| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455597 | A. Building<br>B. Wing | 11/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Memorial Medical Nursing Center | 307 W Cypress St<br>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.

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>(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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 2 of 3 resident rooms (Resident #1 and Resident #2) and 1 of 2 patio door entries observed for housekeeping and maintenance services. 1. The facility failed to provide a functional accessible bathroom door and bedroom door to Resident #1.2. The facility failed to ensure Resident #2's room had broken/torn rubber baseboards, holes in the wall, and broken/missing tiles in the shower.3. The facility failed to ensure the entry/exit door to the patio which led to the smoking area functioned properly and there was no gap between the ramp and the threshold. These deficient practices could place any residents at risk of living in an unclean, unsafe, and unsanitary environment and result in feelings of dissatisfaction.The findings included:1. Record review of Resident #1's face sheet dated 11/14/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included cervical disc disorder with myelopathy (condition where a damaged or herniated disk in the neck compresses the spinal cord leading to neurologic symptoms), osteoarthritis of the right hand (chronic joint disease where the cartilage that cushions the ends of bones gradually wears down), lack of coordination, chronic pain syndrome, and need for assistance with personal care.Record review of Resident #1's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills.During an interview and observation on 11/12/25 at 12:14 p. m., Resident #1 stated he had lived in his room for approximately 3 to 4 months and had informed the Maintenance Director regarding the bathroom door only opening 1/4 of the way and the bedroom door not shutting properly since residing in the room. Resident #1 stated, although he utilized a wheelchair, the bathroom was not accessible because the door only opened 1/4 of the way and it was difficult when he had visitors. Resident #1 stated the bedroom door did not close properly. Observation of Resident #1's bedroom door revealed the bottom hinge was coming off the frame. Resident #1 stated they did not have a functional bathroom door and bedroom door bothered him because the times he had visitors they could not get into the bathroom to use it and if he wanted privacy, it was difficult because the bedroom door could not be closed properly.2. Record review of Resident #2's document titled admission and Baseline Care Plan/Summary, dated 8/29/25 revealed an admission date of 8/29/25 and reflected the resident was cognitively intact for daily decision-making skills, and required total assistance with mobility.During an observation and interview on 11/12/25 at 2:22 p.m., revealed Resident #2's room had a pipe over the head of the bed, on the wall, which had a missing plate that exposed a hole surrounding the pipe that was approximately 1/4 inches in diameter. Observation of Resident #2's shower revealed there were missing tiles, and tiles laid on the floor in the shower room. Observation of Resident #2's room revealed there were missing/torn rubber baseboards next to the resident's closet, on the wall to the right of the resident's bed and in the bathroom. Resident #2 stated he had informed the CNA staff about the broken tiles, the hole in the wall, and the missing/torn rubber baseboards about 3 weeks ago. Resident #2 stated he had seen the Maintenance Director, but not in his room. Resident #2 stated the condition of his bedroom made him feel bad because, I'm paying to live here, and they haven't done anything over here on this side of the unit. Resident #2 stated the entry door from the smoking area was dangerous and the door was heavy, and it did not stay open long enough to allow residents in wheelchairs to come inside and the ramp on the threshold was too high and there was a gap between the ramp and the threshold. 3. Record review of Resident #3's face sheet dated 11/14/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included abnormal posture, severe protein-calorie malnutrition, muscle weakness, and need for assistance with personal care.Record review of Resident #3's most recent comprehensive MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily-decision making skills, utilized a wheelchair, and required substantial/maximal assistance with mobility and transfers. During an observation on 11/12/25 at 2:15 p.m., Resident #3 was observed in her wheelchair attempting to enter the building from the door which led to the smoking area and unable to get inside. Resident #3 called for help and was assisted by an unidentified staff back into the building. Observation of the entry/exit door to the patio which led to the smoking area was observed closing rapidly and the mechanism for slowing the door that was supposed to be mounted at the top of the frame was missing. The entry/exit door threshold was observed with a ramp that had a metal plate over it and there was a one-inch crack/gap on the floor between the entrance and exit. During an interview |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access for 4 of 7 Residents (Resident #4, #6, #1 and #7) reviewed for labeling and medication storage:1. The facility failed to ensure Resident #4 did not have an ampule of Ipratropium-Albuterol Solution (prescribed for use with a nebulizer for breathing treatments for shortness of breath) at the bedside.2. The facility failed to ensure Resident #6 did not have a jar of medicated mentholated ointment (a combination product that is used to relieve itching, minor muscle, or joint pain. This product may also be used as a chest rub to soothe symptoms associated with the common cold), a bottle of eye drops, and a medication cup with antacids at the bedside. 3. The facility failed to ensure Resident #1 did not have a bottle of medication that contained magnesium hydroxide used to relieve constipation, heartburn, or indigestion, and a bottle of vitamins at the bedside. 4. The facility failed to ensure Resident #7 did not have a jar of medicated mentholated ointment and the same product in a roll-on stick (a combination product that is used to relieve itching, minor muscle, or joint pain. This product may also be used as a chest rub to soothe symptoms associated with the common cold) at the bedside.These deficient practices could affect residents who received medications in the facility and place them at risk for not receiving the correct medications, medication misuse or drug diversion.The findings included:1. Record review of Resident #4's face sheet dated 11/12/25 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included sepsis (medical condition that happens when the body has an extreme, dysregulated response to an infection), hypertension (high blood pressure), and chronic obstructive pulmonary disease (a chronic progressive lung disease that makes it hard to breathe due to airflow obstruction that is not fully reversible).Record review of Resident #4's most recent comprehensive MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills.Record review of Resident #4's Order Summary Report dated 12/12/25 revealed the following:- Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3ml inhale orally three times a day for SOB with order date 10/19/25 and no end date.During an observation and interview on 11/12/25 at 10:01 a.m., Resident #4 was observed sitting up in bed and a nebulizer machine was on the resident's nightstand on the left of the bed. The nebulizer mask and tube were resting on the nightstand. Resident #4 stated she had received a breathing treatment earlier in the morning but needed another breathing treatment because she had a history of asthma and knew she needed another breathing treatment. Resident #4 took an ampule of Ipratropium-Albuterol Inhalation Solution that was on the nightstand and placed the nebulizer mask on her face to give herself the breathing treatment. Resident #4 stated RN B had given her the Ipratropium-Albuterol Inhalation Solution that same morning, a few hours ago, and stated she usually kept the ampule in her pocket. During an interview on 11/12/25 at 3:23 p.m., RN B stated Resident #4 received nebulizer breathing treatments and had given the resident the Ipratropium-Albuterol Inhalation Solution on 11/12/25 and should not have because the resident was not able to self-medicate. RN B stated she got busy with a request for narcotics and pain medication for another resident. RN B stated nursing administered breathing treatments, period and Resident #4 could not self-medicate because she would over-medicate herself, and because she would need to follow up with the resident to check for response to the treatment. RN B stated breathing treatments could also elevate the heart rate, which was also a reason for nursing intervention. RN B stated, residents here are not allowed to self-medicate. 2. Record review of Resident 6's face sheet dated 11/14/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included Parkinson's disease (a progressive neurological disorder that affects movement), chronic obstructive pulmonary disease (a chronic progressive lung disease that makes it hard to breathe due to airflow obstruction that is not fully reversible), diabetes (a chronic medical condition where the body has trouble controlling the level of sugar in the blood), heart failure, dementia (a group of conditions that cause a decline in memory, thinking, and daily functioning), acute bronchitis (a short-term inflammation of the airways that carry air in and out of the lungs), acute respiratory failure with hypoxia (a medical condition in which the lungs cannot get enough oxygen into the blood to meet the body's needs), and Alzheimer's disease (a progressive brain disorder that leads to a continuous decline in memory, thinking, behavior, and the ability to carry out daily activities).Record review of Resident #6's most recent comprehensive MDS assessment dated [DATE] revealed the resident was |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 5 residents (Resident #5) reviewed for accuracy of records:The facility failed to ensure nursing staff documented Resident #5's admission nursing assessment.This failure could affect residents whose records were maintained by the facility and could place the residents at risk for errors in care and treatment.The findings included:Record review of Resident #5's face sheet dated 11/13/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included cerebral infarction (type of stroke that occurs when blood flow to a part of the brain is blocked), acute respiratory failure with hypoxia (medical condition in which the lungs suddenly cannot provide enough oxygen to the blood), diabetes (chronic medical condition in which the body has trouble regulating blood sugar), hematemesis (vomiting blood), lack of coordination, need for assistance with personal care, abnormalities of gait and mobility, hyperlipidemia (high cholesterol), epilepsy (chronic neurological disorder in which a person has recurrent, unprovoked seizures), and chronic obstructive pulmonary disease (long term lung disease in which the airways and air sacs become damaged, inflamed, and narrowed, making it difficult to breath).Record review of Resident #5's most recent comprehensive MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills.Record review of Resident #5's History and Physical document revealed an admission physical assessment was completed by the physician on 10/29/25.During an interview on 11/12/25 at 2:41 p.m., Resident #5 stated she could not recall having seen or checked by a doctor since she was admitted on [DATE]. The resident stated she believed she did not receive her diabetes pills, insulin, or seizure medications the first couple of days after being admitted . During an interview on 11/14/25 at 10:56 a.m., the Administrator, who is also an RN, stated it was best practice for Resident #5's nursing admission assessment to be completed at the time of admission and no later than 72 hours. The Administrator stated at the time of Resident #5's admission on [DATE], the admitting nurse had to leave the floor due to a family emergency and the Administrator and the ADON took over. The Administrator stated she verified the physician orders and input the resident's medications into the electronic record. The Administrator stated the nursing admission assessment for Resident #5 was not in the electronic record and could not be found. The Administrator stated there was a problem with not having a complete nursing assessment because the assessment was used to develop the resident's care plan. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 5 residents (Resident #4) reviewed for infection control:The facility failed to ensure Resident #4's oxygen mask and tubing were stored properly when not in use.This deficient practice could place residents at-risk for infection due to improper care practices.The findings included:Record review of Resident #4's face sheet dated 11/12/25 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included sepsis (medical condition that happens when the body has an extreme, dysregulated response to an infection), hypertension (high blood pressure), and chronic obstructive pulmonary disease (a chronic progressive lung disease that makes it hard to breathe due to airflow obstruction that is not fully reversible).Record review of Resident #4's most recent comprehensive MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills.Record review of Resident #4's Order Summary Report dated 12/12/25 revealed the following:- Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML, 3ml inhale orally three times a day for SOB with order date 10/19/25 and no end date.On 11/12/25 at 10:01 a.m., Resident #4 was observed sitting up in bed and a nebulizer machine was on the resident's nightstand on the left of the bed. The nebulizer mask and tube were resting on the nightstand, not properly stored in a bag. Resident #4 stated she had a breathing treatment earlier in the morning but needed another breathing treatment because she had a history of asthma and knew she needed another breathing treatment. Resident #4 took an ampule of Ipratropium-Albuterol Inhalation Solution that was on the nightstand and placed the nebulizer mask on her face to give herself a breathing treatment. During an interview on 11/12/25 at 3:23 p. m., RN B stated Resident #4 received nebulizer breathing treatments and had given the resident the Ipratropium-Albuterol Inhalation Solution and should not have because the resident was not to self-medicate but got busy with a request for narcotics and pain medication for another resident. RN B stated, when the nebulizer mask and tubing were not in use they were supposed to be stored in a bag because spores were everywhere, and it was a break in infection control which could result in the resident getting sick. RN B stated, the nebulizer mask and tubing were changed out every Sunday or as needed.During an observation and interview with the Administrator on 11/13/25 at 8:19 a.m. revealed Resident #4's nebulizer machine on the nightstand to the left of the bed had the nebulizer mask and tubing on the counter and not stored in a bag. The Administrator stated it was her expectation for the nebulizer mask and tubing, when not in use, should be stored in a plastic bag to prevent cross contamination which could result in the resident developing an infection. The Administrator stated, since the nebulizer mask and the tubing were not stored properly, they would have to be discarded. |