STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676091	A. Building B. Wing	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sagecrest Alzheimers Care Center	438 Houston-Harte San Angelo, TX 76903

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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26221 45411 48043 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 of 16 residents (Residents #2, #24, #30 and #45) reviewed for care plans in that: Resident #2 had no care plan in place to address his oxygen use. Resident #24 had no care plan in place to address her oxygen use. Resident #30 had no care plan in place to address the need for palliative care. Resident #45 had no care plan in place to address his Out-Of-Hospital-Do-Not-Resuscitate status. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Review of Resident #2's Face Sheet, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included quadriplegia (unable to use arms or legs), malaise (general feel bad for unknown reason), and respiratory disorders. Review of Resident #2's Annual MDS Assessment, dated [DATE], revealed: He scored a 15 of 15 on his mental status exam with no signs or symptoms of delirium (indicating he was cognitively intact). He received special treatments while a resident that included oxygen. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's Order Summary, dated [DATE], revealed orders dated [DATE] for oxygen at 2 - 4 L/min per nasal cannula as needed. Observation on [DATE] at 9:30 a.m. showed Resident #2 in bed with the head of bed raised. Resident #2 had oxygen on. Review of Resident #2's Care Plan, revision undated, revealed no care plan for the oxygen use. Resident #24 Review of Resident #24's Face Sheet dated [DATE] revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included respiratory failure with hypoxia (low levels of oxygen in the blood) and congestive heart failure. Review of Resident #24's Admission MDS assessment, dated [DATE], revealed: She had active diagnoses of heart failure and respiratory failure. She received special treatments prior to admission and as a resident that included oxygen therapy. Review of Resident #24's Physician Order Sheet, dated [DATE], revealed the following: Albuterol sulfate HFA 90 mcg/actuation aerosol inhaler (2 puffs) as needed every 4 hours (order date [DATE]) Oxygen at 2 L/min per nasal canula continuous (order date [DATE]) Observation on [DATE] at 2:49 PM revealed Resident #24 sitting in her wheelchair in her room after returning from an appointment. Resident #24 was waiting to be assisted to her bed and was wearing a nasal canula attached to a portable oxygen tank set to 2 L/min. Observation on [DATE] at 3:03 PM revealed Resident #24 resting in bed with oxygen via nasal canula attached to her in room oxygen machine at 2 L/min. Review of Resident #24's Care Plan, revision undated, revealed no care plan for oxygen use. Resident #30 Review of Resident #30's Face Sheet dated [DATE] revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included diabetes, dementia, altered mental status, pain, and muscle weakness. Review of Resident #30's quarterly MDS Assessment, dated [DATE], revealed. He scored a 3 of 15 on his BIMS and showed no signs of delirium (indicating severe cognitive impairment). He needed extensive assistance of one or two staff for all ADLs except eating. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #30's Nurse's Notes, revealed notes dated [DATE]: Resident #30's son has now signed Out of Hospital Do Not Resuscitate for elder. Resident #30's son also sent an email expressing the following In light of my conversation with Nurse Practitioner in [DATE], Resident #30's nurse yesterday, Resident #30's latest BIMS score of 3, and after consultation with Resident #30's daughter who is in agreement with this action, [the son] has signed his OOH-DNR order. I've included the Palliative Care form I signed in January as well. Resident #30's son had previously signed Palliative Care back in January however, soon after signing, he expressed he wanted to retract it. Resident #30's son is now in agreement with palliative care services for elder. Review of Resident #30's Care Plan, revision date unknown, revealed: Problem: Advanced Directives: Resident #30 has the following advanced directives; (DNR/OOHDNR, POA Medical or POA Financial, Living Will or Directive to Physicians) Palliative Care signed Goal: Resident #30 /or Family will have wishes respected regarding Directives over next 90 days. Interventions: Hospice referral for Resident #30 as needed. Resident #30 will have DNR/OOHDNR available in the chart. Resident #30's chart will be designated with the appropriate DNR/Full Code status. Support Resident #30 and family with their decisions and respect choices made. Interview on [DATE] at 3:30 PM the ADON stated she was part of the care plan process. She stated when a resident was admitted to the facility there was a care plan that was completed within 48 hours of the initial admission, and it was just part of the admission a RN had to complete. She said by day 20 the resident would have a comprehensive care which was completed by the nursing department, social work, activities, and the dietician. The ADON stated she expected to see ADL status, pain, skin issues, nutrition, hydration, mood, behaviors, cognition, fall risk and just about anything else you would think was pertinent to the resident's care. The ADON stated if the Resident had the oxygen all the time, she would expect a care plan. The ADON reviewed Resident #2's chart and said she did not see a care plan for his oxygen use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on [DATE] at 11:23 AM, the ADON stated an interdisciplinary team did the care plans. The ADON stated Social Work, Activities, and the Dietician were also involved with care plans. The ADON said the expectation for what should be on the care plan included ADL status, pain, falls, skin conditions, psychosocial wellbeing, nutrition, advanced directives, mood, and behaviors. The ADON said specific diagnoses would be care planned if the resident took a medication for it, she added she did not care plan every medication the resident was on. The ADON elaborated that she would care plan a medication if it was about pain, or stuff at affected the resident's continence status. She said respiratory stuff could be care planed . should be care planned if the resident had cardiac diagnoses that affected the oxygen saturations. The ADON stated Resident #24 did have continuous oxygen and an as needed inhaler. The ADON said Resident #24 had not received the as needed inhaler since her admission. The ADON stated she could see why respiratory issues were separate from cardiovascular disfunction. The ADON said palliative care was care planned under advanced directives and did not require its own category. Then the ADON stated she did not know if it would require its own category, she said Palliative Care had its own EMR section and a place information would be scanned in. The ADON stated a resident would have a separate care plan for hospice. Interview on [DATE] at 11:44 AM the DON stated the OOHDNR was the residents CPR status while palliative care was about the resident or family's end of life wishes. The DON said a resident could have an OOHDNR and not be on palliative care so they would require separate care plans. The DON stated the facility would put the approaches together because it was about what the resident's wishes were. The DON read Resident #30's care plan on advanced directives and agreed the care plan did not cover services provided about the palliative care. The DON stated the facility did have a corporate nurse who would come to the facility and audit the care plans at least annually. Resident #45 Review of Resident #45's Admission Record, dated [DATE], revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Disorder of the autonomic nervous system, Encounter for surgical aftercare following surgery on the digestive system, Other Secondary Parkinsonism, Torticollis, Ataxia, Drug induced subacute dyskinesia, Major Depressive Disorder, Anxiety Disorder, Polyosteoarthritis, Hyperlipidemia, Retention of urine, Essential Hypertension, Gastroesophageal Reflux Disease without Esophagitis, Chronic Diastolic Heart Failure, Pain, Constipation, Benign Prostatic hyperplasia with lower urinary tract symptoms, Malnutrition, and Polyneuropathy. Review of Resident #45's Admission MDS, dated [DATE], revealed: -He had clear speech and had no difficulty in normal conversation, social interaction, listening to TV. He did wear hearing aids. -He scored a 10 of 15 on his mental status exam showing moderate signs of impairment. Review of Resident #45's Physician Order Summary Report, dated [DATE], revealed orders: -Out-of-Hospital-Do-Not-Resuscitate (OOH-DNR) (order dated [DATE]) Review of Resident #45's Care Plan dated [DATE] revealed no care plan in place for the Out-of-Hospital-Do-Not-Resuscitate Order. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 9:00 AM, the DON and ADON stated the facility will always address Out of Hospital Do Not Resuscitate Orders in Care Plans. The ADON stated that she completes the Care Plans, and this was always addressed. Review of facility policy Resident Plan of Care, revised [DATE], revealed, in part: Utilizing the resident assessment (MDS) an interdisciplinary team will develop a plan of care for each resident with input from the resident and/or family. 1. An initial care plan will be developed within 48 hours of the resident's admission. This will address immediate care needs, including, but is not limited to, dietary needs, medications, and routine treatments. 2. A comprehensive care plan will be developed within 7 days of completion of the resident's comprehensive assessment (MDS). The Interdisciplinary Team develops it. 3. The plan of care will include input, if given, from the resident and/or the resident's a. family, or the resident's legal representative. All are encouraged to participate in the development of the care plan and subsequent changes to the care plan. 4. The care plan will identify problem areas and interventions needed to meet the needs of the resident. 5. Assessments of residents are on-going and care plans are revised as information about the resident and his/her condition changes. 6. The Interdisciplinary Team is responsible for updating the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the nursing community from a hospital stay; and d. At least quarterly. The Discharge Plan of Care will be developed in coordination with the resident/resident representative to provide for an effective transition to the post-discharge location.

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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. 45399 Based on observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that ensure the accurate administering of all drugs to meet the needs of the residents for 1 of 1 wound care/treatment carts inspected for medication storage in that: There were several expired items found in the facility's wound care/ treatment cart. This failure could place residents at risk of receiving medications that were expired and not produce the desired effect. Findings included: During an observation and record review on 07/19/23 at 3:28 PM the wound care/treatment cart was observed with LVN C present. Observation revealed the following expired supplies and medications: 2 catheter stabilization device kits expired 02/28/2021; 1 Antimicrobial 10 X 12.5 cm dressing expired 3/28/2022; 9 Absorbant wound dressings expired 03/2021; 1 Antimicrobial skin and wound gel (3 oz. tube) expired 05/28/2022; 1 Wound solution (16 fluid oz. bottle) expired 04/2021; 1 PICC line dressing change kit expired 11/30/2019; 2 Duoderm wound dressings expired 06/2022; 1 Non-adhering dressing (3 in. X 3 in.) expired 12/2022. During an interview on 07/19/23 at 3:45 PM, LVN C said that she usually checks the carts when she was working. LVN C stated that she was unaware that the expired supplies were in the cart. LVN C stated that she will throw them out immediately. During an interview on 07/20/23 at 08:45 AM, the DON stated that the nurse assigned to the unit should be checking their medication carts, treatment carts and medication room daily for expired medications and supplies. The DON stated that he rounds and checks the med carts but forgets about the treatment carts and supplies in certain areas. The DON stated he needs to ensure that expired medications were removed from the medication room and medication carts for residents safety. During an interview on 07/20/23 at 9:00 AM, the Administrator stated that DON and ADON should be rounding each unit and checking for expired meds and supplies. The Administrator stated that staff were expected to work as a team to ensure resident safety. Record review of the facility's policy titled Storage of Medications revised 04/02/2018 indicated in part: The facility may not use medication that has been discontinued, outdated, or has deteriorated. In these cases, medication is returned to the dispensing pharmacy or destroyed by the pharmacist and licensed nursing staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 30057 Based on observation, interview, and record review the facility failed to store all drugs and biologicals in locked compartments for 2 of 4 medication carts reviewed for medication storage in that: MA B failed to ensure the medication cart was secured when it was left unattended. LVN A failed to ensure the treatment cart was secured when it was left unattended. These failures could place residents at risk for drug diversion or accidental ingestion. Findings included: During an observation on 07/18/23 at 09:10 AM the medication cart for hall 200 was seen unlocked and unattended. Inside the cart were several medication packets and pill bottles. During an interview on 07/18/23 at 09:14 AM MA B said if she did not push all the cart drawers then they would not all lock. MA B said she thought she had locked the medication cart before she had stepped away. MA B said she knew that she had to make sure the cart was locked because there were some residents that might try to open the drawers on the medication cart and could get access to the medications. During an observation and an interview on 07/19/23 at 10:15 AM the treatment cart for hall 200 was seen unlocked and unattended for approximately 10 minutes. Inside the cart were several medications, ointments and scissors. LVN A said whenever they stepped away from the carts, they were supposed to make sure they were locked. LVN A said he must have forgotten to lock the cart when he stepped away. LVN A said it could be possible for some residents to get into the items in the cart and injure themselves and that he would be more careful to make sure and lock the cart when leaving it unattended. During an interview on 07/20/23 at 11:14 AM the DON said if the medication or treatment carts were out of the staff's eyesight that they had to be locked. The DON said if the carts were left unlocked and unattended a resident could get access of the medications, items that were in the carts and could ingest them. The DON also said staff that were not authorized to the carts could have access to them. The DON said the failure probably occurred because staff got in a hurry and forgot to lock the cart. During an interview on 07/20/23 at 11:36 AM the Administrator said if the staff stepped away from their medication cart or treatment cart, they were supposed to make sure the carts were locked, and nothing left out on the top of the carts. The Administrator said residents could get into the medication cart and possibly ingest medications or ointments due to staff leaving the carts unlocked and unsupervised. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled storage of medications dated 4/8/18 indicated in part: The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Any compartments containing drugs and biologicals shall be locked when not in use and are not to be left unattended if open. Only persons authorized to prepare and administer medications should have access to the medication room and medication cart including any keys.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure stored foods were properly labeled and dated. 2. The facility failed to ensure that expired foods were discarded. These failures could affect residents who received meals prepared meals from the kitchen at risk for food borne illness and cross-contamination. The findings included: Observation on [DATE] at 9:10 AM of the kitchen dry storage room revealed: -8, 5lb bags of deluxe cornbread mix with no expiration or best by date -1, 7lb6oz container of sliced strawberry topping with no expiration or best by date -4, 6lb bags of chocolate flavored brownie mix with no expiration or best by date -1, 5lb bag of graham cracker crumbs with no expiration or best by date -1, 5lb bag of snowflake sweetened coconut with no expiration or best by date -12, 16oz bags of whipped topping mix with no expiration or best by date -2, 24oz bags of cherry gelatin mix with no expiration or best by date -3, 24oz bags of banana instant pudding/pie filling with no expiration or best by date -1, 24oz container of caramel flavored sauce with no expiration or best by date -1, 1-gallon jar of dill slices with no expiration or best by date -1, 1-gallon jar of dill spears with no expiration or best by date -1, 1-gallon jug of rice wine vinegar with no expiration or best by date -11, 24oz bags of orange gelatin mix with no expiration or best by date -8, 24oz bags of instant lemon pudding/pie filling with no expiration or best by date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-8, 24oz bags of chocolate pudding/pie filling with no expiration or best by date -3, 5lb bags of white cake mix with no expiration or best by date -17 boxes of individually wrapped oatmeal cream pies (12 pies per box) with no expiration or best by date -13, 36oz boxes of long grain wild rice with no expiration or best by date -3, 1-gallon containers of mayonnaise with no expiration or best by date -7, 20.35oz bags of sliced scalloped potatoes with no expiration or best by date -28, 4oz containers of mixed fruit in pear juice with no expiration or best by date -10, 12oz bottles of tartar sauce with expiration date of [DATE] -3, 64oz bottles of 100% prune juice with expiration date of [DATE] In an interview on [DATE] at 10:00 AM, the Dietician and Dietary Manager, both were advised of expired food items and lack of expiration/best by dates on food items found during initial inspection of the kitchen. The DM stated that the expired prune juice and the tartar sauce would be disposed of immediately. The Dietician stated that the supplier had been sending the facility items that were very close to the expiration date all the time and they tried to make sure the dates were good before they put anything in the storage areas. The Dietician stated the staff just overlooked the dates on the last delivery. The DM stated that they did not have a system for writing use by dates on food items that were delivered without expiration or use by dates on the label. The DM acknowledged that the staff did have stickers with an area for the date the item was received and a use by date to be written in and then placed on the food item prior to putting it on the shelf. The DM stated the stickers do not always get placed on items. Both stated there should have been a better system in place to prevent expired foods from remaining in the kitchen past their expiration dates. Observation of unit refrigerator #1 on [DATE] at 10:10 AM revealed: -4, 12oz bottles of tartar sauce with expiration date of [DATE] -2, 3.5L containers of apple juice concentrate with no expiration or best by date -2, 3.5L containers of orange juice concentrate with no expiration or best by date -1, 3.5L container of cranberry juice concentrate with no expiration or best by date -1, 12oz bottle of squeeze vegetable oil spread with expiration date of [DATE] -2, 12oz bottles of squeeze vegetable oil spread with expiration date of [DATE] Observation of unit refrigerator #2 on [DATE] at 10:20 AM revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-2, 3.5L containers of apple juice concentrate with no expiration or best by date -1, 3.5L container of cranberry juice concentrate with no expiration or best by date -1, 3.5L container of orange juice concentrate with no expiration or best by date -3, 12oz bottles of tartar sauce with expiration date of [DATE] In an interview on [DATE] at 10:35 AM, the Dietician was advised of expired and undated items in unit refrigerators. The Dietician stated that the juice concentrate containers were supposed to be dated when they were removed from the freezer for use. She stated she did not know why the concentrate containers were not dated. She stated that the expired food items would be disposed of immediately. Review of undated facility policy titled Food Storage & Time Guidelines, revealed, in part: To maintain food quality and prevent foodborne illness, food should be stored for a limited amount of time. Always follow these general storage guidelines: - Label food with its expiration date. - If there is a question about a product's storage or expiration, discard it.