STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	01/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, that residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices for 1 of 5 residents (Resident #1) reviewed for quality of care/treatment. Resident #1 was not given wound care three times in [DATE] and one time in [DATE] for a back tailbone surgical wound. This failure could result in residents needing wound care undergoing a decline in health, non-healing of pressure ulcers or wounds, exposure to infections, and a diminished quality of life.The findings include: Record review of Resident #1's face sheet, dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] and discharged to hospital [DATE] (seizure like symptoms). Resident #1 had diagnoses which included: aftercare for a surgical wound on the tail bone (primary admission diagnosis), Type 2 diabetes, severe protein-calorie malnutrition, low blood pressure, hypertension, and history of substance use. [No diagnosis of seizures] The RP was listed as a family member.Record review of Resident #1's quarterly MDS, dated [DATE], reflected a BIMS score of 11, indicative of moderate impairment in cognition. The ADLs for: B/B were incontinent with substantial to maximum assistance. Transfer and Mobility was substantial to maximum assistance. ROM: no impairments. Assistive device was a wheelchair. Record review of Resident #1's CP undated reflected: Goal of treatment for an altered skin to sacral and lower back abscess (initiated [DATE] before her re-admission on [DATE]). Interventions included: air loss mattress, barrier precautions, and weekly skin inspection. Treatment also included participation in IV infusion program to increase healing and reduce risk of infections. Record review of Resident #1' skin assessments reflected:[DATE]: abscess surgically removed L 4.0 cm X W 3.5cm X D 3.0cm.[DATE]: abscess surgically removed L 1.6 X W 1.7 X D 1.5 [assessment: improvement][DATE]: abscess surgically removed L 0.9 X 1.0 X D 0.9 [assessment: improvement][DATE]: abscess surgically removed L 0.6 X W 0.7 X D 1.0 [assessment: stable][DATE]: surgical L 0.5 X W 0.5 X D 1.0 [assessment: further improvement in L and W stale on D][DATE]th, 2026 surgical L 0.8 X W 0.8 X 1.0 [assessment D was stable L increased by 0.3 and L increased by 0.3-no major change] Record review of Resident #1's physician's orders dated [DATE], read: .Surgical Site.sacral surgical incision: Cleanse with NS/WC. Pat dry, pack with Iodoform strip and secure with dry dressing daily and PRN for soilage or removal. every day shift for wound management. Record review of Resident #1's TAR, reflected:[DATE]:---Wound care not done: [DATE],[DATE], and [DATE]. [DATE]:---Wound care not done: [DATE]. Record review of email dated [DATE] authored by a family member sent to Surveyor A reflected: --- [DATE] - Photograph documents an existing bandage that remained unchanged for an extended duration --- [DATE] - Image shows the same bandage still in place, indicating no documented dressing change since [DATE].Record review of Resident #1's Nurse's Note dated late entry [DATE] authored by RN E reflected: resident was sent to ER on [DATE] around 9:29 AM per family request and MD approval for seizure-like symptoms. Vitals were (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	normal; and resident was able to answer simple questions. Record review of R#1's ER report dated [DATE] reflected resident presented to the ER for an altered mental state and seizure. At the ER the resident coded resulting in 5 minutes of CPR. Resident was transferred to ICU for further observation. Laboratory tests revealed resident had a UTI. ER diagnoses given to the resident were: cardiac arrest on [DATE], obstructive shock (blood clot) caused by massive pulmonary embolism (blockage in a lung artery). Resident was placed on a ventilator. Observation on [DATE] at 10:30 AM, Resident #1 was on a ventilator in an ICU bed, not alert or oriented. During an interview on [DATE] at 10:35 AM, the ICU Nurse stated the resident was admitted to the ICU for a seizure like activity, sepsis (unknown source), and cardiac arrest in the ER for respiratory failure. The ICU Nurse stated the admission was not for the resident's surgical tail bone wound. During an interview on [DATE] at 10:40 AM in the hospital, the RP stated: the family visited the resident daily while she was in the nursing home. The RP alleged the resident was not receiving proper incontinent care with feces and urine sometimes found around the tail bone surgical wound. The RP added that the resident also did not receive proper wound care around the surgical wound (tail bone on back). The RP stated he had photos that attested to the worsening of the resident's surgical wound [photos were sent to the surveyor and were considered as part of the evidence]. During an interview on [DATE] at 4:21 PM, LVN B (wound nurse stated) stated that she could not give an explanation why wound care was not documented in [DATE] with missed dates ([DATE], [DATE] and [DATE]) and [DATE]. LVN B stated she was present on [DATE], [DATE] and [DATE] working on the floors as a nurse and it should have been the back-up nurse to do the wound care as ordered by the physician on Resident #1. Regarding the missed wound care on [DATE], LVN stated she was present as a floor nurse and wound care was not done. LVN B stated she was working the halls as a nurse and did not do wound care on [DATE], and expected the back-up nurse to do the wound care for Resident #1 on [DATE]. LVN B stated she could not remember who the back-up nurse or nurses were on [DATE]. During a telephone interview on [DATE] at 4:55 PM, NP stated that Resident #1's wound to the surgical area had improved over time. The NP stated on [DATE] the wound measured 0.6 cm X 0.7 cm X 1.0 cm with underlying mining of 1.5 cm (edge of wound). The NP stated there was no infection in the wound and no signs of feces or urine being in the wound. NP stated she made weekly wound care to the residents, and the resident was not bed bound. The NP stated on [DATE], the surgical wound measured 0.8cm X 0.8 cm X 1.0 cm with no infection or signs of urine or feces being in the wound. NP stated Resident #1's surgical wound had improved and stabilized prior to her (Resident #1) going to the ER on [DATE]. The NP stated nurses needed to follow MD orders and there was no excuse for wound care not given on the days the nurses missed wound care in [DATE] and [DATE]. NP stated the missed days of wound care did not adversely affect Resident #1 surgical wound or worsen the surgical wound. During an interview on [DATE] at 9:25 AM, the DON stated: Resident #1 received incontinent care at least every shift as standard nursing practice. DON stated weekly skin assessments revealed no skin breakdown or infection due to incontinent care. The DON stated Resident #1 was treated for a surgical wound from the time of admission until discharged on [DATE] to ER. DON stated the surgical wound improved and stabilized. The DON stated on [DATE] the family requested an ER visit because the resident was having seizure-like symptoms. The DON stated vitals taken at time of transfer and were BP=127/89 (normal), pulse=106 (little elevated over 100 (resident was a smoker), respiration=23 (normal), 02 saturation =97 %, temp=98.2 (normal); glucose=247 (normal for DM). The DON stated the resident was not sent to the ER for any issues involving wound care. The DON added she only became aware of the missing wound days involving Resident #1 when presented the evidence by the surveyor. The DON stated she had no explanation for the missing wound days except that the resident's wound condition did (continued on next page)

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