [DATE] at 5:42 PM with the DON confirmed Resident #2's pulse look lower on [DATE] at 9:45 AM was 59 beat per minute, [DATE] at 10:01 PM was 56 beat per minute, and [DATE] at 5:41 AM was 54 beat per minute. Interview on [DATE] at 5:52 PM with the DON confirmed the nurse should have called the physician or nurse practitioner on Resident #2's low blood pressure and pulse. d. Record review of Resident #3's admission record dated [DATE] with admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's order summary order dated [DATE] revealed orders of Accucheck blood sugar three times per day for [MEDICAL TREATMENT]/sliding scale, monitor vital sign every shift report any abnormal result to MD, insulin [MEDICATION NAME] solution 100 unit/mL inject 8 unit subcutaneously one time a day for diabetes. Further review revealed there was order created on [DATE] and ended [DATE] read [MEDICATION NAME] Hypokit Solution Reconstituted 1 MG inject 1 mg subcutaneously one time only for Resident blood sugar at 43 during last round for 1 day. Record review of Resident #3's progress note documented by RN J dated [DATE] at 5:08 AM revealed Resident more effort to arouse on second rounds. Vital sign taken. Resident on [MEDICAL TREATMENT] blood sugar taken to be @ 43mg/dl. [MEDICATION NAME] given. Sugar dissolved in H2O rubbed around in her gums. 30 minutes later resident more easily follows commands. Pending blood sugar value post [MEDICATION NAME] 1mg administration and added sugar to resident's gums. Further review Resident #3's progress note dated [DATE] at 5:56 AM revealed Resident able to follow commands more readily. Able to stick out tongue when giving carbohydrate source. Able to move arms on command to wipe face. B/S currently 60mg/dl 1hr post Glugacon 1mg. Interview on [DATE] at 10:40 AM RN J confirmed while he was documenting at nursing station and an aide informed him that Resident #3 was acting differently. He went to Resident #3's room and assessed her. RN J said Resident #3 was slow to answer the question, Resident #3 know her name, but did not know where she was at. RN J stated he checked her blood sugar and found out it was low, then he gave her [MEDICATION NAME] and supplemental carbohydrate because she was able to take thing by mouth. RN J confirmed the whole facility had standing order for [MEDICATION NAME] and carbohydrate supplemental if resident had low blood sugar and change level of consciousness, he stated, because you don't have time to call the provider. RN J confirmed after giving Resident #3 was given [MEDICATION NAME] and carbohydrate supplemental, she was able to response and answer question appropriately and back to her baseline. Interview on [DATE] at 10:43 AM with RN J confirmed he did not notify the physician or nurse practitioner regarding Resident #3's low blood sugar and needed [MEDICATION NAME] injection. RN J further confirmed he did not document on SBAR report, but he confirmed he document on progress note because of standing order. Interview on [DATE] at 6:11 PM with the DON confirmed the RN J should have notified the physician or nurse practitioner, and RN J should have done the SBAR because Resident #3 had change of condition due to low blood sugar. Interview on [DATE] at 6:16 PM with RN F - Regional Compliance Nurse and the DON confirmed they did not see the SBAR for the incident of Resident #3's low blood sugar on [DATE]. Interview on [DATE] at 8:59 AM with NP R confirmed for resident had low blood sugar the nurse should have used clinical judgment to assess the patient whether the patient was alert, coherent, or having [MEDICAL CONDITION] or respiratory status was stable or not. If resident need oxygen, diaphoretic, non-response, and elevated heart rate the patient can treat with [MEDICATION NAME] and watch them come out of hypoglycemic safely and the vital sign was stable. The nurse should report to the physician about resident's low blood sugar, and there would be a review of medication why patient blood sugar went so low, was it the compliance issue or diet issue, how many times happened before or resident acutely ill. If patient went to situation of blood sugar was low and being corrected with [MEDICATION NAME], once the patient stable the nurse should have check resident blood sugar every hour or at least couple hours to make sure resident eating and go back to check blood sugar as routine schedule. Interview on [DATE] at 9:03 AM NP R confirmed resident #3 had change of condition because she had symptomatic of low blood sugar and need [MEDICATION NAME], therefore, the nurse should have notified the NP or physician and complete SBAR report. Interview on [DATE] at 10:06 AM with the Medical Director confirmed depend on resident condition, if patient conscious, the nurse should administer orange juice or glucose tablet. The Medical Director further confirmed the nurse could administer [MEDICATION NAME] if there was an order was available. The Medical Director stated usually after the nurse stabilized resident with [MEDICATION NAME], the nurse should check blood sugar every 2 hours and if the blood sugar was back to normal they should check resident blood sugar on their regular schedule such as AC&HS - before meal and at bed time or every 6 hours. 2a. Record review of Resident #1's Assessments revealed the last assessment before [DATE] (6 AM - 2 PM shift) was COVID assessment dated [DATE] at 3:58 PM and the next assessment after [DATE] (2 PM -10 PM shift) was COVID assessment dated [DATE] at 00:58 AM. Further review revealed there was no COVID Assessment on [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. Interview on [DATE] at 9:21 AM with LVN I confirmed there was no COVID assessment for Resident #1 on [DATE] during 6 AM -2 PM and 2 PM -10 PM. she stated it was busy during day shift, but night shift had more time to do assessment. Interview on [DATE] at 5:27 PM with the DON confirmed she did not see the COVID Assessment for Resident #1 on [DATE] during 6AM - 2 PM shift and 2PM - 10 PM. She further confirmed she only saw other assessments documented in progress note and vital sign during 6AM - 2PM shift and 2PM - 10 PM shift. b. Record review of Resident #2's Assessments dated on [DATE] revealed Weekly Nursing summary dated [DATE] at 5:54 PM and COVID assessment dated [DATE] at 1:52 PM. Further review revealed there was no documentation on COVID Assessment on [DATE] during 2 PM - 10 PM shift. Interview on [DATE] at 3:24 PM with LVN K confirmed she worked on [DATE] during 2 PM - 10 PM shift on East Wing. LVN K further confirmed there was no COVID assessment for Resident #2 on her shift on [DATE]. LVN K explained she had 5 admissions on that day and another nurse who worked with her on that day should have done COVID assessment for Resident #2. Record review of Resident #2's Assessments revealed the last assessment before [DATE] (6AM - 2PM shift) was COVID assessment dated [DATE] at 1:52 PM and the next assessment after [DATE] (2 PM - 10 PM shift) was COVID assessment dated [DATE] at 4:22 AM. Further review revealed there was no documentation on [DATE] and [DATE] during 6 AM - 2 PM and 2 PM - 10 PM shift. Interview on [DATE] at 7:57 PM with RN H confirmed she did not have time do COVID assessment for Resident #2 on [DATE] and [DATE] during her shift 6AM - 2PM. RN H further confirmed she expected LVN I came in during 2 PM -10 PM shift to help her to complete the COVID Assessment. Interview on [DATE] at 9:16 AM with LVN I confirmed there was no COVID assessment for Resident #2 on [DATE] and [DATE] during 6 AM - 2 PM and 2 PM-10 because it was busy during the morning shift, so night shift had more time to do assessment. c. Record review of Resident #3's electronic chart on Assessments revealed Resident #3 did not have COVID assessment on [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. Record review of Resident #3's Assessment revealed there was no COVID Assessment on [DATE] during 6 AM - 2 PM shift and 2 PM - 10 PM shift. Further review revealed the assessment before [DATE] (6 AM - 2 PM shift) was Skilled Nurses Notes dated [DATE] at 01:35 AM, and the assessment after [DATE] (2 PM - 10 PM shift) was Skilled Nurse Notes dated [DATE] at 04:27 AM. Interview on [DATE] at 4:35 PM with the DON confirmed there was no COVID Assessment for Resident #3 on [DATE] during 6 AM - 2 PM and 2 PM - 10 PM shift. Interview on [DATE] at 4:38 PM with the DON confirmed the license nurse could complete COVID Assessment, Respiratory Screen, or Skilled Nurse Note to consider as assessed Resident with COVID every 12 hours. The DON further confirmed when any resident admitted to the facility, the computer would automatically generate assessment to complete every 12 hours. The DON confirmed the facility updated to assess COVID resident every 8 hours. Interview on [DATE] at 4:43 PM with the DON confirmed vital sign should be done every shift. Interview on [DATE] at 4:44 PM with the DON confirmed she monitored documentation for assessment and vital sign. The DON said if there was documentation missing, she would talk to the nurse. The DON further confirmed the licensed nurses received orientation up on hire and ongoing in-service training on what they are supposed to document on their assessment and vital sign. The DON confirmed weekly monitoring and now daily monitoring even on weekend on chart auditing on major change of condition, vital sign, and assessments. Interview on [DATE] at 4:48 PM the DON confirmed if the license nurse noticed a change of condition, he or she should stabilize the resident first, and call physician to let them know what going with resident. The DON said if the physician had new order for resident, the nurse should initiate the new order, and the nurse need to documentation the communication with doctor and family. Interview on [DATE] at 4:53 PM the DON confirmed there was ongoing in-service with license staff on Resident's change of condition by going over scenarios and getting feedback from staff. Interview on

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

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) [DATE] at 4:55 PM with the DON confirmed run report see who had change of condition, anything change in weekend and follow up with individual resident to find out why they transfer out. The DON further confirmed if there was no documentation, she would follow up with the nurse. Interview on [DATE] at 6:55 PM with the Administrator confirmed he had been rounding on the residents and they stated they were comfortable. Administrator sated they have more than an adequate supply of eye protection (face shields, goggles) available for staff. He further stated staff should be wearing eye protection when providing direct contact care. Administrator stated he was surprised they have not had positive staff in the building as he thought some of the infection control issues were due to staff becoming complacent. He sated he thought staff were being in-serviced on COVID and infection control process by agency. Interview on [DATE] at 10:03 AM with Medical Director confirmed he managed patients at the facility. He confirmed he utilized tele-monitoring to see resident at the facility. The nurse assessed the patient and if there was any issue would reported to the nurse practitioner. Then, the nurse practitioner and the doctor would have conversation online about the patient's situation. The Medical Director confirmed the facility had their own protocol on the assessment and frequency of assessing COVID residents. When the resident had change of condition the nurse should notify the nurse practitioner, then the nurse practitioner provide any necessary order and then the nurse practitioner communicated with the medical director and make change in resident plan of care as needed. Record review of COVID 19 plan dated [DATE] revealed .Resident Screening . Resident will be screened during their stay according to the following: at least daily for the following symptoms: fever, new or worse cough, new or worse shortness of breath, chills, repeated shaking with chills, new muscle pain or aches, headache, sore throat, new loss of taste or smell, new or worse dizziness, nausea/vomiting/diarrhea. If any of the above symptoms are assessed, the resident will be placed on contact/droplet precaution until further evaluation for COVID 19 . This facility will also review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019. Record review of Responding to Coronavirus (COVID-19) in Nursing Homes Responding to COVID-19 dated [DATE] revealed Resident with new-onset suspected or confirmed COVID-19: Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms. retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding on [DATE]. Record review of Notifying the Physician of Change in Status dated [DATE] revealed the nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for medicate medical attention. This facility utilizes the INTERAC tool, Change in Condition - When to Notify the MD/NP/PA to review resident condition and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition require immediate notification of the physician and non-immediate/report on next work day notification of the physician. 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in resident's clinical record . 6. The nurse will monitor and reassess the resident's status and response to interventions. Physician should develop a working [DIAGNOSES REDACTED]. 7. The nurse ill document all attempts to contact the physician, all attempt to notify the family and or legal representative, the physician's response, the physician orders [REDACTED]. 3. a. Observation on [DATE] at 5:00 PM revealed RN B walked in residents' rooms to conduct blood glucose without wearing a face shield or goggles. During an interview on [DATE] at 5:08 PM with RN B confirmed she did not wear face shield or goggle because the facility had a limited supply of eye protection available. Interview on [DATE] at 6:55 PM with the Administrator he confirmed the facility had more than an adequate supply of eye protection (face shields, goggles) available for staff. He further stated staff should be wearing eye protection when providing direct contact care. The Administrator stated he was surprised they have not had positive staff in the building as he thought some of the infection control issues were due to staff becoming complacent. The Administrator stated he thought nursing agency staff were being in-serviced on COVID and infection control process by agency. b. Observation on [DATE] at 5:10 PM revealed Housekeeper A came out of a COVID positive residents' room with a surgical mask on instead of a N95 mask. c. Observation on [DATE] at 5:10 PM revealed Housekeeper A walked out of the back door at end of hall and walked back in with just a surgical mask. Interview on [DATE] at 5:12 PM with RN B confirmed Housekeeper A was wearing surgical mask while he was working in the positive COVID Residents' rooms. RN B further confirmed Housekeeper A should have worn N95 mask while working in COVID positive unit. d. Record review of Resident #29's admission record dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:42 PM revealed CNA C did not wear gloves when she placed meal tray on a bedside table of Resident #29. Further observation revealed CNA C did not sanitize or wash her hands after exiting Resident #29's room. CNA C continue getting another meal tray at the nursing station to deliver to another resident. During an interview on [DATE] at 5:45 PM with CNA C she did not wear gloves when she took the tray into Resident #29's room. She also confirmed she did not wash or sanitize her hands after delivering the tray to Resident #29's room. CNA C further stated she had not had in-service training on caring for COVID positive residents. e. Record review of Resident #9's admission record date [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:42 PM revealed CNA D did not wear gloves when she delivered meal tray to Resident #9's room. Further observation revealed CNA D turned the light switch on in Resident #9's room and placed the meal tray on a bedside table with her bare hands. Without sanitizing or washing her hands, CNA D continued to pass out a meal tray to another resident. Interview on [DATE] at 5:47 PM with CNA D confirmed she turned the light switch on and placed the meal tray on bedside table for Resident #9 without wearing gloves. CNA D further confirmed she did not sanitize or wash her hands after exiting Resident #9's room. f. Record review of Resident #30's admission record date [DATE] revealed an admitted on [DATE] with [DIAGNOSES REDACTED]. Observation on [DATE] at 5:45 PM revealed RN E brought a meal tray into Resident #30's room and assiste
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident with an indwelling urinary catheter received appropriate treatment and services for 1 of 3 residents (Resident #5) reviewed for catheter care, in that: Resident #5 did not have a physician order for [REDACTED].#5's admission record dated 7/17/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #5's MDS admission assessment dated [DATE] revealed Resident #5 had BIMS score of 2 which indicated Resident #5 had severe cognitive impairment for daily decision making. Further review revealed indwelling catheter was documented. Record review of Resident #5's order summary dated 07/16/2020 revealed there was no physician's order for an indwelling urinary catheter and no order for catheter care. Observation on 7/13/2020 at 2:50 PM revealed Resident #5 was sitting in bed and had an indwelling urinary catheter in place with dark brown sediment within the tubing. Observation on 7/14/2020 at 2:14 PM revealed Resident #5 was lying in bed with an indwelling urinary catheter in place with dark brown sediment within the tubing. Observation on 7/15/2020 at 12:56 PM revealed Resident #5 had an indwelling urinary catheter in place with dark brown sediment within the tubing. Observation on 7/16/2020 at 1:12 PM revealed Resident #5 had an indwelling urinary catheter with dark brown sediment within the tubing. Interview on 7/17/2020 at 10:18 AM with LVN M confirmed there was no physician's order of an indwelling urinary catheter for Resident #5. LVN M stated, I don't see one while looking at Resident #5's clinical record. Interview on 7/17/2020 at 10:22 AM with LVN N confirmed Resident #5 was admitted to the facility with an indwelling urinary catheter. LVN N further confirmed there was no physician's order of an indwelling urinary catheter for Resident #5 and the order should have been entered when Resident #5 admitted to the facility. Interview on 7/17/2020 at 10:26 AM with LVN M confirmed there was dark brown sediment within the tubing of Resident #5's indwelling urinary catheter. Interview on 7/23/2020 at 10:01 AM with the DON she confirmed any resident who had indwelling urinary catheter should have a physician's order for the use of [REDACTED]. Interview on 7/23/2020 at 12:44 PM with the Regional Compliance Nurse RN F confirmed there was no policy for physician's order for indwelling urinary catheter.
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.**

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F 0726

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 10)

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interviews, and record reviews, the facility failed to ensure license nurses have the specific competencies and skills sets necessary to care for 3 of 3 residents (Residents #1, #2 and #3) who had change of condition reviewed in that: 1. LVN K and LVN L did not call the physician or nurse practitioner after Resident #1 was placed on 6 liters of oxygen via non-rebreather mask because Resident #1 had oxygen saturation at 80% on room air. 2a. LVN M did not notify physician or the nurse practitioner when Resident #2 had blood pressure dropped to ,[DATE] mmHg and pulse 59 beat per minutes on [DATE] during 6 AM - 2 PM Shift. b. LVN L did not notify the physician or the nurse practitioner when Resident #2 had blood pressure dropped to ,[DATE] mmHg and pulse 56 beat per minutes on [DATE] during 2 PM - 10 PM shift and ,[DATE] mmHg and 54 beat per minutes on [DATE] during 10 PM - 6 AM shift. 3. RN J did not notify physician after Resident #3 had low blood sugar on [DATE]. These failures could place residents in the facility with change of condition at risk for declines in health status, hospitalization or death. The findings were: 1. Record review of Resident #1's admission record dated [DATE] revealed an admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's documentation on oxygen saturation dated [DATE] revealed oxygen saturation at 1:41 AM was 97 % room air, at 9:09 AM was 95% room air, at 6:23 PM 94% room air, at 8:36 PM was 93% high flow oxygen, at 8:46 PM was 97% high flow oxygen. Record review of Resident #1's progress noted dated [DATE] at 20:49 by LVN K revealed Resident presented with a 100.4 fever, this nurse and other nurse helped resident, this nurse gave him Tylenol 650mg by mouth, and other nurse gave Tylenol suppository to help bring down the fever, also placed resident on oxygen 6L via non-rebreather mask. Rechecked temperature of patient and it was 99.5, resident o2 sat was at 97% on 6L via non-rebreather, resident appeared stable and resting. This nurse and other nurse left room for ,[DATE] minutes to attend to other resident's needs, did not call family prior because patient appeared stable. This nurse and other nurse went to check again on the patient and patient was gasping for air and not responding to stimuli, verbal or physical. Other nurse immediately started CPR on resident, CNA went to grab crash cart and brought it to the patient's room. This nurse put AED pads on resident, turned on AED, AED said no shockable rhythm noted, other nurse continued CPR, this nurse came and called emergency responders, emergency responders came and relieved nurse of CPR duties, this nurse came to nurse station and called responsible party of situation. Resident is currently on stretcher with EMS, providing emergency care, will monitor resident. Record review of Resident #1's the SBAR - 8hr. - V2 with effective date [DATE] 20:35 revealed date and time MD or NP notified was on [DATE] at 8:30 PM Record review of EMS Patient Care Report dated [DATE] revealed EMS was notified on [DATE] at 8:20 PM. Review EMS's assessment at 8:36 PM revealed breathing absent, pulse carotid absent; mental status: unresponsive. Interview on [DATE] at 4:14 PM with LVN K she confirmed LVN L was making round shortly after dinner and saw Resident #1 was gasping for air. LVN K stated she checked Resident #1's vital signs which revealed oxygen saturation was at 80% on room air, and temperature 100.4 F. LVN K confirmed she administered Tylenol by mouth and suppository and administered 6 liters of oxygen via non-rebreather for Resident #1. LVN K stated she rechecked Resident #1's temperature and oxygen saturation which revealed 99.5 F and 97% on 6 liters of oxygen via non-rebreather mask. LVN K confirmed Resident #1 appear resting and stable, so LVN K and LVN L left Resident #1 room and went check other residents for 5 - 10 minutes. LVN K confirmed when LVN K and LVN returned and checked on Resident #1, they noticed Resident #1 was gasping for air, did not respond to verbal command and sternal rub. LVN K confirmed LVN L initiated CPR, and LVN K brought crash cart. Interview on [DATE] at 4:28 PM with LVN K confirmed she initiated SBAR after calling 911, and then she notified the nurse practitioner and family. Interview on [DATE] at 5:00 PM with LVN L confirmed LVN K asked LVN L to check on Resident #1 toward the end of shift. LVN L confirmed she found out Resident #1 had elevated temperatures approximately 102-degree Fahrenheit and oxygen saturation was low at 88% on room air. LVN L confirmed she administered Tylenol 650 suppository and administered 6 liters of oxygen via non-rebreather mask. LVN L confirmed she sat with Resident #1 for 20 minutes. Then, she checked Resident #1's temperature and oxygen saturation again revealed temperature was at 99-degree Fahrenheit and oxygen saturation was 98% on 6 liters of oxygen via non-rebreather mask. LVN L stated she went out to change her PPE because her PPE was torn, and LVN K stayed with Resident #1. LVN L further confirmed she then left the unit for break and did not know if LVN K remained to stay with Resident #1. LVN L stated after she went on break for about 20 minutes, and while she was talking with the receptionist, LVN K asked LVN L to come back the unit and told LVN L that I think he passed away. LVN L said she put on PPE and rushed Resident #1's room. LVN L stated she checked Resident #1 revealed no pulse and no breathing, and then she started CPR. LVN L stated Maintenance brought the crash cart, LVN K called EMS. Then, EMS came and took over the CPR. EMS tried to resuscitate Resident #1 for 45 minutes. LVN L stated LVN K had nurse practitioner and family on the phone. Interview on [DATE] at 4:50 PM with the DON confirmed according to the SBAR note revealed the nurse had notified the doctor when she notice the resident elevated temperature and getting order from the physician for Tylenol 650 mg by mouth and suppository. Interview on [DATE] at 4:55 PM with DON confirmed it was ok for the nurse to step out Resident #1's room after stabilizing Resident #1. Interview on [DATE] at approximately 8:49 AM with Nurse Practitioner R confirmed the nurse should have been notified the physician or the nurse practitioner after stabilizing Resident #1 with Tylenol and oxygen. Nurse Practitioner R confirmed if Resident #1 was on room air or was on oxygen via nasal canula and later Resident #1 need to be on 6 liters of oxygen via non-rebreather mask, then Resident #1 had change of condition. The Nurse Practitioner R confirmed he did not know about the situation of Resident #1 was on 6 litters of oxygen via non-rebreather mask. Nurse Practitioner R further confirmed the nurse at the facility communicated with him after Resident #1 expired. 2a. Record review of Resident #2's face sheet date [DATE] revealed an admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Order Summary Report dated [DATE] revealed order of [MEDICATION NAME] tablet 2.5 mg give 1 tablet by mouth one time a day for hypertension, [MEDICATION NAME] capsule 0.4 mg (tamsulosin HCl) give 1 capsule by mouth at bed time for enlarged prostate, [MEDICATION NAME] tablet 20 mg ([MEDICATION NAME]) give 1 tablet by mouth one time a day for blood thinner, Tylenol tablet 325 mg ([MEDICATION NAME]) give 2 tablets by mouth every 6 hours as needed for pain. Record review of Resident #2's Blood Pressure Summary dated [DATE] revealed Resident#2 had systolic blood pressure (the first number - indicated how much pressure of blood is exerting against artery walls when heart beat) from [DATE] to [DATE] was equal or greater than 90 mmHg. Record review of Resident #2's pulse summary dated [DATE] revealed Resident #2 had heart rate (pulse) from [DATE] to [DATE] was greater than 60 beat per minutes. Record review of Resident #2's vital sign was documented by LVN M on [DATE] at 9:45 AM revealed blood pressure was ,[DATE] mmHg and pulse was 59 beat per minute. Record review of Resident #2 Medication Administration Record [REDACTED]#2 on [DATE] for the morning dose. Further review revealed [MEDICATION NAME] tablet 20 mg give 1 tablet by mouth one time a day for blood thinner was documented as administered to Resident #2 on [DATE] for the morning dose. Interview on [DATE] at 11:05 AM with LVN M confirmed she documented on [DATE] at 9:45 AM bp ,[DATE] mmHg and pulse 59 beat per minute. LVN M confirmed she took Resident #2's vital signs, write them down, and moved on to another resident. LVN M confirmed she did not recheck Resident #2's blood pressure and pulse because there was no significant going on with Resident #2. LVN M confirmed blood pressure and pulse did not give her any alarm concern because Resident #2 just woke up and responded, therefore, LVN M did not check his blood pressure again and did not notify the physician or nurse practitioner. b. Record review of Resident #2's vital signs documented by LVN L on [DATE] at 10:01 PM revealed blood pressure was ,[DATE] mmHg and pulse was 56 beat per minute. Further review Resident #2's vital sign documented by LVN L on [DATE] at 5:41 AM revealed blood pressure was ,[DATE] mmHg and pulse was 54 beat per minute. Interview on [DATE] at 5:22 PM with LVN L confirmed she documented Resident #2's blood pressure [DATE] at 10:01 PM was ,[DATE] mmHg and blood pressure on [DATE] at 5:41 AM was ,[DATE] mmHg. LVN further confirmed on [DATE] at 5:24 PM she believed Resident #2's blood pressure - ,[DATE] mmHg and ,[DATE] mmHg was his baseline and his response was normal, so LVN L did not notify the physician or nurse practitioner. Interview on [DATE] at 3:34 PM with LVN L confirmed Resident #2's blood pressure of ,[DATE] mmHg and pulse was 56 beat per minutes and blood pressure ,[DATE] mmHg and pulse was 54, she did not check the blood pressure and the pulse again, did not review resident trending blood pressure and pulse, and she did not notify the physician or nurse practitioner because she was being told by LVN K that Resident #2's blood pressure and heart rate run low. Interview on [DATE] at 5:38 PM with the DON confirmed Resident #2's blood pressure look lower on [DATE] at 9:45 AM was ,[DATE] mmHg, [DATE] at 10:01 PM was ,[DATE] mmHg, and [DATE] at 5:41 AM was ,[DATE] mmHg. Interview on [DATE] at 5:42 PM with the DON confirmed Resident #2's pulse look lower on [DATE] at 9:45 AM was 59 beat per minute, [DATE] at 10:01 PM was 56 beat per minute, and [DATE] at 5:41 AM was 54 beat per minute. Interview on [DATE] at 5:52 PM with the DON confirmed the nurse should have called the physician or nurse practitioner on Resident #2's low blood pressure and pulse. 3. Record review of Resident #3's admission record dated [DATE] with admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's order summary order dated [DATE] revealed orders of Accucheck blood sugar three times per day for [MEDICAL TREATMENT]/sliding scale, monitor vital sign every shift report any abnormal result to MD, insulin [MEDICATION NAME] solution 100 unit/mL inject 8 unit subcutaneously

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) one time a day for diabetes. Further review revealed there was order created on [DATE] and ended [DATE] read [MEDICATION NAME] Hypokit Solution Reconstituted 1 MG inject 1 mg subcutaneously one time only for Resident blood sugar at 43 during last round for 1 day. Record review of Resident #3's progress note documented by RN J dated [DATE] at 5:08 AM revealed Resident more effort to arouse on second rounds. Vital sign taken. Resident on [MEDICAL TREATMENT] blood sugar taken to be @ 43mg/dl. [MEDICATION NAME] given. Sugar dissolved in H2O rubbed around in her gums. 30 minutes later resident more easily follows commands. Pending blood sugar value post [MEDICATION NAME] 1mg administration and added sugar to resident's gums. Further review Resident #3's progress note dated [DATE] at 5:56 AM revealed Resident able to follow commands more readily. Able to stick out tongue when giving carbohydrate source. Able to move arms on command to wipe face. B/S currently 60mg/dl 1hr post Glugacon 1mg. Interview on [DATE] at 10:40 AM RN J confirmed while he was documenting at nursing station and an aide informed him that Resident #3 was acting differently. He went to Resident #3's room and assessed her. RN J said Resident #3 was slow to answer the question, Resident #3 know her name, but did not know where she was at. RN J stated he checked her blood sugar and found out it was low, then he gave her [MEDICATION NAME] and supplemental carbohydrate because she was able to take thing by mouth. RN J confirmed the whole facility had standing order for [MEDICATION NAME] and carbohydrate supplemental if resident had low blood sugar and change level of consciousness, he stated, because you don't have time to call the provider. RN J confirmed after giving Resident #3 was given [MEDICATION NAME] and carbohydrate supplemental, she was able to response and answer question appropriately and back to her baseline. Interview on [DATE] at 10:43 AM with RN J confirmed he did not notify the physician or nurse practitioner regarding Resident #3's low blood sugar and needed [MEDICATION NAME] injection. RN J further confirmed he did not document on SBAR report, but he confirmed he document on progress note because of standing order. Interview on [DATE] at 6:11 PM with the DON confirmed the RN J should have notified the physician or nurse practitioner, and RN J should have done the SBAR because Resident #3 had change of condition due to low blood sugar. Interview on [DATE] at 6:16 PM with RN F - Regional Compliance Nurse and the DON confirmed they did not see the SBAR for the incident of Resident #3's low blood sugar on [DATE]. Interview on [DATE] at 8:59 AM with NP R confirmed for resident had low blood sugar the nurse should have used clinical judgment to assess the patient whether the patient was alert, coherent, or having [MEDICAL CONDITION] or respiratory status was stable or not. If resident need oxygen, diaphoretic, non-response, and elevated heart rate the patient can treat with [MEDICATION NAME] and watch them come out of hypoglycemic safely and the vital sign was stable. The nurse should report to the physician about resident's low blood sugar, and there would be a review of medication why patient blood sugar went so low, was it the compliance issue or diet issue, how many times happened before or resident acutely ill. If patient went to situation of blood sugar was low and being corrected with [MEDICATION NAME], once the patient stable the nurse should have check resident blood sugar every hour or at least couple hours to make sure resident eating and go back to check blood sugar as routine schedule. Interview on [DATE] at 9:03 AM NP R confirmed resident #3 had change of condition because she had symptomatic of low blood sugar and need [MEDICATION NAME], therefore, the nurse should have notified the NP or physician and complete SBAR report. Interview on [DATE] at 10:06 AM with the Medical Director confirmed depend on resident condition, if patient conscious, the nurse should administer orange juice or glucose tablet. The Medical Director further confirmed the nurse could administer [MEDICATION NAME] if there was an order was available. The Medical Director stated usually after the nurse stabilized resident with [MEDICATION NAME], the nurse should check blood sugar every 2 hours and if the blood sugar was back to normal they should check resident blood sugar on their regular schedule such as AC&HS - before meal and at bed time or every 6 hours. Record review of Notifying the Physician of Change in Status dated [DATE] revealed the nurse should not hesitate to contact the physician at any time when an assessment and their professional judgement deem it necessary for medicate medical attention. This facility utilizes the INTERAC tool, Change in Condition - When to Notify the MD/NP/PA to review resident condition and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition require immediate notification of the physician and non-immediate/report on next work day notification of the physician. 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in resident's clinical record . 6. The nurse will monitor and reassess the resident's status and response to interventions. Physician should develop a working [DIAGNOSES REDACTED]. 7. The nurse ill document all attempts to contact the physician, all attempt to notify the family and or legal representative, the physician's response, the physician orders [REDACTED]. Based on interviews and record reviews the facility failed to protect the residents right to personal privacy and confidentiality of his or her personal and medical records, for 1 of 1 (Resident #2) reviewed for HIPPA violations, in that: Resident #2's chest x-ray was made available to a non-licensed employee of the facility. This deficient practice places the resident at risk for harm by making public confidential medical documents. The findings were: Record review of Resident #2's admission record revealed an admission date of [DATE] with a discharge date of [DATE] and [DIAGNOSES REDACTED]. Interview on [DATE] at 11:22 AM with resident #2's legal representative confirmed she was asking for her husband's status of the nurses at the facility and was disappointed, she stated she would often be put on hold and eventually the call would be terminated; The residents' legal representative states there is only one good nurse there and she is activity director S, she reports to me about my husband. Resident 2's legal representative states another family member asked activity director S for her husband's chest x-ray and activities director S emailed it to them. Interview on [DATE] at 11:45 AM with the facility's DON confirmed activities director S emailed a picture of an x-ray report to the family of Resident #2 on [DATE], using the facility's iPad. Interview on [DATE] at 2:14 PM with RN H confirmed she worked on [DATE] and [DATE] from 6:00 AM to 10:00 PM, on each day and was the charge nurse responsible for resident #2. RN H confirmed activity director S has presented herself as a nurse to the spouse of Resident #2. RN H confirms she was informed by activity director S of the family's request for the results of his chest x-ray. RN H confirmed she called the x-ray lab and asked for the x-ray results for Resident #2 be faxed to the facility. RN H confirmed upon receipt of the fax she provided the document to activity director S on [DATE]. Interview on [DATE] at 1:08 PM with activities director S confirmed she presented herself to resident #2's family as a nurse, she confirmed she asked RN H for Resident #2's chest x-ray so she could email it to the son of resident #2. Activities director S confirmed she received the document from RN H and then used the facility's iPad to take a picture and email it to Resident #2's family. Record review of the facility's policy titled Health Information Requests, Release and Production Fee Guidelines subtitled Request for copies of health information: dated ,[DATE], revealed a bullet #1 stating when someone outside of the facility requests copies of information from a residents chart it is first necessary to determine their identity and if they have legal authority to receive any information.; Once rights to the health information has been established an authorization to release health information form must be completed and sent to the director of health information management to be reviewed and approved.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs for 1 of 50 residents (Resident #15) reviewed for pharmacy services, in that: Resident #15 was not administered six doses of the medication Ruxolitinib [MEDICATION NAME] Tablet 10mg as prescribed by the physician. This failure could place residents that receive medications by mouth at risk for not receiving the therapeutic benefits of their medications. Findings include: Review of Resident #15's face sheet dated 07/14/2020 reflected an [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #15's comprehensive MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment. Review of physician orders [REDACTED]. Review of Resident #15's MAR (Medication Administration Record) and revealed Ruxolitinib [MEDICATION NAME] Tablet 10mg, was not administered the AM or PM dose on 06/25/2020, 6/26/2020, and 06/27/2020 with a note for a hold and for other reason/to see notes. Review of Resident #15's progress note dated 06/25/2020 read Ruxolitinib [MEDICATION NAME] Tablet 10mg pending pharmacy delivery. Review of Resident #15's progress note dated 06/26/2020 read Ruxolitinib [MEDICATION NAME] Tablet 10mg not available. Review of Resident #15's progress note dated 06/27/2020 read Ruxolitinib [MEDICATION NAME] Tablet 10mg on order. Resident #15 was discharged prior to investigation, attempted to contact via cell phone with no answer. During an interview on 07/23/2020 at 3:15 PM, the DON stated Resident #15 came with a bottle of medications from the hospital. The DON stated when

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	675896	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER CITY CARE CENTER	921 NOLAN ST SAN ANTONIO, TX 78202

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 12) a resident gets admitted the nurse reconciles the medication list with the Resident and physician and, then adds the orders to the MAR (Medication Administration Record). When the admission is completed, and the Resident is safe and comfortable the Nurse should then print the order form and face sheet and fax to the pharmacy. The DON stated the medication came in as a name brand medication and the nurses were not aware and were looking for a generic medication. The DON stated this is an unusual drug and was not available by the pharmacy they use for most medications, and this medication needed to be ordered from a specialty pharmacy. She stated the LVN should have notified the Charge nurse about the medication not being administered and should have called pharmacy. The DON stated a pharmacist is on call at all times and can be contacted with questions. The DON stated it was her expectation for medications to be administered as prescribed. The DON stated if there was an order for [REDACTED].#15 was admitted on [DATE] at 7:45 PM. LVN X stated she did a personal inventory of the personal belongings and found a medication bottle in the bag. Stated she had to call Resident #15's daughter for assistance with the bottle of medication. It was a bottle of Jakafi 10mg (Ruxolitinib [MEDICATION NAME] Table 10mg - Generic name) with a printed label over the generic name. LVN X stated the daughter of Resident #15 informed her that it was [MEDICAL CONDITION] medication. LVN X stated there were 10 total tablets provided and she printed out the medication list along with the admission face sheet and faxed them to the pharmacy. LVN X then placed the Ruxolitinib [MEDICATION NAME] Tablet 10mg (Brand Name - Jakafi 10mg) in the third drawer, which is the drawer for at home medications or provided medications from an acute hospital of the medication cart for the next administration time. During an interview on 07/24/2020 at 08:30 AM with LVN W revealed when it came time to administer the Ruxolitinib [MEDICATION NAME] Tablet 10mg, he could not find it. LVN W further stated he recognized this as [MEDICAL CONDITION] medication, where the medication is usually brought in by family or acute care hospital. LVN W checked the medication cart and could not locate the medication. LVN W stated he should have notified the Charge nurse or the DON. LVN W further revealed he found the Ruxolitinib [MEDICATION NAME] Tablet 10mg (Jakafi 10mg - Brand name) in the third drawer (where at home medications are stored) of the medication cart and provided to the medication aide for administering on 06/28/2020 the AM dose. Requested policy for the use of at home medications, medications provided by family, or medications provided by acute care facility on 07/23/2020 at 4:00PM the DON revealed they did not have a policy for those instances. Record review of Medication Administration Procedures policy revised on 2010/25/2017 revealed Unless medication is ordered as an emergency medication or specified as a STAT medication by the Physician, all orders are presumed to be administered on the first scheduled medication time following their arrival at the facility through normal pharmacy delivery process. Record review of Medication Reconciliation policy revised on 11/14/2016, revealed Abrupt discontinuation of many medications may result in adverse health consequences.
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** Based on interview and record review the facility failed to maintain medical records in accordance with accepted professional standards and practices that are accurately documented for 2 of 30 residents (Resident #2 and Resident #3) reviewed for records in that 1. RN H did not document on checking Resident #2 again and communication with the Nurse Practitioner after administering Tylenol for Resident #2 for temperature of 101.7F. 2. There was no vital sign for Resident #3 documented vital during 10 PM - 6 AM shift on [DATE] (10 PM - 11:59 PM on [DATE] and 12:00 AM - 6 AM on [DATE]) These deficient practices could affect residents resided in the facility and place them at risk of not receiving the necessary care, declining in health status and/or death. The findings were: 1. Record review of Resident #2's face sheet date [DATE] revealed an admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Order Summary Report dated [DATE] revealed order of [MEDICATION NAME] tablet 2.5 mg give 1 tablet by mouth one time a day for hypertension, [MEDICATION NAME] capsule 0.4 mg (tamsulosin HCl) give 1 capsule by mouth at bed time for enlarged prostate, [MEDICATION NAME] tablet 20 mg ([MEDICATION NAME]) give 1 tablet by mouth one time a day for blood thinner, Tylenol tablet 325 mg ([MEDICATION NAME]) give 2 tablets by mouth every 6 hours as needed for pain. Record review of Resident #2's temperature on [DATE] at 8:40 AM revealed 101.7-degree Fahrenheit. There was no documentation on Resident #2's temperature until 9:30 PM on [DATE]. Interview on [DATE] at 7:27 PM with RN H confirmed she did not document on the temperature after she administered Tylenol for Resident #2 because the computer and internet did not work on [DATE]. RN H further confirmed she did not document on notifying the nurse practitioner regarding Resident #2's temperature of 101.7- degree Fahrenheit because she was busy to take care of other residents. Interview on [DATE] at 6:05 PM with the DON confirmed RN did the intervention by giving resident Tylenol and re-assess the patient with effective the Tylenol in the progress note, but RN did not put the new value of temperature. 3. Record review of Resident #3's admission record dated [DATE] with admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's treatment administration record dated [DATE] - [DATE] revealed vital sign on [DATE] Eve 2 - (2 PM - 10 PM shift) documented: blood pressure ,[DATE] mmHg, temperature 96.9 F, pulse 76 beat per minute, respiration 14, oxygen saturation: 97 % and vital sign on [DATE] night (10 PM - 6 AM shift) also documented: blood pressure: ,[DATE] mmHg, temperature 96.9 F, pulse 76 beat per minute, respiration 14, oxygen saturation: 97 %. Record review of Resident #3's Skilled Nurse Notes dated [DATE] at 00:23 revealed most recent blood pressure date [DATE] at 9:30 PM: ,[DATE] lying right arm; most recent temperature dated [DATE] at 9:30 PM: 96.9 F tympanic, most recent pulse date [DATE] at 9:30 PM: 76 regular, most recent respiration dated [DATE] at 9:03 PM 14, most recent oxygen saturation date [DATE] at 9: 30 PM oxygen via nasal. Interview on [DATE] at 6:57 PM with LVN I confirmed about 5:15 AM on [DATE] while she was with another resident, CNA asked her to check on Resident #3. LVN I confirmed Resident #3 was unresponsive from verbal stimuli and pain stimuli. LVN I said she check Resident #3's apical and carotid pulse and there were no pulse and no respiration. LVN I said she called code and started compression, CNA got crash cart, LVN from another unit call 911 and help with CPR. LVN I said after while 20 - 30 EMS came took over CPR. LVN I confirmed she did not remember when the last time she saw Resident #3. Interview on [DATE] at 7:13 PM with LVN I confirmed the Skilled Nurses Notes dated [DATE] at 00:23 was the time when she had time to sit down and do paperwork. LVN I confirmed there was no vital sign for ,[DATE] shift after looking at the Treatment Administration Record. LVN I confirmed she pulled the same value of vital sign from 2 PM -10 PM shift to put in 10 PM - 6 AM. LVN I confirmed she pulled the vital sign from 2 PM - 10 PM to 10 PM - 6 AM shift because she was behind on her work and click on the computer too fast. Interview on [DATE] at 6:24 PM with the DON confirmed that the vital sign on [DATE] at 9:30 PM in the evening 2 PM -10 PM shift carried on over the night 10 PM - 6 AM shift. DON further confirmed if the nurse did not manually put the vital sign in the computer will automatically carried on from the previous shift. Interview on [DATE] at 4:43 PM with the DON confirmed vital signs should be done every shift.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment for 5 of 30 Residents (Resident #9, #27, #28, #29 and #30) reviewed for COVID-19, 3 of 30 Residents (Resident #1, #2, and #3) reviewed for COVID 19 Assessment, and 7 of 77 employees (RN B, Housekeeper A, CNA C, CNA D, RN E, LVN K, MA O) reviewed for proper PPE, in that: 1. RN B did not wear eye protection when she performed blood sugar checks for COVID positive Residents. 2a. Housekeeper A came out of a COVID positive residents' rooms went with a surgical mask instead of a N95 mask. b. Housekeeper A walked out of the back door at end of hall and walked back in with a surgical mask instead of N95 mask. 3. Housekeeper A walked out of the hot zone positive COVID hall with PPE to the warm zone and returned to the hot zone with same PPE on. 4. Staff did not wear proper PPE while working in the COVID positive unit. a. CNA C did not wear gloves when delivering meal tray to Resident #29 and did not sanitize or wash her hands after delivering meal tray. b. CNA D did not wear gloves and did not sanitize or wash her hands after touching the light switch and delivery of a meal tray to Resident #9. c. RN E did not wear a face shield or goggles when she entered to Resident #30's room to deliver a meal tray. d. LVN K did not wear a face shield or googles when she performed swab test for Resident #27 and Resident #28. e. Medication Aide O entered positive COVID unit without PPE and did not put on PPE until she entered the medication room inside the COVIVD positive unit. 5. LVN K allowed surveyor to enter the facility without screening for COVID-19 and checking surveyor's temperature. 6. a. Resident #1 did not have COVID assessment on 7/4/2020 during 6AM - 2 PM shift and 2 PM - 10 PM Shift. b. Resident #2 did not have COVID assessment on 7/3/2020 during 2PM - 10 PM shift and on 7/4/2020 and 7/5/2020 during 6 AM - 2 PM shift and 2 PM - 10 PM shift. c. Resident #3 did not have COVID assessment on 7/5/2020 during 6 AM - 2 PM shift and 2 PM - 10 PM shift. These deficient practices

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) affected residents at the facility and place them at risk of infection from transmission of communicable diseases and could result in a decline in health and/or death. These failures resulted in identification of Immediate Jeopardy (IJ) on 07/12/2020 at 10:42 PM. While the IJ was removed 7/21/2020, the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place to ensure residents were being monitored and assessed for signs and symptoms of COVID-19. The findings were: 1. Observation on 7/12/20 at 5:00 PM revealed RN B walked in residents' rooms to conduct blood glucose without wearing a face shield or goggles. During an interview on 7/12/20 at 5:08 PM with RN B confirmed she did not wear face shield or goggle because the facility had a limited supply of eye protection available. Interview on 7/12/2020 at 6:55 PM with the Administrator he confirmed the facility had more than an adequate supply of eye protection (face shields, goggles) available for staff. He further stated staff should be wearing eye protection when providing direct contact care. The Administrator stated he was surprised they have not had positive staff in the building as he thought some of the infection control issues were due to staff becoming complacent. The Administrator stated he thought nursing agency staff were being in-serviced on COVID and infection control process by agency. 2a. Observation on 7/12/20 at 5:10 PM revealed Housekeeper A came out of a COVID positive residents' room with a surgical mask on instead of a N95 mask. 2b. Observation on 7/12/20 at 5:10 PM revealed Housekeeper A walked out of the back door at end of hall and walked back in with just a surgical mask. Interview on 7/12/20 at 5:12 PM with RN B confirmed Housekeeper A was wearing surgical mask while he was working in the positive COVID Residents' rooms. RN B further confirmed Housekeeper A should have worn N95 mask while working in COVID positive unit. 3. Observation 7/12/20 at 5:15 PM revealed Housekeeper A walked out of the hot zone positive COVID hall with PPE to the warm zone and returned with same PPE on. Interview on 7/12/2020 at 5:15 PM with RN B confirmed housekeeper A went from hot zone to warm zone with the same PPE. 4. a. Record review of Resident #29's admission record dated 08/06/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on 7/12/20 at 5:42 PM revealed CNA C did not wear gloves when she placed meal tray on a bedside table of Resident #29. Further observation revealed CNA C did not sanitize or wash her hands after exiting Resident #29's room. CNA C continue getting another meal tray at the nursing station to deliver to another resident. During an interview on 7/12/20 at 5:45 PM with CNA C she did not wear gloves when she took the tray into Resident #29's room. She also confirmed she did not wash or sanitize her hands after delivering the tray to Resident #29's room. CNA C further stated she had not had in-service training on caring for COVID positive residents. b. Record review of Resident #9's admission record date 08/06/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on 7/12/20 at 5:42 PM revealed CNA D did not wear gloves when she delivered meal tray to Resident #9's room. Further observation revealed CNA D turned the light switch on in Resident #9's room and placed the meal tray on a bedside table with her bare hands. Without sanitizing or washing her hands, CNA D continued to pass out a meal tray to another resident. Interview on 7/12/20 at 5:47 PM with CNA D confirmed she turned the light switch on and placed the meal tray on bedside table for Resident #9 without wearing gloves. CNA D further confirmed she did not sanitize or wash her hands after exiting Resident #9's room. c. Record review of Resident #30's admission record date 08/06/2020 revealed an admitted on 07/03/2020 with [DIAGNOSES REDACTED]. Observation on 7/12/2020 at 5:45 PM revealed RN E brought a meal tray into Resident #30's room and assisted Resident #30 to sit up. Further observation revealed RN E did not wear face shield or googles. RN E wore regular eyeglasses. Interview on 7/12/2020 at 5:59 PM RN E confirmed she did not wear goggles or face shield because it was her first day of work, and she did not know where to get the face shield or goggles. d. Record review of Resident #27's admission record dated 08/06/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #28's admission record dated 08/06/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on 7/13/2020 at 3:23 PM revealed LVN K entered Resident #27's room with a test tube. Further observation revealed LVN K did not wear face shield or goggles. During an interview on 7/13/2020 at 3:26 PM with LVN K she confirmed she performed a COVID test for Resident #27 and did not wear face shield or goggle when she performed COVID test. LVN K stated she had hyperventilation - sustained abnormal increase in breathing when she wore a face shield or goggles. Observation on 7/13/2020 at 3:30 PM revealed LVN K exited Resident #28's room with a test tube without wearing face shield or goggles. Interview on 7/13/2020 at 3:30 PM with LVN K confirmed she just finished with COVID test for Resident #28. LVN K further confirmed she did not wear face shield or goggle when she performed the COVID for Resident #28. During an interview on 7/13/2020 at 3:37 PM with LVN DD - ADON confirmed LVN K should have worn either goggle s or face shield when she provided direct patient care. Interview on 7/23/2020 at 9:56 AM with the DON and RN E - Regional Compliance Nurse confirmed there was no staff brought to their attention about having attention that had hyperventilation or health issues when they wore face shields or goggles. The DON and Regional Compliance nurse further confirmed if any staff had medical issue s with wearing full PPE while working with COVID positive residents, the facility would transfer the staff member to a sister facility that did not have COVID positive residents and did not require full PPE. e. Observation on 7/18/2020 at 2:04 PM revealed Medication Aide - MA O entered the COVID positive unit without wearing PPE. Further observation revealed MA O put on a gown, N95 mask, gloves, and face shield in the medication room of the COVID positive unit. Interview on 7/18/2020 at 2:41 PM with MA O confirmed she put on PPE in the medication room after entering the unit because she left her goggles and N95 mask in the medication room when she went on break. Record review of the facility's policy titled PPE Use When Positive COVID Residents are in the Facility, undated, revealed COVID positive or Suspected Positive: Staff working in this area must wear gown, gloves, N95 if available, if not surgical mask, face shield or eye protection when working with COVID positive/suspect patient. If working with more than one COVID positive patient only need to change gloves and perform hand hygiene in between patients. 5. Observation on 7/17/2020 at 4:13 AM revealed LVN K opened the door for surveyor to enter the facility, and then LVN K went straight to the positive COVID unit without screening surveyor for COVID 19 and checking surveyor 's temperature. Surveyor was waiting at the front desk and in the dining area until 4:19 AM, but there was no staff came back to screen surveyor for COVID 19 and check surveyor's temperature. During an interview on 7/17/2020 at 4:57 AM with LVN K she confirmed she let the surveyor enter the facility without screening her for COVID 19 and checking her temperature. LVN K further confirmed the facility did not have receptionist during the night shift. LVN K also stated there were only 2 nurses for both units and she had to return immediately to her unit because there was a new admission who was on hospice and not doing too well. Interview on 7/23/2020 at 9:58 AM with the DON confirmed any facility staff that opened the door for a visitor to enter the facility should screen for COVID symptoms and check temperature. Record review of the facility's COVID 19 Plan dated 5/29/2020 revealed Signing in/screen of visitors, and any others who do not work in the facility will be required to sign in/be screened at the nurses' station or other area near the entrance and attest that they do not meet the criteria for entry. Information on the log includes, visitor temperature, name of visitor, resident visiting, date and time, visitor phone number and the city/state where they reside. 6. a. Record review of Resident #1's admission record dated 7/12/2020 revealed an admitted on 7/2/2020 and readmitted on 7/8/2020 with [DIAGNOSES REDACTED]. Record review of Resident #1's Assessments revealed the last assessment before 7/4/2020 (6 AM - 2 PM shift) was COVID assessment dated [DATE] at 3:58 PM and the next assessment after 7/4/2020 (2 PM -10 PM shift) was COVID assessment dated [DATE] at 00:58 AM. Further review revealed there was no COVID Assessment on 7/4/2020 during 6 AM - 2 PM shift and 2 PM - 10 PM shift. Interview on 7/15/2020 at 9:21 AM with LVN I confirmed there was no COVID assessment for Resident #1 on 7/4/2020 during 6 AM -2 PM and 2 PM -10 PM. she stated it was busy during day shift, but night shift had more time to do assessment. Interview on 7/21/2020 at 5:27 PM with the DON confirmed she did not see the COVID Assessment for Resident #1 on 7/4/2020 during 6AM - 2 PM shift and 2PM - 10 PM. She further confirmed she only saw other assessments documented in progress note and vital sign during 6AM - 2PM shift and 2PM - 10 PM shift. b. Record review of Resident #2's face sheet date 07/12/2020 revealed an admitted on 6/23/2020 with [DIAGNOSES REDACTED]. Record review of Resident #2's Assessments dated on 7/3/2020 revealed Weekly Nursing summary dated 7/3/2020 at 5:54 PM and COVID assessment dated [DATE] at 1:52 PM. Further review revealed there was no documentation on COVID Assessment on 7/3/2020 during 2 PM - 10 PM shift. Interview on 7/14/2020 at 3:24 PM with LVN K confirmed she worked on 7/3/2020 during 2 PM - 10 PM shift on East Wing. LVN K further confirmed there was no COVID assessment for Resident #2 on her shift on 7/3/2020. LVN K explained she had 5 admissions on that day and another nurse who worked with her on that day should have done COVID assessment for Resident #2. Record review of Resident #2's Assessments revealed the last assessment before 7/4/2020 (6AM - 2PM shift) was COVID assessment dated [DATE] at 1:52 PM and the next assessment after 7/5/2020 (2 PM - 10 PM shift) was COVID assessment dated [DATE] at 4:22 AM. Further review revealed there was no documentation on 7/4/2020 and 7/5/2020 during 6 AM - 2 PM and 2 PM - 10 PM shift. Interview on 7/14/2020 at 7:57 PM with RN H confirmed she did not have time do COVID assessment for Resident #2 on 7/4/2020 and 7/5/2020 during her shift 6AM - 2PM. RN H further confirmed she expected LVN I came in during 2 PM -10 PM shift to help her to complete the COVID Assessment. Interview on 7/15/2020 at 9:16 AM with LVN I confirmed there was no COVID assessment for Resident #2 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER CITY CARE CENTER	921 NOLAN ST SAN ANTONIO, TX 78202

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) 7/4/2020 and 7/5/2020 during 6 AM - 2 PM and 2 PM-10 because it was busy during the morning shift, so night shift had more time to do assessment. c. Record review of Resident #3's admission record dated 7/12/2020 with admitted on 7/2/2020 with [DIAGNOSES REDACTED]. Record review of Resident #3's Assessment revealed there was no COVID Assessment on 7/5/2020 during 6 AM - 2 PM shift and 2 PM - 10 PM shift. Further review revealed the assessment before 7/5/2020 (6 AM - 2 PM shift) was Skilled Nurses Notes dated 7/5/2020 at 01:35 AM, and the assessment after 7/5/2020 (2 PM - 10 PM shift) was Skilled Nurse Notes dated 7/6/2020 at 04:27 AM. Interview on 7/23/2020 at 4:35 PM with the DON confirmed there was no COVID Assessment for Resident #3 on 7/5/2020 during 6 AM - 2 PM and 2 PM - 10 PM shift. Interview on 7/23/2020 at 4:38 PM with the DON confirmed the license nurse could complete COVID Assessment, Respiratory Screen, or Skilled Nurse Note to consider as assessed Resident with COVID every 12 hours. The DON further confirmed when any resident admitted to the facility, the computer would automatically generate assessment to complete every 12 hours. The DON confirmed the facility updated to assess COVID resident every 8 hours. Interview on 7/23/2020 at 4:43 PM with the DON confirmed vital sign should be done every shift. Interview on 7/23/2020 at 4:44 PM with the DON confirmed she monitored documentation for assessment and vital sign. The DON said if there was documentation missing, she would talk to the nurse. The DON further confirmed the licensed nurse was received orientation up on hire and ongoing in-service on what they supposed to document on their assessment and vital sign. The DON confirmed weekly monitoring and now daily monitoring even on weekend on chart auditing on major change of condition, vital sign, and assessments. Interview on 7/23/2020 at 4:48 PM with the DON confirmed if the license nurse noticed a change of condition, he or she should stabilize the resident first, and call physician to let them know what going with resident. The DON said if the physician had new order for resident, the nurse should initiate the new order, and the nurse need to documentation the communication with doctor and family. Interview on 7/23/2020 at 4:53 PM the DON confirmed there was ongoing in-service with license staff on Resident's change of condition by going over scenarios and getting feedback from staff. Interview on 7/23/2020 at 4:55 PM with the DON confirmed run report see who had change of condition, anything change in weekend and follow up with individual resident to find out why they transfer out. the DON further confirmed if there was no documentation, she would follow up with the nurse. Interview on 7/12/20 at 6:55 PM with the Administrator confirmed he had been rounding on the residents and they stated they were comfortable. Administrator sated they have more than an adequate supply of eye protection (face shields, goggles) available for staff. He further stated staff should be wearing eye protection when providing direct contact care. Administrator stated he was surprised they have not had positive staff in the building as he thought some of the infection control issues were due to staff becoming complacent. He sated he thought staff were being in-serviced on COVID and infection control process by agency. Interview on 7/24/2020 at 10:03 AM with Medical Director confirmed he managed patient at the facility. He confirmed he utilized tele-monitoring to see resident at the facility. The nurse assessed the patient and if there was any issue would reported to the nurse practitioner. Then, the nurse practitioner and the doctor would have conversation online about the patient's situation. The Medical Director confirmed the facility had their own protocol on the assessment and frequency of assessing COVID residents. When the resident had change of condition the nurse should notify the nurse practitioner, then the nurse practitioner provide any necessary order and then the nurse practitioner communicated with the medical director and make change in resident plan of care as needed. Record review of COVID 19 plan dated 5/29/2020 revealed .Resident Screening . Resident will be screened during their stay according to the following: at least daily for the following symptoms: fever, new or worse cough, new or worse shortness of breath, chills, repeated shaking with chills, new muscle pain or aches, headache, sore throat, new loss of taste or smell, new or worse dizziness, nausea/vomiting/diarrhea. If any of the above symptoms are assessed, the resident will be placed on contact/droplet precaution until further evaluation for COVID 19 . This facility will also review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019. Record review of Responding to Coronavirus (COVID-19) in Nursing Homes Responding to COVID-19 dated 4/30/2020 revealed Resident with new-onset suspected or confirmed COVID-19: Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections. Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms. retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding on 7/28/2020. The Administrator was notified on IJ on 7/12/2020 at 10:42 PM and was given a copy of the IJ templated and a Plan of Removal was requested. The Plan of Removal accepted on 7/17/2020 at 11:50 AM. On 07/13/2020 at 5:47 PM Plan of Removal received from the DON. The facility's Plan of Removal included the following steps to be taken by the facility: ALLEGED ALLEGATION: Infection Control: Staff did not use proper handwashing. Staff did not complete proper DONNING/DOFFING when leaving the specific unit. Staff did not wear correct PPE such as goggles and face shield Interventions: The following in-services were initiated by the DON, ADON and regional nurse on 7/12/20: Any staff member not present or in-serviced on 7/12/20, will not be allowed to assume their duties until in-serviced. Staff will be (in-serviced) on the following: DONNING/DOFFING - Staff will be (re-in-serviced) on donning and doffing sequencing All Agency staff will be orientated to the facility and (in-serviced) on proper Donning/Doffing and handwashing. The medical director was notified of the immediate jeopardy situation on 11:39pm (7/12/2020) Monitoring: The DON / designee will observe PPE use by randomly selecting 10 staff members weekly on various shifts including weekends. The DON / designee will observe handwashing techniques randomly on 10 staff members weekly on various shifts including weekends The QA committee will review findings and makes changes as needed. ALLEGED ALLEGATIONS: Documentation / Neglect: Staff facility failed to assess residents' vital signs and signs and symptoms of COVID residents. Interventions: The following in-services were initiated by the DON, ADON and regional nurse on 7/12/20: Any staff member not present or in-serviced on 7/12/20, will not be allowed to assume their duties until in-serviced. Licensed Nurses will be In Service on the following: In- Service on Documentation in PCC In-Service on COVID Assessment q shift - completing COVID Assessment Q shift In Service on obtaining Vital Signs - Inservice on Obtaining Vital Signs each shift and as needed. Inservice on Change of Condition which includes a specific change and Physician/NP notification, and any interventions or orders. In service on Abuse/Neglect The medical director was notified of the immediate jeopardy situation on 11:39pm (on 7/12/2020) Monitoring The DON / designee will monitor scheduled assessments 7 days a week to ensure all assessments were completed. The Don/designee will ask 10 nurses randomly on various shifts per week for 6 weeks What they would do and document if a resident had a change of condition. The DON / designee will review the 24-hour report 7 days a week to ensure COVID assessments are done each shift and vital signs are taken as ordered. The QA committee will review findings and makes changes as needed. The surveyor verification of the Plan of Removal on 7/18/2020 was as follows: Interview on 7/18/2020 at 2:22 PM with LVN W confirmed he got in-service/training on completing COVID assessments every shift, checked resident vital sign every 4 hour, call physician and document on Resident change of change of condition under SBAR form because COVID patient changed drastically. LVN W further confirmed resident change of condition could be resident become confused, decrease in urine output, or vital sign was out of range. LVN W confirmed he received and understood in-service/training on infection control such as PPE requirements in COVID unit, don-doff PPE, and hand washing. LVN W stated PPE included gown, gloves, N95, and face shield needed to put on before entering the COVID unit. LVN W confirmed PPE needed to be removed before exiting the COVID unit. Interview on 7/18/2020 at 3:53 PM with agency staff - LVN Z and EMT AA confirmed they received and understood the training on infection control such as donning PPE before entering COVID unit and doffing PPE before exiting COVID, and hand washing. LVN Z and EMT AA confirmed COVID assessment need to complete every shift and vital sign every 4 hour for COVID residents. LVN Z and EMT AA also confirmed receiving training on abuse and neglect. Observation on 7/18/2020 at 4:36 PM revealed RN BB washed hands before checking resident #25's blood sugar and before exiting the resident#25's room. Interview on 7/18/2020 at 4:50 PM with RN BB confirmed he received training on infection control donning on and donning off PPE while working in COVID unit. RN BB confirmed he got training on documentation in PCC regarding completing COVID assessment, document vital sign, and documentation on notify physician when resident had change of condition. RN BB further confirmed received training on abuse and neglect. Interview on 7/18/2020 at 4:57 PM with RN B confirmed she received and understood training on PPE requirement while working in COVID and sequence of don/doff PPE. RN B also confirmed she received training on documentation of COVID Assessment, vital sign, notifying physician and document on resident's change of condition Interview on 7/18/2020 at 5:11 PM with LVN CC confirmed she received training on hand washing, need to put on N95, face shield, gown, and gloves when working in COVID unit. LVN CC confirmed the need to put on PPE before entering COVID unit and taking PPE off before exiting COVID unit. LVN CC confirmed she received training during mandatory meeting about documentation. LVN CC confirmed documentation on COVID assessment, vital signs. LVN CC confirmed she need to inform the physician when resident had any change such as vital sign off baseline and residents not their normal self. LVN CC confirmed she need to document on intervention, notifying physician and imitated SBAR form. LVN CC

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F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 15) confirmed she received training on abuse and neglect. Observation on 7/18/2020 at 5:31 PM revealed LVN Z took off gown, gloves, and face shield. Further observation LVN Z washed her hands before exiting the COVID unit on West Wing. Interview on 7/18/2020 at 7:21 PM with LVN I confirmed she received in-service training on how to don - doff PPE. LVN I also confirmed she received in-service training on documentation on PCC such as SBAR form for resident change of condition, vital sign and COVID assessment. Observation on 7/18/2020 at 7:27 PM revealed LVN I already wore N95 mask. LVN I put on gown, gloves, and face shield before entering the COVID unit on East Wing. Interview on 7/19/2020 at 12:46 PM with Maintenance Assistant EE confirmed she received and understood training on Infection Control regarding PPE which included N95, gown, face shield/goggles and gloves before entering COVID unit and to take took off all PPE before exiting COVID unit. Interview on 7/19/2020 at 1:54 PM with housekeeper A - 2 pm - 10 pm shift receiving and understanding the training on infection control such as PEE to work in the COVID unit include gown, gloves, mask, face shield, and boot. Housekeeping A confirmed he need to put on PPE before entering the COVID unit. Housekeeping A confirmed took off gown, gloves, and face shield before exiting the COVID unit. Interview on 7/19/2020 at 2:06 PM with CNA FF - agency staff - confirmed receiving infection control in-service on 7/17/2020. She further confirmed she understood the infection control in-service included gloves use, hand washing, and procedure of removing PPE and putting on PPE. Interview on 7/19/2020 at 2:12 PM with Housekeeper GG - confirmed getting on infection control on 7/17/2020. Housekeeper GG confirmed PPE requirements for working in COVID unit including gloves, N95, face shield, and gown. Housekeeper GG confirmed the in-service was also about don and doff PPE and sanitize between gloves changes. Record review of the facility in-service training attendance roster titled Completing COVID Assessment - Nurse will complete COVID Assessment on Resident Q shift. Each shift will obtain new set up vital signs and assess resident and complete COVID assessment dated [DATE] revealed 14 of 14 Licensed staff signed the in-service roster; 7 of 7 licensed agency nurses signed the in-service roster Record review of facility in-service training attendance roster titled Notifying the physician of change in status dated 7/13/2020 revealed 14 of 14 Licensed staff signed the in-service roster; 7 of 7 licensed agency nurses signed the in-service roster. Record review of the facility in-service training attendance Roster titled infection control overview dated 7/13/2020 revealed 40 of 66 staff signed the in-service roster; 13 of 13 agency staff signed the in-service roster; and 6 of 6 therapy signed the in-service roster. Record review of the facility in-service training attendance Roster titled with Proper PPE use on the COVID unit dated 7/13/2020 revealed 42 of 66 staff signed the in-service roster; 11 of 13 agency staff signed the in-service roster; 2 of 6 therapy staff signed the in-service roster. Record review of the facility in-service training attendance roster titled Infection control - handwashing dated 7/13/20 revealed 29 of 66 staff signed the in-service roster, 6 of 6 therapy staff signed the in-service roster. 1 of13 agency staff signed the in-service roster. Record review on PPE Monitoring - Random PPE Donning/Doffing Review revealed DON checked 3 staff on 7/13; 2 staff on 7/14; 2 staff on 7/15; 1 staff on 7/16; 2 staff on 7/17; 3 staff on 7/18; 3 staff on 7/19; 3 staff on 7/20. Record review on Handwashing Monitoring revealed DON check on staff each day from 7/17/2020 to 7/20/2020 On 4/21/2020 at 4:41 PM, the Area Director of Operations, Regional Compliance Nurse - RN F, Assistant Administrator, Director of Nursing, and LVN G - Assistant Director of Nursing were informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm with a scope identified as a pattern due to residents on-going need for assessments for signs and symptoms of COVID-19. .
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observations, interviews and record reviews the facility failed to provide a safe, functional, and comfortable environment for residents, staff and the public, for 50 of 50 residents reviewed for safety and comfort, in that; 1) Resident #4 was hospitalized and deceased complicated by the heat in his room. 2) Resident #6 Complained of heat discomfort. The temerature in Resident #6's Bedroom was 83 degrees Fahrenheit. 3) Resident #7 Complained of heat discomfort. The temerature in Resident #7's Bedroom was 84 degrees Fahrenheit. 4) Resident #19's room temperature was 81.6 degrees Fahrenheit. Resident #19 was not interview able. 5) Resident #13 stated it was hot and uncomfortable, room temperature read 78.8 degrees Fahrenheit in room. There was a portable air conditioner unit set to 63.0 degrees Fahrenheit and a circulating fan. 6) Resident #10's room temperature was 82.2 degrees Fahrenheit. Resident #10 was not interview able. 7) Resident #16's room temperature was 82.4 degrees Fahrenheit. Resident was sleeping, not using sheet and blanket which was at the bottom of the bed. 8) Resident #17's room temperature was 81 degrees Fahrenheit. Portable air conditioning unit set to 63.0 degrees Fahrenheit, placed by window. Resident #17 was not benefitting from the portable air conditioning unit. 9) Resident #20 room temperature was 79.9 degrees Fahrenheit. Portable air conditioning unit set to 63.0 degrees Fahrenheit, placed by window. 10) Resident #18's room temperature was 81.8 degrees Fahrenheit. Resident #18 was awake during temperature checks but did not answer questions. 11) Resident #21's room temperature was 82.4 degrees Fahrenheit. Resident #21 was sleeping during room temperature checks. 12) Resident #22's room temperature was 82.4 degrees Fahrenheit. Resident #22 was sleeping during room temperature checks. 13) Resident #23's room temperature was 81.2 degrees Fahrenheit. Resident #23 was not interviewable. 14) Resident #24's room temperature was 81.5 degrees Fahrenheit. Resident #24was not interview able, staff was in room with resident. This deficient practice placed the residents at risk for declines and complications in their health. The findings were: 1) Observation on [DATE] at 5:20 PM of the east wing of the facility revealed no hallway heating ventilation air-conditioning vent between rooms 40 to 51. Air temperature measurements of the single HVAC vents in rooms #41 was 84' Fahrenheit, room [ROOM NUMBER] 83' Fahrenheit, and room [ROOM NUMBER] was 84' Fahrenheit. Record review of Resident #4's admission record revealed an admitted [DATE] and a discharge date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #4's census report revealed he was moved from room [ROOM NUMBER] to room [ROOM NUMBER] on [DATE]. Record review of Resident #4's progress notes revealed an entry on [DATE] at 6:00 PM, authored by RN H stating Pt in respiratory distress/ unresponsive. 911 called and transferred to downtown (local hospital.) (family) notified. Interview on [DATE] at 10:20 AM with Resident #4's family confirmed resident #1 was admitted to the hospital on [DATE] with the [DIAGNOSES REDACTED]. Interview on [DATE] at 2:14 PM with RN H confirmed she worked on [DATE] and [DATE] from 6:00 AM to 10:00 PM, on each day and was the charge nurse responsible for resident #4. She confirmed Resident #4 had refused some medications and fluids and had presented with mental confusion and developed a fever on [DATE] and [DATE]. RN H confirmed the air condition in the facility was not cooling the facility well and was very uncomfortable for Resident #4 on [DATE] and [DATE]. RN H confirmed she attempted to perform nursing interventions and offered Resident #4 water and applyed wet towels to his person. RN H confirmed she moved Resident #4 from room [ROOM NUMBER] to room [ROOM NUMBER] on [DATE], related to room [ROOM NUMBER] was cooler than room [ROOM NUMBER]. RN H confirmed on [DATE] she called emergency services 911 and sent Resident #4 to the hospital related to heat induced convulsions. 2) Record review of Resident #6's admission record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's census record revealed him to reside in room [ROOM NUMBER]. Observation on [DATE] at 5:22 PM of resident #6's bedroom revealed a temerature at the single HVAC vent to be 83 degrees Fahrenheit. Interview on [DATE] at 5:30 PM with Resident #6 confirmed he resides in room [ROOM NUMBER], he states he was hot and suffering on the weekend of [DATE]. Resident #6 states the room feels cooler now, but he is still uncomfortable even with a portable temporary fan in the room. 3) Record review of Resident #7's admission record revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's census record revealed him to reside in room [ROOM NUMBER]. Observation on [DATE] at 5:23 PM of Resident #7's bedroom revealed a temerature at the single HVAC vent to be 84 degrees Fahrenheit. Interview on [DATE] at 5:30 PM with Resident #7 confirmed he resides in room [ROOM NUMBER], he states he was hot and suffering on the weekend of [DATE]. Resident #7 states the room feels cooler now, but he is still uncomfortable even with a portable temporary fan in the room. 4) Record review of Resident #19's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #19's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #19's admission MDS dated [DATE] revealed Resident #19 had a BIMS score of 2, which indicates severe cognitive impact. 5) Record review of Resident #13's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #13's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #13's admission MDS dated [DATE] revealed Resident #13 had a BIMS score of 9 which indicates moderate cognitive impairment. 6) Record review of Resident #10's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of

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F 0921

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 16)

Resident #10's census record revealed to reside in room [ROOM NUMBER]-B. Record review of Resident #10's admission MDS dated [DATE] revealed a BIMS score was not obtained due to severe cognitive impairment. 7) Record review of Resident #16's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #16's admission MDS dated [DATE] revealed a BIMS score of 8 which indicates moderate cognitive impairment. 8) Record review of Resident #17's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #17's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #17's admission MDS dated [DATE] revealed a BIMS score of 15 which indicates normal cognitive ability. 9) Record review of Resident #20's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]., age-related physical disability. Record review of Resident #20's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #20's admission MDS dated [DATE] revealed a BIMS score was not obtained due to severe cognitive impairment. 10) Record review of Resident #18's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #18's census record revealed to reside in room [ROOM NUMBER]-B. Record review of Resident #18's admission MDS dated [DATE] revealed a BIMS score of 5 which indicates moderate cognitive impairment. 11) Record review of Resident #21's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #21's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #21's admission MDS dated [DATE] revealed a BIMS score of 4 which indicates severe cognitive impact. 12) Record review of Resident #22's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #22's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #22's admission MDS dated [DATE] revealed a BIMS score of 9 which indicates moderate cognitive impairment. 13) Record review of Resident #23's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #23's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #23's admission MDS dated [DATE] revealed a BIMS score of 9 which indicates moderate cognitive impairment. 14) Record review of Resident #24's face sheet dated [DATE] revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #24's census record revealed to reside in room [ROOM NUMBER]-A. Record review of Resident #24's admission MDS dated [DATE] revealed a BIMS score of 14 which indicates normal cognitive ability. 1,2, & 3) Observation on [DATE] at 5:00 PM of the facility's outdoor HVAC system compressors and condensers revealed them lacking insulation on the return cold gas [MEDICATION NAME] piping leading into the building with condensation. Observation on [DATE] at 5:20 PM of the east wing of the facility revealed no hallway heating ventilation air-conditioning vent between rooms 40 to 51. Air temperature measurement of the single HVAC vent in rooms #41 was 84' Fahrenheit, room [ROOM NUMBER] 83' Fahrenheit, and room [ROOM NUMBER] was 84' Fahrenheit; Air temperature measurement of the single HVAC vent in room [ROOM NUMBER] was 68' Fahrenheit. Interview on [DATE] at 3:30 PM with the facility Administrator confirmed he learned on [DATE] of the warm temperatures in the facility, stating he contacted the facility's Maintenance Director whom contacted the Regional Maintenance Supervisor P and the three coordinated with Cold Air and Heat contractor T to assess the failure of their HVAC system. On [DATE] in the afternoon the facility bought temporary air conditioners and fans and deployed them throughout the home and in residents' rooms. Beginning on [DATE] in the afternoon the HVAC contractor T worked on site with the facility's maintenance staff to repair and replace HVAC systems. The facility purchased a new outdoor 5-ton compressor-condenser and the contractor installed it on [DATE] at 2:00 PM. Interview on [DATE] at 3:50 PM with the Cold Air & Heat contractor T confirmed he was contracted by the facility for HVAC failure evaluation and repair, stating the facility's outdoor HVAC compressor / condensers were dirty, lacking refrigerant, and lacking insulation, causing them to struggle with the heat. Interview on [DATE] at 4:00 PM with the facility's maintenance director confirmed the facility's HVAC system failed on the weekend of ,[DATE] to [DATE], stating he and his staff contacted the HVAC contractor and facilitated the repair and replacement to the HVAC system with the installation of a new outdoor air conditioning compressor-condenser unit and deploying temporary fans and water coolers down the hallways. The maintenance director confirmed the Cold Air & Heat contractor T cleaned and recharged several other condensers / compressors. Interview on [DATE] at 5:00 PM with the maintenance director confirmed the east wing hallway has no HVAC vent between rooms 40 to 51 and air temperature measurement of the single HVAC vent in rooms #41 was 84' Fahrenheit, room [ROOM NUMBER] 83' Fahrenheit, and room [ROOM NUMBER] was 84' Fahrenheit. The maintenance director confirmed several condensers / compressor units were lacking insulation and would replace the insulation on the piping. Record review of the facility's HVAC contractor receipts for the period ,[DATE] to [DATE] revealed a receipt dated [DATE] from HVAC contractor T from Cold Air & Heat stating was out on both [DATE]th and 5th at night during day. Found unit G, H, I, and J struggling thru heat unit H lost compressor. Record review of the facility's HVAC contractor receipts for the period ,[DATE] to [DATE] revealed a letter from Reynolds Heating and Air a HVAC contractor, dated [DATE], stating Over the weekend of 4th & 5th July we discussed at various times differential temperatures in the building and solutions. I recommended several checks to ensure correct head temperatures, cleanliness of coils and temperatures in the attic .several options to increase air flow, these being the installation of additional roof top units, mini split systems and additional vents in the halls where needed. ,[DATE]) Observation on [DATE] from 1:10 PM to 5:00 PM observed temperatures in front lobby, East Wing, and West wing to be over 81 degrees Fahrenheit. Individual/Portable air conditioners in every resident room observed with circulating fans, which did not lower temperatures to be below 81 degrees Fahrenheit in all resident rooms. All temperatures were obtained via Maintenance P's laser thermometer. Maintenance P stated he is a corporate ambassador of buildings and oversees this building. Interview on [DATE] at 2:07PM with LVN T, stated it gets hot when moving around, the company has been working on the air conditioner for over 2 weeks. Interview on [DATE] at 2:11PM with CNA U stated, providing ice water often makes the resident more comfortable, there have been residents complaining about the heat and CNA U notified the charge nurse. Observation on [DATE] at 2:18 PM lobby/dining room thermostat read 81.0 degrees Fahrenheit. Interview on [DATE] at 2:30PM with Housekeeper A stated it has been hot in the facility for the last month, states he often sweats through his clothes while working. Observation on [DATE] at 2:53 PM thermostat in West Wing hallway to be 88.0 degrees Fahrenheit. Observation on [DATE] from 1:48 PM to 3:05 PM observations in Lobby/Dining area, West wing, and East wing continue to be over 81 degrees Fahrenheit. Individual/Portable air conditioner units in every resident room with circulating fans, which did not lower all temperatures below 81 degrees Fahrenheit. Observation on [DATE] from 12:15 PM to 3:26 PM Reynolds air conditioning arrived at facility. Started replacing 3 air conditioning units. Interview on [DATE] at 3:45PM with Contractor Y stated, maintenance on air conditioning units needed to be done twice a year, after 3 air condition units went down there was too much pressure on the rest of the system which ultimately shut down the entire system. Three 5-ton air conditioning units are being replaced and 2 additional air condition units are to be added to each hallway. Observation on [DATE] from 1:00PM to 5:00PM observed temperatures to be below 81.0 degrees Fahrenheit. Observation on [DATE] from 1:10 PM - 3:30 PM Reynolds Air Conditioning adding two new air conditioning units to West wing and East wing., also observed new return vents being added to the end of each hall by the exit door. Temperatures were over 81 degrees Fahrenheit while work was being done, individual air conditioning units and circulating fans to negate hot air coming in from exit doors and attic access panels. Observation on [DATE] from 12:00 PM to 2:30 PM revealed temperature to be below 75 degrees Fahrenheit in all areas. No temperature observed to be over regulation at this time. Reynolds Air Conditioner company still completing work to facility. Observation on [DATE] 09:30 AM - 3:30 PM Temperatures were within regulations; all air conditioning wok has been completed. Interview on [DATE] at 2:00PM with Maintenance P revealed there has been problems with the air conditioning not cooling the building on very hot days for a few months. On [DATE] Cool Texas Air was out to inspect the units and recommended at that time there was a need to replace all AC units. The Maintenance Director at the time sent the recommendation up the chain of command but due to overall cost they chose to get a second opinion from Reynolds Heating and Air. On [DATE] Reynolds Heating and Air came to facility and denied that all AC units needed to be replaced, the contractor replaced valves and pistons, closed the ticket and left the facility. Maintenance P then stated he was notified on [DATE] and notified about the heat and air conditioning problems. Stated he went to a sister facility to obtain portable air conditioning units to place in every resident room. Called Duke Cold Air and Heat to come in and check the status, this resulted in finding a low pressure in one unit and freon added to another unit. The company left that day and the work order was closed. Maintenance P stated he checked the temperatures later that day and was between ,[DATE] degrees Fahrenheit. Maintenance P stated he came to facility every day and throughout the night to check temperatures. On [DATE] Maintenance P brought more portable air conditioning units and circulating fans to help cool the building. At this time Maintenance P decided to call another contractor to check the air conditioning units. Texas Cold Air and Heating came and advised the units were working as they should. Maintenance P still not satisfied called yet another contractor Reynolds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVER CITY CARE CENTER	**921 NOLAN ST SAN ANTONIO, TX 78202**

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 17) Heating and Air arrived at facility on [DATE] and replaced 3 AC units, and added 1 AC unit to East wing, and another added to the West wing.