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 _____	03/13/2020

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 0577 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on observation, record review and interview, the facility failed to have reports with respect to any complaint investigations made respecting the facility during the three preceding years, and any plan of correction in effect with respect to the facility available for any individual to review upon request in a place readily available for the availability of survey results for 3 of 4 days during the survey. The facility failed to have investigation reports with the plan of corrections available for family members and residents to review. This failure could affect residents who resided in the facility and could result in a lack of awareness for visitors, family and residents regarding of the investigation results and the plan of corrections submitted by the facility. The findings were: During the Resident Council Meeting on 3/11/20 at 10:07 a.m., residents revealed they were not sure where the survey binder, which is a binder used to hold the survey and investigation reports, was kept. During an interview on 3/12/20 at 9:33 a.m., the DON revealed she had the survey report binder in her office because there was a resident that would tear it up if they left it at the receptionist desk. Observation of a bulletin board behind the receptionist desk on 3/12/20 at 11:11 a.m. revealed a sign which read the survey binder was in the DON's office. Record review of the survey binder revealed the report in the binder was from the last survey on 8/28/19. Further review revealed no documented evidence of the investigation results conducted on 11/13/19, 12/19/19 and 1/08/20. During an interview with the DON at 11:13 a.m., the DON confirmed the last report in the survey binder was from the last survey on 8/28/19. The DON reported she was not aware the investigation reports also had to be in the survey binder.
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide notice to residents when changes in coverage were made to items and services covered by Medicare as soon as reasonably possible for 1 of 3 residents (Resident #24) reviewed for Medicare discharges. Resident #24 was not given a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) when she was discharged from skilled services. This failure could affect residents who received skilled services and place them at risk for not being provided with information regarding a discharge from services covered by Medicare and their right to appeal. The findings included: Review of Resident #24's face sheet, dated 3/13/20, revealed the resident was admitted on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #24's SNF Beneficiary Protection Notification Review form, provided by the facility on 3/11/20, reflected the resident's Medicare Part A skilled services episode start date was 1/23/20, and the last day covered was 2/09/20. Under the question, How was the Medicare Part A Service Termination/Discharge determined? A check mark was next to the following, The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. The form further reflected Resident #24 was provided a SNFABN and NOMNC (Notice of Medicare Non-Coverage). Record review of Resident #24's clinical record revealed she was provided a NOMNC but not an SNFABN. During an interview on 3/10/20 at 4:30 p.m., the MDS Coordinator confirmed Resident #24 received a NOMNC, but not an SNFABN because the resident initiated her discharge from skilled services. Record review of Resident #24's SLP, OT and PT Discharge Summaries, revealed the reason for discharge was change in payer source for the OT discharge summary and highest practical level achieved as the reason for the PT and SLP discharge. During an interview on 3/11/20 at 9:35 a.m., the MDS Coordinator reported he spoke with the Therapy department staff and they confirmed the resident was discharged from skilled services because she refused the services. The MDS Coordinator confirmed the OT, PT and SLP discharge summaries indicated Resident #24's discharge from services was because of a change in payer source and that she reached the highest practical level. During an interview with OTA J on 3/11/20 at 9:37 a.m., OTA J confirmed Resident #24 was receiving OT services. OTA J confirmed the resident was discharged from OT services because she changed from a payer source of Medicare part A to part B services. During an interview on 3/11/20 at 9:41 a.m., the MDS Coordinator revealed Resident #24 had 81 days remaining that were unused.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure resident assessments accurately reflected the resident's status for 1 of 14 residents (Resident #25) whose MDS assessments were reviewed in that: Resident #25's Annual MDS indicated the resident was not determined by the level 2 Preadmission Screening and Resident Review (PASRR) as having mental illness when the resident was found to have a positive [DIAGNOSES REDACTED]. This deficient practice could affect residents who are PASRR positive and could place them at risk of inappropriate care based on inaccurate assessment. The findings were: Record review of Resident #25's face sheet, dated 2/28/20, revealed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #25's Annual MDS, dated [DATE], documented the resident had a BIMS score of 6, indicating the resident was severely cognitively impaired. The MDS also indicated the resident had been evaluated by Level II PASRR and not was determined to have serious mental illness and/or mental [MEDICAL CONDITION] or a related condition. Review of Resident #25's PASSR level 1 (PL 1), dated 7/25/19, indicated there was evidence or an indicator this was an individual that had a mental illness. Review of Resident #25's PASSR Evaluation or PASRR Level 2 (PE), dated 7/29/19, documented the resident did meet the PASRR definition of mental illness and recommended the Local Authority (LA) provide the resident with individualized skills training. Record review of Resident #25's Initial IDT Meeting Notes, dated 8/07/19, revealed the LA was going to provide Resident #25 with individualized medication and individuals skills training. Review of Resident #25's Care Plan, dated last revised 1/29/20, revealed the resident had a focus of Resident has MI, ID, or DD and is PASRR positive with an intervention of specialized services will be provided per LA recommendations. During an interview 3/12/20 at 2:13 p.m., the MDS Coordinator confirmed Resident #25's most recent Annual MDS indicated the resident was not determined by the PE to have a serious mental illness. The MDS Coordinator also confirmed Resident #25's PE indicated the resident met the criteria for PASRR services due to her mental illness. The MDS Coordinator reported he may have codes the MDS as not meeting the PE definition for serious mental illness because the facility was not recommended to provide any PASRR specialized services. The MDS Coordinator confirmed the Annual MDS needed to be corrected.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**

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

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 _____	03/13/2020

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan for three (#16, #40 and #61) of twenty-two reviewed for care plans. 1. The facility failed to develop a care plan that accurately reflected dental care for Resident #24. 2. The facility failed to develop a care plan that accurately reflected refusal of medications for Resident #45. This failure could affect the health and safety of all residents and place them at risk for not receiving necessary care, treatment and services. The findings include: 1. Review of Resident #24 face sheet revealed an [AGE] year-old female resident admitted [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #24's medical record revealed a phone order for Dentist Consult PRN on 01/09/2019. Further review revealed the history and physical dated 2/28/2020 failed to reference the condition of her teeth. Review of Resident #24 annual MDS dated [DATE] reflected a BIMS score of 11 indicating moderate cognitive impairment. Review of the quarterly MDS revealed that Resident # 24's Section L-0200 only had a check mark by D: obvious or likely cavity or broken natural teeth. Review of Resident #24's care plan dated 1/29/2020 failed to include Resident #24 had extremely poor dentition and required the need of a dental consult. During an interview with the Director of Nurses on 03/12/2020 at 8:16 AM, she stated a discussion with the resident about the mobile dental office yielded a possible appointment on the dentist's next visit. During an interview with Resident #24 on 03/13/2020 at 11:07 AM, she stated she was afraid of going to the dentist's office. Further interview revealed the resident was not aware the Facility dentist had a mobile office which allowed the resident to obtain an appointment and dental check on the Facility property. During the interview, it was noted the resident's teeth were in extremely poor condition. 2. Review of Resident #45 face sheet reflected a [AGE] year-old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #45's quarterly MDS dated [DATE] reflected a BIMS score of 14 indicating no cognitive impairment. Further review of Resident #45's MDS, reflected Resident #45 rejected care four to six days but less that daily. Review of the February 2020 Medication Administration Record [REDACTED]. Review of Resident #45's care plan dated 2/21/2020 failed to document refusal of medications. Interview with the Social Worker on 3/12/2020 at 3:39 P.M. the Social Worker said she had informed Resident #45 of the Facility's difficulty in placing him in any other nursing home because of his behavior of medication refusal. During an interview on 03/12/2020 at 2:35 P.M. Resident #45 stated he wanted to return to Corpus Christi to be closer to his family. He said he could have occasional overnight stays there. Review of Resident #45's care plan dated 2/21/2020 failed to document refusal of medications. Record review of facility's policy on Behavior Assessment and Monitoring dated February 2014 revealed The interdisciplinary team would develop a care plan with input from the resident and the family, to the extent possible. The care plan would incorporate findings from the comprehensive assessment and be consistent with current standards of practice. When medications are prescribed for behavioral symptoms, the care plan will include a. rationale for use; b. specific target behaviors and expected outcomes, c. dosage, d. duration, e. monitoring for efficacy and adverse consequences; and f. plans (if applicable) for gradual dose reduction.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 2 of 14 residents (Residents #12 and #25) whose care plans were reviewed, in that: 1. Resident #12's care plan was not revised to include he was PASRR negative. 2. Resident #25's care plan was not revised to indicate the right [DIAGNOSES REDACTED]. These deficient practices could affect residents in the facility and place them at risk for not having their needs identified and addressed. The findings were: 1. Review of Resident #12's face sheet dated 3/12/2020 revealed he was initially admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #12's Annual MDS dated [DATE] revealed a BIMS score of 10 which indicated moderate cognitive impairment for daily decision making. Further review revealed Resident #12 was not currently considered by the state level II PASRR process to have serious mental illness. Review of Resident #12's Care Plan dated 7/12/19 revealed Resident #12 was PASRR positive due to mental illness. Intervention included Follow state PASRR policy related to specialized services and case management. During an interview on 3/12/2020 at 8:18 a.m., MDS LVN revealed Resident #12 was suspected positive during PASRR screen related to head injury and did not meet the criteria during PASRR Evaluation. MDS LVN further confirmed Resident #12's care plan indicated PASRR positive and was not updated to reflect the most recent evaluation, PASRR negative. 2. Record review of Resident #25's face sheet, dated 2/28/20, revealed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #25's Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 12, indicating the resident was moderately cognitively impaired. The MDS also indicated the resident had the active [DIAGNOSES REDACTED]. Record review of Resident #25's Care Plan, dated last revised 1/29/20, revealed the resident requires [MEDICAL CONDITION] medications [MEDICATION NAME] and [MEDICATION NAME] for [DIAGNOSES REDACTED]. Record review of Resident #25's Order Summary Report, dated 3/12/20 revealed the following orders: - [MEDICATION NAME] Tablet 0.5 MG ([MEDICATION NAME]) Give 1 tablet by mouth at bedtime related to [MEDICAL CONDITION]'s Disease take with 2 mg tablet to equal 2.5 mg with a start date of 12/01/2019 and no end date. - [MEDICATION NAME] Tablet 2 MG ([MEDICATION NAME]) Give 2 mg by mouth one time a day related to [MEDICAL CONDITION]'s Disease Administer one (1) tablet by mouth every morning with a start date of 06/14/2019 and no end date. - [MEDICATION NAME] Tablet 2 MG ([MEDICATION NAME]) Give 1 tablet by mouth at bedtime related to [MEDICAL CONDITION]'s Disease with a start date of 12/01/2019 and no end date. - [MEDICATION NAME] Suspension 234 MG/1.5 ML ([MED] [MEDICATION NAME]) Inject 1.5 ml intramuscularly one time a day every 30 day(s) related to [MEDICAL CONDITION]'s Disease with a start date of 10/23/2019 and no end date. During an interview on 3/12/20 at 2:15 p.m., the MDS Coordinator confirmed Resident #25's care plan indicated the resident was taking [MEDICATION NAME] and [MEDICATION NAME] for [DIAGNOSES REDACTED].#25's physician orders [REDACTED]. The MDS Coordinator reported he believed the medication was probably not used to treat the [MEDICAL CONDITION]'s disease and not the [MEDICAL CONDITION] disorder, but confirmed the physician order [REDACTED].
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 1 resident (Resident #39) reviewed for oxygen and nebulizer treatments in that: Resident #39's oxygen was not being administered as ordered for 2 of 2 days observed and the oxygen administration was not documented on the Treatment Administration Record (TAR). This deficient practice could affect residents who received oxygen continuously and could result in residents receiving incorrect or inadequate oxygen support and a decline in health. The findings were: Record review of Resident # 39's face sheet, dated 3/13/20, revealed an admission date of [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 39's Order Summary Report, dated 3/12/20, revealed order - may use oxygen at 2 liters per minute via nasal cannula for oxygen saturation less than 92% or shortness of breath every 8 hours as needed for shortness of breath related to shortness of breath (and) hypoxemia, with a start date of 2/08/20 and no end date. Record review of Resident #39's Significant Change MDS, dated [DATE], revealed the resident had a BIMS score of 6 which indicated the resident was severely cognitively impaired. The same record also revealed Resident was receiving hospice services. Record review of Resident #39's electronic Care Plan, dated last reviewed on 2/25/20, revealed a focus of The resident has Oxygen Therapy for comfort measures related to terminal diagnosis. Record review of Resident #39's EMR Vital Signs revealed the resident was receiving oxygen when her oxygen saturation level was above 92%: 3/11/2020 19:53 99.0 % Oxygen via Nasal Cannula 3/11/2020 10:10 98.0 % Oxygen via Nasal Cannula 3/10/2020 19:46 97.0 % Oxygen via Nasal Cannula 3/10/2020 11:58 98.0 % Oxygen via Nasal Cannula 3/10/2020 10:09 97.0 % Oxygen via Nasal Cannula 3/10/2020 10:00 98.0 % Oxygen via Nasal Cannula 3/10/2020 09:00 97.0 % Oxygen via Nasal Cannula 3/10/2020 00:21 98.0 % Oxygen via Nasal Cannula [DATE]20 17:52 98.0 % Oxygen via Nasal Cannula 3/8/2020 23:55 96.0 % Oxygen via Nasal Cannula 3/8/2020 20:28 97.0 % Oxygen via Nasal Cannula 3/8/2020 13:18 97.0 % Oxygen via Nasal Cannula 3/8/2020 03:18 97.0 % Oxygen via Nasal Cannula 3/7/2020 01:00 94.0 % Oxygen via Nasal Cannula 3/6/2020 16:32 98.0 % Oxygen via Nasal Cannula 3/6/2020 10:45 99.0 % Oxygen via Nasal Cannula 3/3/2020

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 _____	03/13/2020

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) 02:02 98.0 % Oxygen via Nasal Cannula [DATE] 16:35 99.0 % Oxygen via Nasal Cannula 2/29/2020 04:32 93.0 % Oxygen via Nasal Cannula 2/28/2020 01:48 98.0 % Oxygen via Nasal Cannula 2/27/2020 04:32 93.0 % Oxygen via Nasal Cannula 2/25/2020 04:29 100.0 % Oxygen via Nasal Cannula 2/22/2020 16:01 98.0 % Oxygen via Nasal Cannula 2/21/2020 05:00 93.0 % Oxygen via Mask [DATE] 12:25 100.0 % Oxygen via Nasal Cannula [DATE] 01:23 96.0 % Oxygen via Nasal Cannula Record review of Resident #39's February and March 2020 TAR for the order May use oxygen @ 2 liters per minute via nasal cannula for oxygen saturation less than 92% or shortness of breath every 8 hours as needed for Shortness of Breath revealed the resident was only documented as receiving this order on 2/17/20 and nothing thereafter. Record review of Resident #39's Progress Notes from 3/10/20-3/12/20, did not reveal the resident had any distress or shortness of breath. During an observation on 3/10/20 at 10:21 a.m., Resident #39 was observed sleeping in her bed. Resident #39 was also observed to have oxygen cannula in her nares going at a rate of 1.5 liter per minute (LPM). During an observation on 3/12/20 at 2:46 p.m., Resident #39 was observed sleeping in her bed. Resident #39 was also observed to have oxygen cannula in her nares going at a rate of 2 liter per minute. During an interview 3/12/20 at 2:52 p.m., the DON confirmed Resident #39's oxygen order indicated the use of supplemental oxygen when the resident's oxygen saturation was less than 92% or when Resident #39 was experiencing shortness of breath and should only be administered when those criteria were met. The DON also confirmed Resident #39's EMR documentation indicated the resident's oxygen saturation levels were above 92% and she still received oxygen via nasal cannula. The DON further confirmed Resident #39's MAR indicated [REDACTED]. At the same time, the DON and Surveyor entered Resident #39's room, Resident #39's oxygen concentrator was on and being administered to her at 2 liters per minute via nasal cannula.
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 of each resident for 2 of 14 residents (Residents #25 and #39) being reviewed for pharmacy services, in that: Resident #25 and #39 had multiple days of not receiving the prescribed medication due to being asleep and there was no documentation their physicians were notified of the missed doses. This deficient practice could place residents at risk for receiving less than therapeutic benefits from medications. The findings were: 1. Record review of Resident #25's face sheet, dated 2/28/20, revealed the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #25's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 12, which indicated the resident was moderately cognitively impaired. Further review revealed the resident had the active [DIAGNOSES REDACTED]. Record review of Resident #25's Order Summary Report, dated 3/12/20, revealed orders for: - [MEDICATION NAME] Tablet Delayed Release 500 MG ([MEDICATION NAME] Sodium) Give 1 tablet by mouth at bedtime related to [MEDICAL CONDITION] disorder, current episode manic without psychotic features, moderate, with a start date of 11/15/19 and no end date. - [MEDICATION NAME] Capsule 1 MG Give 2 mg by mouth at bedtime for [MEDICAL CONDITION] give with 3mg to equal 5mg with a start date of 1/30/20 and no end date. - [MEDICATION NAME] Capsule 3 MG Give 1 capsule by mouth at bedtime for [MEDICAL CONDITION] give with 2mg to equal 5mg with a start date of 1/30/20 and no end date. - [MEDICATION NAME] Tablet 0.5 MG ([MEDICATION NAME]) Give 1 tablet by mouth at bedtime related to [MEDICAL CONDITION]'s Disease take with 2mg tablet to equal 2.5 mg with a start date of 12/01/19 and no end date. - [MEDICATION NAME] Tablet 2 MG ([MEDICATION NAME]) Give 1 tablet by mouth at bedtime related to [MEDICAL CONDITION]'s Disease with a start date of 12/01/19 and no end date. - Austedo Tablet 12 MG (deutetrabenazine) Give 1 tablet by mouth two times a day related to [MEDICAL CONDITION]'s Disease with a start date of 11/22/19 and no end date. - Austedo Tablet 6 MG (Deutetrabenazine) Give 1 tablet by mouth two times a day related to [MEDICAL CONDITION]'s Disease give with 12m tablet to equal 18 mg with a start date of 11/22/19 and no end date. - [MEDICATION NAME] Tablet 25 MG Give 1 tablet by mouth two times a day [MEDICAL CONDITION] IF BP LESS THAN 110/60 OR PULSE LESS THAN 60, with a start date of 1/09/19 and no end date. - [MEDICATION NAME] Tablet 1 MG ([MEDICATION NAME]) Give 1 tablet by mouth three times a day related to Anxiety disorder with a start date of 2/05/20 and no end date. - EQ [MEDICATION NAME] Tablet 200 MG ([MEDICATION NAME]) Give 3 tablet by mouth three times a day for Mild Pain; Moderate Pain with a start date of 9/24/19 and no end date. Record review of Resident #25's MAR for March 2020, dated 3/12/20 revealed the resident was coded for the following medications: [REDACTED]. - The 7:00 PM doses for: [MEDICATION NAME] Tablet 1 MG and [MEDICATION NAME] Tablet 25 MG were coded the resident was sleeping for the doses for 3/08/2020-3/6/50 and 3/10/20 and the medications were not administered. Record review of Resident #25's Progress Notes for 3/01/20-3/12/20, did not revealed the resident's physician had been notified the resident had missed multiple doses of medication by sleeping and if the physician wanted to modify the resident's orders. 2. Record review of Resident # 39's face sheet, dated 3/13/20, revealed an admission date of [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #39's Significant Change MDS, dated [DATE], revealed the resident had a BIMS score of 6 which indicated the resident was severely cognitively impaired. Record review of Resident #39's Order Summary Report, dated 03/12/20, revealed orders for: - [MEDICATION NAME] Capsule 3 MG Give 2 capsule by mouth at bedtime for Agitation; [MEDICAL CONDITION] with a start date of 3/03/20 and no end date. - Rosuvastatin Calcium Tablet 40 MG Give 1 tablet by mouth at bedtime for lipid control with a start date of 3/03/20 and no end date. -[MEDICATION NAME] Acid Solution 250 MG/5ML (Valproate Sodium) Give 20 ml by mouth at bedtime for [MEDICAL CONDITION] with a start date of 3/03/20 and no end date. - [MEDICATION NAME] Tablet 100 MG Give 1 tablet by mouth two times a day for Preventative with a start date of 3/03/20 and no end date. - 2 Cal with meals Give 1 Can with a start date of 4/09/19 and no end date. - [MEDICATION NAME] Tablet 1 MG Give 1 tablet by mouth three times a day for Anxiety with a start date of 3/03/20 and no end date. - [MEDICATION NAME] Tablet 325 (65 Fe) MG Give 1 tablet by mouth three times a day for supplementation with a start date of 3/03/20 and no end date. - [MEDICATION NAME] HCl Tablet 10 MG Give 1 tablet by mouth three times a day related to Essential Hypertension hold if SBP < 110 or HR < 60 with a start date of 2/29/20 and no end date. Record review of Resident #39's MAR for March 2020, dated 3/12/20 revealed the resident was coded for the following medications: [REDACTED]. - The 5:30 PM doses for: 2 Cal was coded the resident was sleeping for the doses for 3/4/2020-3/5/50, [DATE]-3/11/20 and the medication was not administered. Record review of Resident #39's Progress Notes for 3/01/20-3/12/20, did not reveal the resident's physician had been notified the resident had missed multiple doses of medication by sleeping and if the physician wanted to modify the resident's orders. During an interview on 3/12/20 at 4:50 p.m., MA I confirmed Residents #25 and #39 had been indicated as asleep for multiple days for their medication administration in the evening. MA I reported he attempts to administer the medications to the resident twice before he codes them as asleep. MA I reported he has let the nurses know Residents #25 and #39 missed medications due to the residents being asleep and they would communicate the information to the resident's physicians. MA I revealed he would notify the nurse usually after the resident has missed 2-3 days of missed medication. During an interview on 3/12/20 at 4:52 p.m., LVN B reported she was not aware Residents #25 and #39 were being documented as sleeping for multiple days for their medication administration. LVN B reported if she would have known of the resident's missed doses, she would have completed a Negotiated Risk Assessment and notified their physicians to see if they wanted to make any order changes. During an interview on 3/13/20 at 10:14 a.m., the DON reported with each refusal or the resident being asleep there should be two attempts made by the medication aide to administer the medication. The DON also reported if refused/sleeping the staff should notify the nurse. The DON also reported the nurse then would follow-up with talking to the resident or notifying the physician about the refusals/sleeping and if they wanted to change the order. The DON further reported there should also be a Negotiated Risk Assessment completed by the nurse that indicated the resident was educated and the physician and resident representative were notified. The DON confirmed the last Negotiated Risk Assessment for Resident #25 was completed in [DATE] and that one could not be found for Resident #39. The DON also reported the nurses' follow up could have been documented in a progress note or assessment. The DON confirmed Resident #25 and #39 did not have any progress notes or assessments indicating that their physicians were notified.

F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, for 1 of 4 medication carts (East Wing Medication Cart) reviewed for secured medications and medication storage, in that: The East Wing Medication Cart contained an open bottle of [MED] Lactobacillus which was stored at room temperature. The [MED] Lactobacillus and was not stored under refrigeration in accordance to the manufacturer. This deficient practice could affect residents that received by mouth medication and could place them at risk for decreased medication potency. The findings were: Observation on 3/11/2020 at 3:50 PM of the East Wing Medication Cart revealed an open bottle of [MED] Lactobacillus (a [MEDICATION NAME] capsule) was stored in the top drawer. MA A opened the bottle and showed the surveyor the bottle was 3/4 full. The label on the bottle of [MED] Lactobacillus read, Refrigerate after opening to help maximize potency. In an interview on 3/11/2020 at 3:54 PM with MA A, after she looked at label on the bottle of [MED] Lactobacillus, she stated she never noticed the label said to refrigerate after opening. In an interview on 3/12/2020 at 3:03 PM with the DON, she confirmed the [MED] Lactobacillus should have been refrigerated after it was opened if the label indicated it should be refrigerated. Review of the facility's contracted pharmacy policy titled Recommended Medication Storage, revised 7/2012, revealed Medications that require an 'open date' as directed by the manufacturer should be dated when opened in a manner that it is clear when the medication was opened. Below is a list of medications that required a date when opening and the recommended time frame the medication should be used. This is not an all-inclusive list and the manufacturer recommendations will supersede this list. Review of the medications listed on the policy revealed [MED] Lactobacillus was not included.
F 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** Based on observation, interview, and record review the facility failed to provide laboratory services to meet the needs of

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 _____	03/13/2020

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 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) its residents to ensure the quality of the services for 1 of 2 glucometers reviewed, in that: LVN B did not correctly perform glucometer calibration which is used to test the accuracy of the glucometer's results to make sure an accurate blood glucose level reading is provided to manage a resident's health appropriately. This deficient practice could affect residents who received blood sugar monitoring and place them at risk of inaccurate readings. The findings were: Observation and interview on 3/12/2020 at 2:26 PM revealed when LVN B calibrated the glucometer for the West Wing Nurse's cart, the LVN placed a drop of the calibration test solution onto a glucometer strip and could not get a reading. The glucometer had L2 on the display. LVN B then tried another test strip with the same test solution and received the same reading on the glucometer. LVN B repeated this step two more times with the same result. Interview with LVN B at this time revealed she had calibrated a glucometer in the past but could not do it this time. LVN B stated the facility had the glucometer for a few months, she did not know where the manual for the glucometer was, but knew it was not in the medication cart. Interview on 3/12/2020 at 3:03 PM with the DON revealed the nurses would calibrate the glucometer on the night shift and the calibration test would be recorded on the glucometer log. Observation on 3/12/20 at 3:46 PM of the display case by the front door of the facility revealed the facility's CLIA (Clinical Laboratory Improvement Amendments) Waiver was posted and was effective until 8/18/2021. Record review of the facility's policy titled Glucometer revised 2/13/2017 revealed 3. Quality of Control solutions and Test Strips 1. Do not use Test Strips of Control Solutions after expiration date. 2. Bottle must be dated when opened. 3. Store both at room temperature, 59-86 F. 4. Control solution is good for 3 months then discarded. Under Quality Control Testing was 1. Testing will be done routinely 2. Perform quality control testing by using Control Solutions: High and Low every per manufacturer recommendations. 3. Control ranges are printed on box of Test Strips. 4. If Control Range limits are exceeded: 1. Check code number on meter display and Test Strip number. 2. Repeat test if still out of range. 3. Perform Check strip Test. 4. Call toll-free number if test remains out of range. 5. Report unresolved problems to DON/ADON. 6. Do not use meter until problem is resolved. Obtain meter from another (nurses') station.
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist residents in obtaining routine dental care for 1 of 1 resident (Resident #24) reviewed for dental services, in that: Resident #24 was not offered a dental screening or services by the dentist after admission, to assess dental needs. This deficient practice could affect residents who require dental services and place them at risk of a decline in physical condition. The findings were: Record review of Resident #24's face sheet, dated 3/10/2020, revealed the resident was initially admitted [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #24 annual MDS dated [DATE] reflected a BIMS score of 11 indicating moderate cognitive impairment. Further review of Resident #24's quarterly MDS revealed Section L-0200 only had a check mark by D: obvious or likely cavity or broken natural teeth. Review of Resident #24's care plan dated 1/29/2020 did not include Resident #24 had extremely poor dentition and required a dental consult. During an interview with the Director of Nurses on 03/12/2020 at 8:16 AM, she stated a discussion with the resident about the mobile dental office yielded a possible appointment on the dentist's next visit. Her poor dentition did not allow her to eat solid food effectively. During an interview with Resident #24 on 03/13/2020 at 11:07 AM, the resident stated she was afraid of going to the dentist's office. Further interview revealed the resident was not aware the facility dentist had a mobile office which allowed the resident to obtain an appointment and dental check on the Facility property. During the interview, it was noted the resident's teeth were in extremely poor condition. She denied pain to her teeth. Record review of facility's policy on Behavior Assessment and Monitoring dated February 2014 revealed the interdisciplinary team would develop a care plan with input from the resident and the family, to the extent possible. The care plan would incorporate findings from the comprehensive assessment and be consistent with current standards of practice.
F 0805 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.** Based on observation, interviews, and record review, the facility failed to ensure food was prepared in a form designed to meet individual needs for 1 of 1 meal (noon meal), in that: Cook F did not puree the meat loaf to mashed potato consistency as required for pureed diet. This deficient practice could affect residents at the facility on pureed diets by contributing to difficulty eating, poor intake, weight loss and/or choking. Record review of the Diet Spreadsheet for Fall/Winter Week 1 Wednesday Lunch, revealed the residents on a pureed diet were to receive pureed meatloaf, pureed baked mac & cheese, pureed collard greens, pureed cornbread and pureed cherry cake. Observation on 3/11/2020 at 10:30 a.m. revealed Cook F pureed meatloaf and transferred to the serving pan without checking the consistency of the meat. During observation on 3/11/2020 at 10:32 a.m., surveyor tasted the pureed meatloaf and tasted large grainy pieces in the pureed meat. Interview on 3/11/2020 at 10:32 a.m. with Cook F revealed pureed meat should be smooth consistency like mashed potatoes. During an interview on 3/11/2020 at 10:32 a.m., the Food Service Manager (FSM) tasted the pureed meat and stated The pureed meat was not mashed potato consistency and needed to be pureed more to reach the consistency. Review of facility policy dated 2012 Consistency Modification revealed in part We will adequately meet nutritional needs of the resident and provide food in a consistency that the resident can tolerate. The pureed diet is given to residents with chewing, swallowing or choking problems. The desired consistency for blended foods is that of applesauce to mashed potatoes.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interviews and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 (main kitchen) of 1 kitchen reviewed for kitchen sanitation in that: 1. The clean side of the three-compartments counter was dirty with food particles. 2. Cook G did not demonstrate correct procedures for three-compartment use. 3. Cook F did not monitor food temperatures prior to lunch meal. These deficient practices could affect all residents who received meals from the main kitchen and could place them at risk for food borne illnesses. The findings were: 1. Observation on 3/11/2020 at 10:58 a.m. revealed Cook G used the three-compartment sink to clean pots, pans and serving utensils. Further observation revealed the counter where clean pots, pans and serving utensils were air dried was dirty with cooked pasta and other food debris. During an interview on 3/11/2020 at 11:03 a.m., Cook G confirmed the clean counter where pot and pans were stored was dirty with food debris. During an interview on 3/11/2020 at 11:03 a.m., Food Service Manager (FSM) acknowledged the clean counter was dirty with cooked pasta and other food debris. The FSM further said the cook should have cleaned the area prior to use. Review of the Texas Food Establishment Rules (TFER) 2015, page107, section 228.113(3) indicated non-food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 2. Observation on 3/11/2020 at 11:08 a.m. revealed Cook G checked sanitizing solution concentration on surveyor's request. Further observation revealed Cook G placed the test strip into the water and immediately took it out and the concentration reading was below the recommended level of 150 ppm. During an interview on 3/11/2020 at 11:08 a.m., Cook G said she checked the sanitizing solution concentration by dipping the test strip into the water and immediately taking it out. Cook G further stated she was not aware of any time requirement for test and the recommended sanitizing solution concentration was between 100-200. Further interview, Cook G said the cleaned items should be dipped in and taken out immediately from the sanitizing solution. During an interview on 3/11/2020 at 11:08 a.m., the FSM stated the test strip should be dipped in the sanitizing solution for 10 seconds for accurate reading. The FSM further said the cleaned items should be immersed in the sanitizing solution for at least one minute. Review of the three-compartment sink procedures undated, posted by the sink revealed dip test paper in sanitizing solution for 10 seconds, do not shake. Compare strip to color chart on the test paper dispenser at once. Test paper must read 150-400 ppm. Further review of posted three-compartment sink procedures revealed completely immerse clean items in the sanitizer solution for at least one minute. 3. Observation of lunch meal on 3/11/2020 at 11:17 a.m. revealed Cook F started tray line and served five trays without monitoring temperatures. During an interview on 3/11/2020 at 11:20 a.m., Cook F said she normally monitored temperatures of food prior to starting tray line. Cook F further confirmed she did not check food temperatures this date prior to starting tray line and should have. Interview with FSM on 3/11/2020 at 11:20

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 _____	**03/13/2020**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) a.m. confirmed the cook should have taken the food temperatures prior to starting tray line. Review of facility policy dated 2012 Daily Food Temperature Control revealed in part We will assure that food is served at a safe temperature. Temperatures of all hot and cold food shall be taken prior to every meal service and recorded on the temperature log. This is done to help ensure that food is safe and is served within acceptable ranges. Prior to meal service, the cook shall take the temperature of all hot and cold foods.
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 14 residents (#2 & 7) whose medical records were reviewed, in that: 1. Resident #2's medical record revealed a physician's orders [REDACTED]. 2. Resident #7's medical record revealed a physician's orders [REDACTED]. These deficient practices could affect all residents and could result in the records not being an accurate representation of the resident's medical condition and could result in errors in care and treatment. The findings were: 1. Review of Resident #2's Face Sheet, dated 3/13/2020 revealed the resident was initially admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's Annual MDS dated [DATE] revealed a BIMS score of 8 which indicated moderate cognitive impairment for daily decision making. Further review of MDS revealed Resident #2 required extensive assistance with 2 persons assist for bed mobility. Review of Resident #2's physician's orders [REDACTED]. Review of Resident #2's Care Plan dated [DATE] revealed the resident required the assistance of 2 staff for ADL and personal care and 2 CNAs assist for ADL and personal care. Observation on 3/10/2020 at 10:36 a.m. revealed Resident #7 lying in bed and no bed rails attached to bed. Interview on 3/10/2020 at 10:36 a.m. with Resident #7 revealed he did not use side rails for bed mobility. During an interview on 3/12/2020 at 11:39 a.m. with CNA C confirmed there were no bed rails on Resident #2's bed and resident did not use bed rails for bed mobility. An interview on 3/12/2020 at 2:51 p.m. with the DON confirmed Resident #2 had an order for [REDACTED]. Review of Resident #7's Face Sheet, dated 3/12/2020 revealed the resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #7's Admission MDS dated [DATE] revealed a BIMS score of 15 which indicated cognition was intact for daily decision making. Review of Resident #7's physician's orders [REDACTED].#7 was on transmission-based precautions. Observation on 3/10/20 at 11:42 a.m. revealed there was no isolation cart outside Resident #7's room. During an interview on 3/10/20 at 11:44 a.m. with CNA D revealed Resident #7 was currently not on isolation. Interview on 3/10/2020 at 1:56 p.m. with Resident #7 revealed resident was not interested in talking to the surveyor. An interview on 3/10/2020 at 4:10 p.m. with LVN E, the charge nurse for Resident #7 revealed the resident was currently not on isolation. LVN E further revealed Resident #7 received [MEDICATION NAME] treatment for [REDACTED]. LVN E also confirmed Resident #7 had an order for [REDACTED].#7 were treated for [REDACTED].#7 was discontinued from isolation at the end of February and the order should have reflected the discontinued order. Review of facility policy physician's orders [REDACTED]. If the order requires documentation, it will be directed to the proper electronic administration record once the order is completed. The nurse will enter the order in to PCC (Point Click Care) for the resident and select either verbal or telephone depending on how the nurse received the order.