

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2024
NAME OF PROVIDER OR SUPPLIER Memorial Medical Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 307 W Cypress St San Antonio, TX 78212	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753</p> <p>Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but not later than 2 hours after the allegation was made to the State agency for 1 of 7 staff (Resident #1) reviewed for failure to report. in that:</p> <ol style="list-style-type: none"> 1. CNA B did not report an allegation of abuse at the time of the suspected abuse for Resident #1 on 05/31/2024. 2. CNA C did not report an allegation of abuse at the time of the suspected abuse for Resident #1 on 05/31/2024. <p>This failure could place residents at risk of abuse or neglect.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet revealed she was a [AGE] year-old female who was originally admitted to the facility on [DATE] with diagnoses which included: type 2 diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar), depression, and anxiety.</p> <p>Record review of Resident #1's annual MDS, dated [DATE], revealed Resident #1 had a BIMS score of 2, indicating severe cognitive impairment. Resident #1's MDS also revealed Resident #1 was usually able to make self-understood and was usually able to understand others and comprehends most conversations.</p> <p>Record review of Resident #1's care plan, initiated 09/17/2020 and revised on 10/27/2021, revealed Resident #1 was resistive to care and at times refuses to shower, at times refuses facial hair to be trimmed, at times refuses meds, at times refuses meals/supplements, refused PNA shot, at times refuses treatment/wound care, at times refuses to be weighed.</p> <p>Record review of Resident #1's care plan, initiated 01/06/2022, revealed Resident #1 had bladder incontinence. Resident #1's care plan, initiated 07/10/2020, Resident #1 had bowel incontinence.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2024
NAME OF PROVIDER OR SUPPLIER Memorial Medical Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 307 W Cypress St San Antonio, TX 78212	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's June 2024 MAR revealed an order for Ativan oral tablet 1mg. Give 1 tablet by mouth two times a day related to anxiety disorder.</p> <p>During an interview with a previous facility employee, on 06/01/2024 at 11:00a.m., the previous employee stated she received a call at 6:12 am on 06/01/2024 from CNA C and an unnamed employee who reported they thought they might have seen semen on Resident #1's vagina. The former employee stated she called and spoke to the Administrator and reported the allegation to her at 6:21a.m on 06/01/2024.</p> <p>During an interview with the facility Administrator, on 06/01/2024 at 12:25p.m., the Administrator stated she received a call from the former employee on the morning of 06/01/2024 and was notified of the allegation. The Administrator took immediate steps to investigate the allegation. During this time, she called and spoke to CNA C who confirmed she did call the former employee because something was not right between her legs. The Administrator stated CNA C then stated she had changed Resident #1 three times over the night and noticed what she thought was semen in Resident #1's brief. The Administrator stated she asked CNA C if she reported the incident to the charge nurse at the time of the alleged sighting and she said no, I didn't know what to do. The Administrator stated she asked CNA C why she did not report it immediately and CNA C said, I wasn't sure it was anything that needed to be reported. The Administrator stated she asked CNA B and CNA C to write a statement and remain at the facility until she arrived so they could discuss the incident further. The Administrator stated she called the Charge Nurse, LVN A, who was still at the facility, and he was not aware of the allegation. The Administrator stated she asked LVN A to go into Resident #1's room and complete an assessment of Resident #1. LVN A called the Administrator back and reported that Resident #1 had some vaginal discharge and a BM in her brief. LVN A stated Resident #1 was not exhibiting any sign of distress and had no redness, bruising, discolorations, or marks in her vaginal area. The Administrator stated when she and the DON arrived at the facility, CNA B and CNA C were no longer at the facility. The Administrator said the DON completed a head-to-toe assessment and found no signs of bruising, discolorations, or marks on Resident #1. The DON did observe Resident #1's bladder distended and obtained a urine sample with a catheter to test for a urinary tract infection. The Administrator stated the police department, the physician, and Resident #1's representative, and health and human services had been notified of the allegation and the facility was sending Resident #1 to the hospital for a SANE exam.</p> <p>During an interview with Resident #1, on 06/01/2024 at 1:15p.m., Resident #1 appeared alert and calm and was exhibiting no signs or symptoms of distress or fear. Resident #1 was able to answer questions appropriately and did not exhibit any signs of distress during the interview. Resident #1 denied any pain or discomfort at the time of the interview. Resident #1 reported being happy with the staff and the care and treatment of the facility staff. Resident #1 denied anyone had harmed her, touched her inappropriately, raped her, or mistreated her. Resident #1 denied any fear or concern with male employees. When asked what she would do if anyone tried to harm her or touch her inappropriately, she said I would report it to the front office or my nurse. Resident #1 reported feeling safe at the facility and stated she felt safe reporting an incident if something happened to her.</p> <p>During an interview with a police officer, on 06/01/2024 at 1:45p.m., the police officer stated he interviewed Resident #1, and Resident #1 expressed no concerns and made no outcry of abuse or sexual assault. The officer stated the police department would not be filing a formal report or sending the resident for a SANE exam based on the information he gathered. The officer stated the facility could send the resident to the hospital for a SANE exam.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2024
NAME OF PROVIDER OR SUPPLIER Memorial Medical Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 307 W Cypress St San Antonio, TX 78212	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CNA B on 06/01/2024 at 2:40p.m., CNA B stated she was working a double shift on 05/31/2024 and usually does not work in the evenings. She said she changed Resident #1's brief around 5:30p.m. and then passed out dinner trays to the other residents. She said she was going back in Resident #1's room around 8:30p.m. and she was told by CNA C that CMA D said not to go in Resident #1's room because he already took care of her and fed her. CNA B said she did not go in there but heard Resident #1 yelling and making noises. CNA B said she does not like CMA D and that CMA D acts like he is in charge of everyone. CNA B said she glanced in Resident #1's room at 8:45p.m. and she looked fine, and she was kind of screaming out like she does when she wants something. CNA B stated after CMA D left the facility at the end of his shift, she went into Resident #1's room to change her brief. CNA B said when she changed Resident #1, she noticed a vaginal discharge that looked like semen to me and it was soaked in urine. CNA B said she cleaned Resident #1 but left a little bit of it just in case it needed to be tested. CNA B said she didn't know what to do or what to think about what she witnessed, and she knew she should have told someone but she just didn't know what to think. CNA B stated a little while later I went and got CNA C and took her into the room and showed her. CNA B said CNA C then asked Resident #1 if that black guy touched her and if he was doing something to her and Resident #1 said yes. CNA B said she called the rape crisis center around 3:00a.m. and asked them what to do and they told her to notify the police. CNA B said she called the police, and they told her to notify the Abuse Coordinator at the facility. When asked who the Abuse Coordinator was at the facility, CNA B stated the Administrator's name. When asked why she did not report the allegation when she first suspected abuse she stated, I just didn't know what I was seeing and didn't know what to think. CNA B said she and CNA C started looking around the facility for the phone numbers to call that morning and called the number to the Administrator and no one answered. They then called another number they found and reached the ex-employee around 6:00a.m. When CNA B was asked if she had received training on abuse and neglect, she stated, yes.</p> <p>During an interview with CNA C on 06/01/2024 at 4:40p.m., CNA C stated she observed CMA D go into Resident #1's room to feed her dinner and then observed him come out of the room. CNA C said she was feeding another resident dinner and could hear Resident #1 yelling out. She said she was going to the room to check on her and when she got to the room CMA D told her to leave Resident #1 alone, so she did. CNA C said sometime after 11pm CNA B came and got her and asked her to go to Resident #1's room with her. CNA C said CNA B opened Resident #1's brief and CNA C saw her vagina spitting out semen. CNA C said she asked Resident #1 did that black man put his pee pee in you and Resident #1 said yes. CNA C said she did not report it to anyone at that time and said, I got busy doing showers and I don't know what CNA B did about it. CNA C stated in the early morning of 06/01/2024, CNA C and CNA B started looking around the facility for a phone number of someone to call and stated CNA C called the Administrator and the DON and got no answer. CNA C said she then called the ex-employee and reported the allegation. When CNA C was asked why she did not report it immediately she replied, because I got busy and did not know who to call. When CNA C was asked why she did not report it to the Charge Nurse she stated, I did not think he would do anything. CNA C was asked if she had received any training on abuse and neglect and she said, no.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2024
NAME OF PROVIDER OR SUPPLIER Memorial Medical Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 307 W Cypress St San Antonio, TX 78212	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with CMA D on 06/01/2024 at 5:08p.m., CMA D stated he fed Resident #1 dinner the previous night in her room around 6:30p.m. CMA D said he was in the room approximately ten to fifteen minutes while feeding Resident #1 and said Resident #1 was calm during dinner. CMA D said he had fed her dinner at least four times over the last week. CMA D said after feeding her dinner he continued with his medication pass. CMA D said he overheard Resident #1 yelling out and observed CNA B and CNA C in front of her room. CMA D stated he did not and has never provided any brief changes or peri care to Resident #1 and denied any accusations. CMA D stated he had received training on abuse, when to report abuse, and named the Administrator as the Abuse Coordinator.</p> <p>During an interview with LVN A on 06/02/2024 at 7:00a.m., LVN A stated he was not aware of an allegation until he received a call from the DON on the morning of 06/01/2024. LVN A stated he went to the room to assess Resident #1 and observed Resident #1 in no distress. LVN A stated he removed her brief and observed Resident #1 had no bleeding, her vaginal area was slightly pink, and she had a little bit of vaginal discharge. It was white or grayish and looked like vaginal discharge. It looked like a discharge a female gets when they have a UTI. LVN A said Resident #1 returned from the hospital during his shift on the evening of 06/01/2024 and Resident #1 was not making any allegations and was exhibiting no distress.</p> <p>During an interview with the hospital SANE nurse on 06/02/2024 at 10:51a.m., the SANE nurse stated Resident #1 arrived at the hospital for a SANE exam but Resident #1 was not making an outcry of sexual assault and was denying the allegation. The SANE Nurse said she could not conduct the SANE exam due to the police department not authorizing the SANE exam. The SANE nurse said she spoke to the police department, and they were not investigating the allegation and therefore the SANE kit could not be collected or submitted for evidence. The SANE nurse stated she spoke to Resident #1 at length and Resident #1 was able to answer all of her questions appropriately. She stated Resident #1 stated nothing happened to her, no one had hurt her, and she felt safe at the facility. The SANE Nurse said Resident #1 asked to be sent back to the facility and called it her home. The SANE Nurse stated I know someone said they thought they saw semen in her brief, but I can tell you, I have been a SANE Nurse and investigated sexual assaults for a long time and it is impossible to tell the difference between semen and other types of vaginal discharge without the use of a microscope. There is no other way to make that determination The SANE Nurse said she did perform an exam of Resident #1's vaginal area with the emergency room physician and said Resident #1's peri area was not red, swollen, no discolorations, no tears, bruising, or pain. The SANE Nurse said there were no signs of trauma or sexual intercourse. The SANE Nurse also stated they conducted a test for sexually transmitted disease and the results were negative. The SANE Nurse stated, I firmly do not believe anything happened to Resident #1 based on the exam and her interview.</p> <p>During an interview with the DON on 06/02/2024 at 11:34a.m., The DON stated her expectation was for staff to report allegations of abuse immediately. She stated staff had received education on reporting abuse and neglect. The DON stated she had received a call on the night of 05/31/2024 around 5:30p.m. from CNA B about another matter and asked CNA B why she did not call and report the allegation to her at 11pm when she had called the DON earlier in the night. She said CNA B said, I didn't want to bother you and stated CNA B stated as the night went on she kept seeing more sperm in Resident #1's vagina so that was when she decided to report it, at the end of her shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2024
NAME OF PROVIDER OR SUPPLIER Memorial Medical Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 307 W Cypress St San Antonio, TX 78212	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on 06/02/2024 at 1:39p.m., The Administrator stated it was her expectation that staff report abuse and neglect immediately to her and to the Charge Nurse so the allegation can be investigated. The Administrator stated signs were posted within the facility at the nurse's stations identifying the Administrator as the Abuse Coordinator with her phone number and the Social Worker as a backup phone number.</p> <p>Observation during initial rounds on 06/01/2024 at 12:45p.m. revealed signs in the front common area listing the Abuse Coordinator as the Administrator, resident rights posters, Ombudsman posters, and compliance and hotline posters. Observation at three nurses' stations revealed a sign listing the name and number of the Administrator as the Abuse Coordinator and also listed the Social Workers name and number.</p> <p>Observation of Resident #1, 06/01/2024 at 3:52p.m., revealed Resident #1 on a stretcher with two EMS personnel taking her through a large open common area of the facility and overheard Resident #1 say can you spin me around. Observed the EMS personnel laugh and spun Resident #1 in a gentle circle on the stretcher.</p> <p>Record review of Resident #1 progress note, dated 06/01/2024 at 9:37a.m., revealed a noted by the DON stating Resident #1 received a head-to-toe assessment and no bruising or discoloration were noted to breast, abdomen, thighs, or groin. Note also stated and in and out catheter was performed, and the DON collected about 200ml of urine that appeared yellow, cloudy, and with a foul odor.</p> <p>Record review of Resident #1's progress notes, dated 06/01/2024 at 5:57p.m., 01/01/2024 at 8:15p.m., 01/01/2024 at 8:30p.m., and 06/02/2024 at 1:47a.m., revealed resident had returned from the hospital and was calm, at baseline, and in no distress.</p> <p>Record review of a form titled in-service attendance form, dated 06/01/2024-06/02/2024, revealed an in-service that stated the Administrator was the Abuse Coordinator, staff should report immediately, and listed the Administrator's phone number.</p> <p>Record review of facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, dated 04/2021, revealed residents have the right to be free from abuse neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental sexual or physical abuse and physical or chemical restraint not required to treat the resident's symptoms. The policy also stated, investigate and report any allegations within timeframes required by federal requirements.</p> <p>Record review of a facility form Job Title: Certified Nursing Assistant, revision date 05/2019, revealed report immediately to the proper legal authorities if you have reason to believe a resident has been physically, emotionally, or sexually abused, or been a victim of theft of their personal property. The job description is signed by CNA B on 04/17/2024.</p> <p>Record review of a facility form Job Title: Certified Nursing Assistant, revision date 05/2019, revealed report immediately to the proper legal authorities if you have reason to believe a resident has been physically, emotionally, or sexually abused, or been a victim of theft of their personal property. The job description is signed by CNA C on 04/17/2024.</p>		