STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676498	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village at Incarnate Word	4707 Broadway Street San Antonio, TX 78209

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 2 newly admitted residents (Resident #103) reviewed for baseline care plans in that: Resident #103's baseline care plan did not include her use of oxygen when needed for shortness of breath This deficient practice could result in newly admitted residents receiving improper care. The findings were: Record review of Resident #103's face sheet, dated 09/26/2024 revealed an admitted [DATE] and admitting diagnoses which included: Acute and chronic respiratory failure with hypoxia (low oxygen levels in body); Neutropenia (an abnormally low count of a type of white blood cell in blood); Myelodysplastic Syndrome (a disorder which causes disruption in production of blood cells) and anemia (low level of red blood cells in blood) in chronic kidney disease. Record review of Resident #103's 5-day MDS assessment dated [DATE] revealed Resident #103 had a BIMS score of 15, indicating normal cognition. Further review of the 5-day MDS revealed that the Active Diagnoses section and Section O; Special Treatments, Procedures and Programs, which is the section that includes use of oxygen therapy had not yet been completed. Record review of Resident #103's physician orders, dated 09/26/2024, revealed an order for Oxygen @2-4 L/M per nasal cannula/mask PRN respiratory distress and Oxygen concentrator maintenance to be done weekly on Saturday as follows: Change Humidified bottle: Wash filter in warm water; Change oxygen tubing. Record review of Resident #103's baseline care plan, dated 09/17/2024, revealed her PRN use of oxygen therapy was not included in the plan. During an interview with Resident #103 on 09/24/2024 at 10:35 a.m., Resident #103 stated she used oxygen when she became short of breath, and usually used oxygen every night when she slept. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the MDS Nurse on09/26/2024 at 4:10 p.m, the MDS Nurse stated that the use of oxygen was not included in Resident #103's Baseline Care Plan, but should have been, noting it had been missed through simple oversight. She stated that not including Resident #103's need for oxygen therapy on the Baseline Care Plan could result in Nursing staff not having all the information they need to provide optimal care. During an interview with the DON on 09/2/7/2024 at 12:13 p.m., the DON stated the MDS Nurse is responsible for completing the baseline care plans and confirmed that use of oxygen therapy should have been included in Resident #103's baseline care plan. Record review of the facility policy, Care Plans, revised March 2022, revealed, the Person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical mental and psychosocial well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33866 Based on interview 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 1 of 18 residents (Resident #10) reviewed for care plans. The facility failed to ensure Resident #10's care plan dated 08/20/2024 reflected the resident's current diet texture order which had been updated/changed 08/30/2024. This failure could place residents at risk of not receiving appropriate care to meet their current needs. Findings include: Record review of a facility face sheet for Resident #10 dated 09/24/2024 indicated that he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: paroxysmal atrial fibrillation (irregular, often rapid heart that causes poor blood flow); Presence of cardiac pacemaker (an implanted device used to control irregular heart rhythm); Major Depressive Disorder (a mental health disorder characterized by persistent depressed mood or loss of interest) and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) Record review of Resident #10's Quarterly MDS assessment dated [DATE], revealed under Section C Cognitive Patterns, a BIMS score of 11 indicating moderate cognitive impairment. Further review of the MDS assessment under Section K - Swallowing/Nutritional Status revealed therapeutic diet, was checked, but not mechanically altered diet. Record review of Resident #10's Care Plan dated 08/20/2024 revealed a focus area of Regular, mech Soft, Thin diet Record review of physician orders dated 09/24/2024 for Resident #10 revealed a diet order for Regular diet Mechanical Soft texture, nectar consistency, with order date of 08/30/2024. Record Review of Resident #10's Speech Therapy SLP Evaluation and Plan of Treatment dated 08/29/2024 revealed a finding of swallowing disorder involving the Oral Phase and Pharyngeal Phase and was a Definite risk for: Aspiration, Delayed or slow swallow reflex and Wet or gurgly voice quality after swallowing liquids, with recommendation for skilled SLP services for dysphagia (difficulty swallowing.) Record review of Resident #10's tray card dated 09/24/2024 revealed a diet listed as Mech soft, Nectar Thick. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with SLP-B on 09/26/2024 at 01:00 p.m., SLP-B stated she put in the order to change his liquids texture from thin to nectar thick liquids on 08/30/2024 because when she last assessed Resident #10, she observed him coughing when given thin liquids which can be a sign of aspiration. She stated a swallow study was not done because swallow therapy is indicated prior to exam to increase ability to participate with objective testing, and noted he is currently receiving swallow therapy. During an interview with MDS Nurse on 09/26//2024 at 4:10 p.m., the MDS Nurse stated that Resident #10's Comprehensive Care Plan had not been revised when his diet texture order was changed from thin liquids to nectar thick liquids, on 08/30/2024, but should have been. MDS Nurse further stated she just didn't catch it when the order changed, and that she has since updated his Care Plan to reflect his current diet texture of nectar thick liquids. The MDS Nurse stated the resident's care needs may not be met if the Care Plan did not contain current accurate information. Record review of the facility policy, Care Plans, Comprehensive Person-Centered, Revised September 2022, revealed the following documentation: Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7. The comprehensive, person-centered care plan: e. Reflects currently recognized standards of practice for problem areas and conditions. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met 41651 46131

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days unless the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record, and indicate the duration for the PRN order for 1 of 3 residents (Resident #49) reviewed for pharmacy services . The facility failed to ensure Resident # 49 had a stop date for PRN Lorazepam 0.5 mg (a medicine used to treat the symptoms of anxiety) This failure could affect residents who received antipsychotic/psychoactive medications and could place residents at risk of receiving unnecessary psychotropic medications. The findings included: Record review of Resident # 49's face sheet dated 9/27/24, reveled a 95- year old female admitted to the facility on [DATE] with diagnosis that included : [Anxiety] a feeling of fear, dread, and uneasiness , [Dementia] the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities and [Alzheimer's disease] is a brain disorder that is characterized by changes in the brain that lead to deposits of certain proteins Record review of Resident #49 's most recent comprehensive MDS assessment, dated 8/22/24 revealed the resident was moderately cognitively impaired for daily decision-making skills and was treated with anti-anxiety medications. Record review of Resident #49's comprehensive care plan dated 8/16/24 revealed the resident had a diagnosis of anxiety and used antianxiety medication as ordered by the physician. Record review of Resident #49's Order Summary Report, dated 9/27/24 revealed the following: - Lorazepam Oral Tablet 0.50 MG, give 1 tablet by mouth every 4 hours as needed for anxiety disorder, with start date 8/17/24 and no stop date. Record review of Resident #49's Medication Administration Record for September 2024 revealed the following: - Lorazepam 0.50 mg was not administered PRN all month in September 2024. During an observation and interview on 9/27/24 at 10:01 a.m., Resident #49 was observed in wheelchair awake and alert. Resident #49 stated she needed the anxiety medication at times. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 2:12 p.m., during an interview, LVN C disclosed that she had previously given Alprazolam to Resident #49 to help with anxiety. LVN C explained that psychotropic medications like Lorazepam should be used for a limited time, usually up to 14 days. After 14 days, the nurse is required to contact the physician to reassess the resident's need for the medication. LVN C was unsure why the order for Alprazolam for Resident #49 was written for an indefinite period, and she expressed concern that the resident was at risk of falls by taking the medication for more than 14 days. During an interview and record review on 9/28/24 at 1:20 p.m., the (DON) revealed that Resident #49 required the use of Lorazepam as recommended by the physician due to the resident's diagnosis. The DON stated that if the medication was taken all the time, it could result in Resident #49 being overmedicated. After reviewing Resident #49's order summary, the DON confirmed that there was no stop date on the order for prn Lorazepam. The DON revealed that the order for Lorazepam was possibly overlooked, The DON stated that she was currently responsible for overseeing that psychotropic drugs are limited to 14 days, and her Assistant Director of Nursing (ADON) was to start monitoring this monthly moving forward to prevent this from occurring again. Record review of the facility policy and procedure titled, Antipsychotic Medication use , dated 2001, updated July 2022, revealed in part, PRN orders for antipsychotic medications will not be renewed beyond 14 days unless health care practitioner has evaluated the resident .

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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. 41651 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 for 1 of 1 kitchen reviewed in that: 1. A fire extinguisher inspector was not wearing a beard guard or full hair net in the kitchen during food preparation. 2. Pudding cups in Refrigerator #1 were neither labeled nor dated. 3. Chili in Refrigerator #2 was neither labeled nor dated. 4. Pie crusts in Freezer #1 were unsealed. These deficient practices could result in foodborne illness for those who consume snacks and meals prepared in the kitchen. The findings were: 1. Observation on 10/27/2024 at 10:32 a.m., revealed a man was inspecting the fire extinguisher in the kitchen. Further observation revealed he was wearing a hairnet with approximately four inches of hair extending from his neck to his shoulders and uncovered by the hairnet. Further observation revealed he had a beard and moustache which were not covered. During an interview with the Chef on 10/27/2024 at 10:33 a.m., the Chef confirmed the fire extinguisher inspector was not wearing a beard guard or full hair net in the kitchen during food preparation and should have been. 2. Observation on 10/27/2024 at 10:40 a.m. revealed a tray of pudding cups in Refrigerator #1 were neither labeled nor dated. During an interview with the Chef on 10/27/2024 at 10:33 a.m., the Chef confirmed the tray of pudding cups in Refrigerator #1 were neither labeled nor dated and should have been. 3. Observation on 10/27/2024 at 10:55 a.m., revealed a container of chili in Refrigerator #2 was neither labeled nor dated. During an interview with the Chef on 10/27/2024 at 10:33 a.m., the Chef confirmed the container of chili in Refrigerator #2 was neither labeled nor dated and should have been. 4. Observation on 10/27/2024 at 11:00 a.m., revealed a box of pie crusts in Freezer #1 were unsealed and exposed to freezer burn. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Chef on 10/27/2024 at 11:00 a.m., the Chef confirmed a box of pie crusts in Freezer #1 were unsealed and exposed to freezer burn and should not have been. Record review of the facility policy, Food and Supply Storage, revised 01/23, revealed, All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Record review of the facility policy, Uniform Dress Code, revised 01/23, revealed, Wear the approved hair restraint when on duty .restrain all facial hair with a beard net/restraint .

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items for 2 of 5 (Rooms #13 and room [ROOM NUMBER]) residents' refrigerators reviewed in that: The personal refrigerators in Rooms #13 and #14 contained food items which were unlabeled and undated. This deficient practice could place residents at risk of foodborne illness due to consuming foods which are spoiled. The findings were: Observation on [DATE] at 9:25 a.m. revealed the personal refrigerator in Resident room [ROOM NUMBER] contained chicken tenders, which was unlabeled and undated. Observation on [DATE] at 11:20 a.m. revealed a container with chicken tenders was still present in Rooms #13's personal refrigerator. Observation on [DATE] at 9:35 am revealed the personal refrigerator in room [ROOM NUMBER] contained opened strawberry jam container that was unlabeled and undated. Observation on [DATE] at 11:25 a.m. revealed opened strawberry jam container was still present in room [ROOM NUMBER]'s personal refrigerator. During an interview on [DATE] at 11:25 am, LVN C confirmed that personal refrigerator in resident room [ROOM NUMBER] contained chicken tenders that were undated and unlabeled and personal refrigerator in resident 14 room contained a jar of strawberry jam that was opened undated and unlabeled. She stated that both residents risked possibly eating food that was expired causing some form of food borne illness. During an interview with the DON on [DATE] at 12:40 p.m., the DON confirmed that perishable food and drinks in residents' personal refrigerators should be labeled and dated to prevent residents from consuming spoiled foods. The DON stated that night shift Charge Nurses, are responsible for overseeing this and currently this was not being monitored. Record review of thee facility policy, Food from outside sources, undated, revealed, Food or beverages brought into the facility for individual consumption will be labeled and dated for food safety.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to maintain medical records that are accurately documented for 1 (Resident #29) of 18 residents reviewed, in that: Resident #29's prescription for Tylenol included incorrect excessive dosage parameters. This deficient practice could result in liver failure due to residents receiving excessive dosages of acetaminophen. The findings were: Record review of Resident #29's face sheet, dated 10/25/2024, revealed she was admitted to the facility on [DATE] with diagnoses including: Pain Unspecified, Unspecified Fracture of Shaft of Right Femur, and Unspecified Atrial Fibrillation. Record review of Resident #29's Quarterly MDS assessment, dated 06/14/2024, revealed a BIMS score of 13 which indicated intact cognition. Record review of Resident #29's care plan, revised 12/26/2023, revealed [Resident #29] will live in comfort and dignity and be treated with courtesy and respect through this assessment period. Record review of Resident #29's clinical record, as of 10/25/2024, revealed an order, Give 2 tablet by mouth every 4 hours as needed for For Mild Pain/Fever related to PAIN, UNSPECIFIED (R52) Do Not Exceed 45 G of APAP [acetaminophen] in 24 hours. Record review of the National Center for Biotechnology Information, updated 01/11/2024, accessed 10/03/2024, revealed, Notably, the maximum daily dosage of acetaminophen should not exceed 4000 mg [milligram]. During an interview with the DON on 09/25/2024 at 4:50 p.m., the DON read Resident #29's Tylenol 325 order and stated, That has to be a typo. During an interview with the Consultant Pharmacist on 09/25/2024 at 5:00 p.m., the Consultant Pharmacist confirmed that receiving more than 4000 milligrams of acetaminophen in a twenty-four-hour period could lead to liver failure. Record review of the facility policy, Charting and Documentation, revised July 2017, revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interviews and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #37) observed for wound care in that: LVN-A failed to sanitize her hands between glove changes while performing wound care and failed to wash or sanitize her hands or change her gloves after touching the bedside table while providing wound care to Resident #37. These failures could result in cross contamination of germs and could result in an infection or hospitalization . The findings were: Record review of Resident #37's face sheet dated 09/27/2024 revealed he had an original admission on 04/04/1022 and a re-admission on 07/03/2024, with diagnoses which included : Osteomyelitis (bone infection) of vertebra (irregular bone that is part of spine), sacral and sacrococcygeal region (Bottom of spine near tailbone); and stage 4 pressure ulcer (most severe type of injury to skin and underlying tissue resulting from prolonged pressure on the skin) of left buttock. Record review of Resident #37's quarterly MDS assessment dated [DATE] revealed Resident #37 was always incontinent bowel and bladder and had a pressure ulcer of left buttock, Stage 4. Further review of the MDS revealed Resident 37's BIMS score was a 10, indicating moderate cognitive impairment. Record review of Resident #37's Care Plan dated 07/02/2024 revealed a focus area of Documented stage 4 Pressure Ulcer to left/right buttock with intervention to provide wound care per treatment order. Record review of Resident #37's Physician Orders dated 09/26/2024 revealed an order for left buttocks - cleanse wound with wound cleanser. Pat dry with dry gauze. Apply light dusting of collage powder into depth of wound bed, using cotton tip applicator insert 1/4 iodoform packing strip into wound bed revealing small wick emitting from the wound, cut to fit calcium alginate ag over wound bed opening. Cover with absorbent gentle bordered dressing every M-W-F and PRN soiling/accidental removal, every day shift for Stage 4 to left buttock. Observation on 09/27/2024 at 10:30 a.m. revealed that LVN-A did not sanitize her hands in-between glove changes while providing wound care for Resident #37. Further observation revealed while providing wound care, specifically while packing wound with packing strip for Resident #37, LVN-A grabbed the edge of the bedside table with her gloved hand and pulled the table closer to her so she could grab the scissors that were on top of the table. Without sanitizing or changing her gloves, LVN-A then proceeded to cut the packing strip with the scissors and proceeded to push remaining packing strip into the wound with the same gloved hand she used to grab the bedside table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an Interview on 09/27/2024 at 11:05 a.m., LVN-A stated not sanitizing her hands between glove changes or after touching the bedside table, could cause cross-contamination and could result in the resident getting an infection. During an interview with the DON on 09/27/2024 at 12:13 p.m., the DON stated the Nurse should have sanitized her hands in-between glove changes and after touching bedside table to prevent any infections from cross-contamination. She confirmed the nursing staff were trained in infection control. Review of the facility policy titled Standard Precautions revised September 2022, revealed Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care and hand hygiene is performed with alcohol-based hand rub (ABHR) or soap and water: (4) after contact with items in the resident's room; and (5) after removing gloves.

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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.

(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	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** 41651 Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, clean, comfortable and homelike environment for one of four resident hallways (Red Hall) reviewed, in that: The water temperature in the Red-Hall (Rooms 18, 20, 21, and 27) exceeded 110 degrees Fahrenheit. This deficient practice cause scalding or other physical injuries to residents and staff. Findings included: 1. Observation on 9/26/24 at 1:24 p.m., revealed the fixtures in room [ROOM NUMBER] measured 113 degrees Fahrenheit when tested with a probe type thermometer. 2. Observation on 9/26/24 at 1:30 p.m., revealed the fixtures in room [ROOM NUMBER] measured 113 degrees Fahrenheit when tested with a probe type thermometer. 3. Observation on 9/26/24 at 1:35 p.m., revealed the fixtures in room [ROOM NUMBER] measured 112 degrees Fahrenheit when tested with a probe type thermometer. 4. Observation on 9/26/24 at 1:40 p.m., revealed the fixtures in room [ROOM NUMBER] measured 113 degrees Fahrenheit when tested with a probe type thermometer. Record review of the Water Temperature Log provided by the Maintenance director on 09/26/24 at 3:50 p.m., revealed the facility had been having issues controlling the water temperatures as early as 05/10/24. In an interview on 9/26/24 at 1:50 p.m., the Maintenance director confirmed the temperature readings of the bedrooms sinks and showers exceeding 110 degrees Fahrenheit. He stated he has been having trouble keeping the water temperatures under 110 degrees Fahrenheit and would have complaints about the water temperatures being too cold by residents. He further stated he would adjust the mixing valve for temperature stabilization as soon as possible. He stated residents could potentially be affected by scalding or other physical injuries. Record review of the facility policy, Homelike Environment, revised February 2021, revealed, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.