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	04/26/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on interviews and record review, the facility failed to ensure residents and/or the residents' representatives the right to participate in the development and implementation of his or her person-centered plan of care for 4 of 8 residents (Residents #20, #8, #3, and #29) reviewed for care plans. The facility failed to invite and include the input of the resident (Resident #20, #8, #3, and #29) and/or residents' representatives as members of the interdisciplinary team in Care Plan Conference meetings. This failure could place residents at risk of not receiving the interventions, treatments and care necessary for the resident to reach their highest practicable physical, mental, and psychosocial well-being by not involving the resident and/or residents' representatives in Care Plan Conference meetings. The findings included: 1. Record review of the Admission Record revealed Resident #20 was a [AGE] year-old female originally admitted on 7/09/2020. Record review of the comprehensive MDS dated [DATE], revealed Resident #20 had a BIMS summary score of 2, indicative of severe cognitive impairment. Resident #20's primary medical condition category that best described the primary reason for admission was medically complex condition related to type two diabetes mellitus. Other active diagnoses included moderate intellectual disabilities, contracture of an unspecified foot, morbid (severe) obesity due to excess calories and abnormal weight loss. Resident #20 had a formal, clinical assessment that determined she was at risk of developing pressure ulcers/injuries but did not receive any skin and ulcer/injury treatment. Resident #20 source of information regarding participation in assessment and goal setting was coded as family. (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

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	04/26/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/23/2024 at 11:30 AM, a family member of Resident #20 stated that the family member had not been informed of any care plan meetings for Resident #20. The family member stated the facility will notify the family member when there was a change in condition, an urgent situation, or when there was COVID-19 in the building. The family member stated having a care plan meeting periodically would have been something the family member wanted. The family member stated, maybe that could have prevented some of Resident #20's physical decline. The family member stated Resident #20 had new wounds to her shin and that the family member had not been informed of before the family member visited that morning [4/23/2024]. The family member stated Resident #20 had developed contractures on her lower legs since her admission to the facility. The family member stated Resident #20 had been able to feed herself when she first arrived at the facility with minimal verbal prompts but now had to be fed and had lost weight at one point. Record review revealed Resident #20's last Care Plan was dated 2/27/2024. The Care Plan document did not include information regarding the date or time the Care Plan Conference meeting was held, who was invited, nor who attended. 2. Record review of the admission record revealed Resident #8 was a [AGE] year-old male originally admitted on 11/23/2015. Record review of the quarterly MDS assessment, dated 3/13/2024, revealed Resident #8 had a BIMS summary score of nine, indicative of moderate cognitive impairment. Resident #8's primary medical condition category that best describe the primary reason for admission was coded as a stroke. Other active diagnosis included hemiplegia or hemiparesis, seizure disorder or epilepsy, schizophrenia, human immunodeficiency virus personal history of COVID-19. Under section Q - participation in assessment and goal setting only the resident was coded as active participant in the assessment process. Record review revealed Resident #8's last Care Plan was dated 12/19/2023. The Care Plan document did not include information regarding the date or time the Care Plan Conference meeting was held, who was invited, nor who attended. In an interview on 4/23/2024 at 2:39 PM, Resident #8 stated he did not know what a care plan meeting was. Resident #8 stated he had not been invited to a care plan meeting that he could recall. Resident #8 stated he did not have family that would be willing to attend the meeting for him. Resident #8 stated he would attend a meeting if he were feeling up to it at the time. Resident #8 stated he goes out of the facility to see special doctors sometimes, and that might mess up a meeting in the building. 3. Record review of the Admission Record revealed Resident #3 was a [AGE] year-old female. Resident #3 was originally admitted on [DATE]. (continued on next page)

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	04/26/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment, dated 4/03/2024, revealed Resident #3 had a BIMS summary score of 14, indicative of intact cognition. Resident #3's primary medical condition category that best described the primary reason for admission was coded as debility, cardiorespiratory conditions related to obstructive sleep apnea [characterized by recurrent episodes of complete or partial obstruction of the upper airway leading to reduced or absent breathing during sleep]. Other active diagnoses included asthma, chronic obstructive pulmonary disease, or chronic lung disease. Under section O, Special Treatments, Resident #3 received Oxygen therapy while a resident of the facility and within the last 14 days. Record review revealed Resident #3's last Care Plan was undated. However, the Goals column included revisions dated 12/23/2023. The Care Plan document did not include information regarding the date or time the Care Plan Conference meeting was held, who was invited, nor who attended. In an interview on 4/24/2024 and at 12:05 PM, Resident #3 stated she had not been invited to any care plan meetings since she admitted to this facility. Resident #3 stated, Oh, that would be a good idea. I would like to attend that kind of meeting. Resident #3 stated she could not imagine that a family member would be invited to a care plan meeting in her place, and she would not be invited to the meeting as well. Resident #3 stated the staff members do a pretty good job in communicating what was going on around the facility, such as COVID-19, events like local [NAME] and festivals, and when the dentist was expected, as far as she could tell. 4. Record review of admission record revealed Resident #29 was a [AGE] year-old male originally admitted on [DATE]. Record review of the quarterly MDS assessment dated [DATE] revealed Resident #29 had a BIMS summary score of 10, indicative of moderate cognitive impairment. Resident #29's primary medical condition category that best described the primary reason for admission was coded as other orthopedic conditions related to cervical disc disorder with myelopathy [a nervous system disorder that can permanently affect the spinal cord; Cause a loss of sensation, loss of function, and pain or discomfort]. Resident #29 was coded as the only active participant in the assessment process in Section Q, Participation in Assessment and Goal Setting. Record review revealed Resident #29's last Care Plan was dated 2/01/2024. The Care Plan document did not include information regarding the date or time the Care Plan Conference meeting was held, who was invited, nor who attended. In an interview on 4/24/2024 at 10:28 AM, Resident #29 stated he cannot recall ever being included in a care plan meeting. Resident #29 stated he did not have family to attend in his place. Resident #29 stated, he might attend a care plan meeting depending how often it was schedule and what was talked about. (continued on next page)

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	04/26/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/25/2024 at 9:46 AM, ADON F, stated she could only speak to what had occurred since she started at the facility in March 2024. ADON F stated that she had initiated care plan conferences to be done correctly when she started; she stated she did not think they had been done correctly prior to her start at the facility. ADON F stated she would function as a participant and submit information for the care plan conference, but she was not facilitator nor the responsible staff member for the meeting itself. ADON F stated care plan conferences were held typically twice a week. ADON F stated some family members, and some residents choose to participate in the care plan conference, and some do not participate in the care plan conference. In an interview on 4/25/2024 at 10:50 AM, the SW stated he had only worked at the facility for the last month. The SW stated he keeps an office 360 excel spreadsheet of scheduled care plan conferences which he now updates with care plan conference attendees. The SW stated mandatory attendees include an ADON, DOR, ADOR, the SW, a family member and/or resident. The SW stated he was holding care plan conferences biweekly to ensure that all residents are having timely care plan conferences. The SW stated when he has called family members to invite them to a care plan conference, they seem unaware of the concept of periodic care plan meetings. In an interview on 4/25/2024 at 10:16 AM, the ADM stated the previous social worker entered progress notes in the EHR for each resident after a care plan conference meeting was held. The ADM stated she believed the previous social worker held care plan conferences once a week. The ADM stated care plan conferences were held upon admission, and with a change of condition. The ADM stated she was unsure how often care plan conferences were required for long term residents. The ADM stated that there was just a couple of weeks gap between the end of the previous social workers employment and the start of the current social worker. The ADM stated care plan conferences were held much more regularly with the current social worker. The ADM stated she did not believe care plan meetings were being conducted correctly under the previous social worker. The ADM stated the process for care plan conferences had improved recently. The ADM stated she would check on her computer for any information on dates for care plan meetings, who was invited, and who attended over the last few months and would provide that information if she found it. In an interview on 4/26/2024 at 2:53 PM, the DON stated she has worked for the facility for a little less than a year at this point. The DON stated that care plan meetings were the responsibility of the social worker. The DON stated an ADON, or direct care nurse would attend depending on which resident the care plan meeting was for. The DON stated that many of the processes were a work in progress. The DON stated that since the ADM, the DON and SW started along with the two ADONs, compliance had improved significantly with things like documentation, accountability, care plans, and communication. Record review of Care Planning - The Interdisciplinary Team policy, revised March 2022, revealed Policy statement reflecting that the interdisciplinary team was responsible for development of resident care plans. Under the heading policy interpretation and implementation, the IDT included the registered nurse, a nursing assessment, nutrition services staff, and the resident and or the residents' representative. Further, the resident, residents' family member, residents' legal representative or guardian or surrogate are encouraged to participate. In step 6.) If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record. (continued on next page)

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	04/26/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facilities Charting and Documentation policy revised July 2017, revealed under Policy Interpretation and Implementation, step 2. Information to be documented in the resident medical record: f.) progress toward or changes in the care plan goals and objectives.

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	04/26/2024

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 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** 41651 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that included services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 30 residents (Residents #46, #53, and #85) reviewed for comprehensive person-centered care plans, in that: 1. Resident #46's care plan did not address the resident's broken and missing teeth. 2. Resident #53's care plan did not address the resident's diet, need for assistance with activities of daily living, or discharge plans, and contained incomplete sentences/incomplete care information. 3. Resident #85's care plan did not address the resident's diet, advance directive, wounds, medication, need for assistance with activities of daily living, specialized medical equipment, or discharge plans. This deficient practice could place residents at risk of illness or injury due inadequate care. The findings were: 1. Record review of Resident #46's facesheet, dated 04/26/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Type 2 Diabetes Mellitus, Generalized Anxiety Disorder, and Colostomy Status. Record review of Resident #46's Quarterly MDS, dated [DATE], revealed a BIMS score of 13 which indicated intact cognition Record review of Resident #46's care plan, revised 04/15/2024, revealed the care plan did not address the resident's broken and missing teeth. Observation on 04/23/2024 at 10:30 a.m. revealed Resident #46 appeared to have broken and missing teeth. During an interview with Resident #46, at the same time as the observation, Resident #46 stated that all of his teeth were either missing or broken and stated that the facility had not offered dental care to him. 2. Record review of Resident #53's facesheet, dated 04/26/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Other Cystitis without Hematuria, Sepsis, and Rheumatoid Arthritis. Record review of Resident #53's Admission MDS, dated [DATE], revealed a BIMS score of 12 which indicated moderately impaired cognition. (continued on next page)

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	04/26/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #53's care plan, revised 04/22/2024, revealed it did not address the resident's diet, need for assistance with activities of daily living, or discharge plans. Further review of Resident #53's care plan revealed incomplete sentences, including: Impaired Communication due to ., Resident forgets things and [sic] (INDIVIDUALIZE HERE) ., Needs pain management and monitoring related to ., Pressure ulcer actual or at risk due to ., and Resident has physical functioning deficit related to . 3. Record review of Resident #85's facesheet, dated 04/26/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Peripheral Vascular Disease, Pressure Ulcer of Sacral Region, and Chronic Kidney Disease. Record review of Resident #85's admission MDS, dated [DATE], revealed a BIMS score of 13 which indicated moderately cognitive cognition. Record review of Resident #85's care plan, dated 04/23/2024, did not address the resident's diet, advance directive, wounds, medication, need for assistance with activities of daily living, specialized medical equipment, or discharge plans. During an interview with MDS Coordinator L on 04/26/2024 at 3:45 p.m., MDS Coordinator L confirmed Resident #46's care plan did not address the resident's broken and missing teeth, Resident #53's care plan did not address the resident's diet, need for assistance with activities of daily living, or discharge plans, and contained incomplete sentences/incomplete care information, and Resident #85's care plan did not address the resident's diet, advance directive, wounds, medication, need for assistance with activities of daily living, specialized medical equipment, or discharge plans. MDS Coordinator L confirmed that the absence of such information could lead to shortfalls in the care provided and confirmed that ensuring the care plans were completed accurately was the responsibility of the MDS/Care Plan Coordinator. MDS Coordinator L stated the facility did not have their own MDS/Care Plan Coordinator, that she was employed by another facility and was providing short-term assistance until an MDS/Care Plan Coordinator was hired. Record review of the facility's Comprehensive Person-Centered Care Plan policy, revised December 2016, revealed, 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 reach resident. The care plan should meet the resident's psycho-social and functional needs and build on the resident's strengths.

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	04/26/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 27923 Based on interviews and record reviews the facility failed to develop, implement, and revise a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 33 residents (Residents #43 and #55) reviewed for care plans, in that: 1. The facility failed to include insulin administration on Resident #43's Care Plan. 2. The facility failed to revise a care plan to address Resident #55's insulin administration on the care plan dated 3/29/24. This failure could have placed residents at risk of not having their needs identified and met. The findings included: 1. Record review of the quarterly MDS assessment dated [DATE] revealed Resident #43 was a [AGE] year-old male admitted on [DATE]. Resident #43 had a BIMS summary score of 11, indicative of moderate cognitive impairment. Resident #43 was coded as independent with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once a meal is placed before the resident). Resident #43's primary medical condition category that best described the primary reason for admission was stroke [occurs when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients]. Other active diagnoses included diabetes mellitus, unspecified polyneuropathy. Resident #43's Swallowing/Nutritional Status was coded as 25% or less of total calories the resident received through parenteral or tube feeding; Average fluid intake was coded as 500 cc per day or less. Resident #43 was coded as having received 7 insulin injections in the last 7 days. Resident #43 was coded as taking with an indication noted for hypoglycemic (including insulin) high-risk drug classes. Record review of Order Summary Report, printed 4/26/2024 at 9:27 AM, revealed Resident #43 had active physician orders for: finger stick check [of blood glucose] at breakfast and bedtime per resident request with a start date of 1/02/2024; Basaglar KwikPen subcutaneous solution pen-injector 100 unit[s] per milliliter inject 35 unit[s] subcutaneously at bedtime for diabetes with a start date of 11/28/2023; NovoLog flex pen subcutaneous solution pen-injector 100 unit[s] per milliliter (insulin aspart) inject 10 units subcutaneously as needed, give NovoLog 10 units subcutaneously if glucose greater than 400 at breakfast or hour of sleep with a start date of 11/11/2023. Record review of Resident #43's Care Plan with a last review completed date of 3/29/2024 revealed a diagnosis of type 2 diabetes mellitus with diabetic neuropathy. The care plan did not include interventions, goals, or focus areas related to type 2 diabetes or insulin administration. (continued on next page)

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	04/26/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #55's face sheet, dated 4/25/24, revealed an admitted [DATE] with diagnosis that included: congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), type 2 diabetes (a condition in which the body's blood sugar was not controlled), and anxiety disorder (a condition of strong feelings of worry, anxiety, or fear that interferes with daily activities). Record review of Resident's #55's Quarterly MDS assessment, dated 4/2/24, revealed a BIMS score of 15 which indicated intact cognition. Record review of Resident #55's physician's order summary dated 4/25/24 revealed an order for Novolin 70/30 100ML insulin with a start date of 2/1/24. Record review on 4/25/24 of Resident #88's care plan revised on 2/15/24 with a target date of 4/2/24 revealed that insulin administration was not included in the care plan. During an interview with Resident #55 on 4/25/24 at ____ revealed the resident stated she had diabetes. During an interview with the DON on 4/25/24 at 11:50 a.m., the DON stated several nursing staff take part in the completion of the resident's care plan. She stated that insulin administration should have been included in Resident # 55's care plan so that all of the resident's treatment interventions are noted. During an interview with the RN/MDS-E on 4/25/24 at 12:05 p.m., RN/MDS-E stated Resident # 55's care plan should have included insulin administration for staff to be aware of blood sugar monitoring. Record review of the facility's policy on Care Planning-Interdisciplinary Team dated 03/2022 stated the resident care plans are developed according to time frames for comprehensive care plans and are based on resident assessments. 44906

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	04/26/2024

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** 44906 Based on observations, interviews, and record reviews the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 8 (Resident #20) reviewed for quality of care in that: Resident #20 did not receive ordered weekly skin assessments between 2/23/2024 and 4/22/2024. This failure could place residents at risk of not receiving the necessary interventions to reach their highest practicable physical, mental, and psychosocial well-being. The findings included: Record review of the Admission Record revealed Resident #20 was a [AGE] year-old female originally admitted on [DATE]. Record review of Resident #20's comprehensive MDS, dated [DATE], revealed the resident had a BIMS summary score of 2, indicative of severe cognitive impairment. Resident #20's primary medical condition category that best described the primary reason for admission was medically complex condition related to type two diabetes mellitus. Other active diagnoses included moderate intellectual disabilities, contracture of an unspecified foot, morbid (severe) obesity due to excess calories and abnormal weight loss. Resident #20 had a formal, clinical assessment that determined she was at risk of developing pressure ulcers/injuries but did not receive any skin and ulcer/injury treatment. Resident #20 source of information regarding participation in assessment and goal setting was coded as family. Record review of Resident #20's Order Details revealed the resident had physician orders for weekly skin assessment every Monday with an order date of 2/23/2024. Record review of Resident #20's physician progress note, dated 4/05/2024, revealed the resident was documented as having scabbing to her left side of face, left great toe knuckle with eschar-like area, but no skin issues documented for lower extremities. Record review of Resident #20's nurse practitioner progress note, dated 4/10/2024, revealed the resident was documented as having left leg abrasion times 2 under the skin assessment review of systems section. Record review of the treatment administration record revealed Resident #20 was checked off as having weekly skin assessment on the following dates: 3/04/2024 by the DON 3/11/2024 by LVN H 3/18/2024 by LVN I (continued on next page)

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	04/26/2024

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	3/25/2024 by LVN H 4/01/2024 by LVN J 4/08/2024 by LVN H 4/15/2024 by LVN C 4/22/2024 by LVN I. Record review of Resident #20's electronic health record assessments tab revealed the resident had weekly head to toe skin checks documented on 1/12/2024 [prior to the order], 3/18/2024, and 4/22/2024. Record review of the Weekly Head to Toe Skin Check, authored by LVN K dated 1/12/2024 revealed Resident #20 was documented as having no skin issues at that time. Record review of the Weekly Head to Toe Skin Check, authored by LVN I dated 3/18/2024 revealed Resident #20 was documented as having no skin issues at that time. Record review of the Weekly Head to Toe Skin Check, authored by LVN I dated 4/22/2024 revealed Resident #20 was documented as having skin tears to left shin area; scabbed around edges. In an interview on 4/23/2024 at 11:30 AM, a family member of Resident #20 stated Resident #20 had new wounds to her shin and that the family member had not been informed of those wounds before the family member visited that morning [4/23/2024]. The family member stated a treatment provider had been by and provided care while the family member was there that morning [4/23/2024]. The family member stated she did not know when the wounds developed but did not believe the wounds were present at her last weekly visit. The family member stated that she was a former certified nursing assistant and would provide care to Resident #20 when she visited that included feeding or incontinence care as necessary to Resident #20 when the family member was in the building. The family member stated Resident #20 had developed contractures in her feet and was worried that the new wounds were caused by the position [legs tightly crossed, with the heel of the top leg pressed to the shin of the lower leg when side lying] Resident #20 would adopt when left to her own devices. In an interview on 4/25/2024 at 11:11 AM, ADON G stated she had started working as the Treatment Nurse ADON on 3/18/2024. ADON G stated it was her responsibility to perform all skin and wound treatments during the week; on weekends the direct care nurses had tasks that would pop-up reminders for those tasks to be completed. ADON G stated that if weekly skin assessments were not performed as scheduled, risk to residents could be significant if there were ever any missed or untreated wounds. ADON G stated she had not been checking that weekly skin assessments were done on residents without known skin issues and had only been checking the weekly skin assessments were performed on residents with known skin issues or wounds. ADON G stated she would be responsible for checking that residents all get a weekly skin assessment; she checks all residents that have known wounds to ensure that wound care was being performed and documented correctly. ADON G stated she would ensure that weekly skin assessments were performed for all residents going forward. (continued on next page)

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	04/26/2024

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	In an interview on 4/25/2024 at 4:50 PM, the DON stated she did not have a policy on non-pressure injury wound prevention. The DON stated the guidelines provided in the policy for Prevention of Pressure Injuries could also be applied to non-pressure injury wounds. The DON stated LVN I was working, and she would have her stop by for an interview. DON stated that LVN H no longer worked for the facility. The DON stated she would provide contact information for LVN C and LVN J. In an interview on 4/26/2024 at 1:58 PM, via telephone, LVN C stated she had worked at the facility for the previous few months before being hired on as a regular employee within the last three weeks. LVN C stated she had performed weekly skin assessments on Resident #20 on occasion in the past and could not recall that Resident #20 had any issues such as skin breakdown, pressure injuries or rashes. LVN C stated that EHR had a pop-up reminder for things that were scheduled weekly or monthly on your shift for that day. LVN C stated she knew Resident #20 recently developed a skin tear to the shin, but LVN C had not been involved in the resident's care since that occurred. LVN C stated that she knew weekly skin care assessments were to be documented as per facility protocol. LVN C stated she could not recall if that training was included when she was brought on board as an agency nurse. LVN C stated performing and documenting weekly skin assessments was included in the onboarding training for new employees as she had gone through that within the last few weeks. LVN C stated there was a possibility she forgot to document on the correct EHR form. In an interview on 4/26/2024 at 2:53 PM, the DON stated that weekly skin assessments should be performed as scheduled as per MD orders. The DON stated that her expectation was that weekly skin assessments should be performed as scheduled as per the MD orders. The DON stated the risk of weekly assessments skin assessments not being performed or documented would be a missed or delayed assessment and intervention and could result in harm to the resident. The DON stated the provision of care should be documented immediately upon completion in the EHR. The DON stated the facility trains the nurses upon hire, at annual competencies and in in servicing trainings periodically on an as needed basis. The DON stated that she was confident provision of care was being done, but perhaps the documentation of the provision of care was lacking. The DON stated that since she had started, along with many new team members and management she felt the facility was improving, but that it was still a, work in progress on many areas. Record review of the facility's policy titled, Charting and Documentation, revised July 2017, revealed, a policy statement that progress towards the care plan goals or any changes in the residence condition shall be documented in the residence medical record regarding the resident's condition and response to care. Under the heading Policy Interpretation and Implementation, Step 2.) the following information is to be documented in the resident's medical record: c.) treatments or services performed; d.) changes in condition. Record review of the facility's policy titled, Care Planning - Interdisciplinary Team, revised March 2022, revealed under the heading Policy Interpretation and Implementation, resident care plans are based on resident assessments and developed by an interdisciplinary team. Record review of the facility's policy titled, Prevention of Pressure Injuries, revised April 2020, revealed under the heading Skin Assessment, 1.) conduct a comprehensive skin assessment . as indicated according to the residents' risk factors. 3.) inspect the skin on a daily basis when performing or assisting with personal care. Under the heading Monitoring 1.) evaluate, report, and document potential changes in the skin; 2.) review the interventions and strategies for effectiveness on an ongoing basis.

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	04/26/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible and that each resident received adequate supervision to prevent accidents for 2 (Residents #68 and #87) of 30 residents, and in 1 of 5 hallways (Hall 100) reviewed for accident hazards, in that: 1. Resident #68 was observed with a package of cigarettes and a cigarette lighter in the facility dining room. 2. Resident #87 was observed with a package of cigarettes and utilizing a cigarette lighter and pair of scissors in the facility courtyard. 3. A storage room on Hall 100 was marked, Clean Linen was open and unlocked and contained bathing supplies including razors. 4. Shower room [ROOM NUMBER] on Hall 100 was open and unlocked and container bathing supplies including razors. This deficient practice could place residents at risk of injury due to accidents. The findings were: 1. Observation on 04/23/2024 at 12:48 p.m. revealed Resident #68 self-propelled in his wheelchair to a table in the Main Dining Room, retrieved a package of cigarettes and a cigarette lighter from his pocket and placed them on the table within reach of any other resident who may sit at ambulate near the table. Further observation at the same time revealed the presence of approximately 15 residents in the Main Dining Room. During an interview with the Administrator on 04/23/2024 at 12:53 p.m., the Administrator confirmed that a package of cigarettes and a cigarette lighter were sitting on a resident table in the Main Dining Room and should not have been. 2. Observation on 04/24/2024 at 11:48 a.m. revealed Resident #87 self-propelled in his wheelchair to the facility courtyard, retrieved a package of cigarettes and a cigarette lighter from a pocket attached to his wheelchair. Further observation revealed Resident #87 retrieved a pair of scissors from a pocket attached to his wheelchair and cut open his package of cigarettes. Further observation revealed the presence of 4 other residents in the courtyard and no members of staff. Record review of Resident #87's Smoking Assessment, dated 02/16/2024, revealed the resident was safe to smoke without supervision. (continued on next page)

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	04/26/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility Accident/Incident log from January 2024 to the time of the investigation, no accidents involving cigarette lighters were noted. During an attempted interview with Resident #87, on 04/24/2024 at 11:52 a.m., Resident #87 declined to participate. During an interview with COTA N on 04/24/2024 at 11:54 a.m., COTA N confirmed that Resident #87 had a package of cigarettes, a cigarette lighter, and a pair of scissors in a pocket on his wheelchair. 3. Observation on 04/23/2024 at 10:30 a.m. revealed a storage room on Hall 100, marked, Clean Linen, was open and unlocked and contained bathing supplies including approximately 10 razors, 10 bottles of mouthwash, and 10 bottles of shampoo, and 15 tubes of toothpaste. Further observation revealed residents routinely ambulated past the open storage room. During an interview with Housekeeper M 04/23/2024 at 10:31 a.m., Housekeeper M confirmed the storage room was open and unlocked and contained bathing supplies including razors and should not have been. 4. In an observation on 4/23/2024 at approximately 10:15 AM of Shower room [ROOM NUMBER] on 100 hallway, the door was unlocked. On the back of the sink was an opened package containing approximately 6-8 disposable razors [see P1]. On the shower handrail, were 2 shaving cream canisters, and 2 deodorant spray canisters [see P2]. On the shower handrail, near the faucet, was a bottle of cleanser [see p3]. This shower room appeared to have been recently used as evidence by the humidity in the room, and small water droplets on the shower walls. The shower room door had a keypad coded lock on it, however upon approach the door opened just by pushing on the door. There were ambulatory residents and residents who self-mobilized their assistive devices in the immediate vicinity, along with staff and visitors. During an interview with the Administrator on 04/25/2024 at 4:30 p.m., the Administrator stated that while some residents had been assessed to safely smoke independently, none were meant to keep cigarettes or cigarette lighters in their possession. The Administartor stated that no residents had injured themselves or others with a cigarette lighter but confirmed that the potential for injury existed. The Administrator further stated that residents should not have sharp objects such as scissors in their possession, and confirmed that bathing supplies such as razors, shaving cream, soaps, and sprays should be secured when not in use. Record review of the facility policy, Safety and Supervision of Residents, dated July 2017, revealed, Our facility strives to make the environment as free from accident hazards as possible.

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	04/26/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 4 of 4 residents (Residents #3, #12, #42, and #63) reviewed for oxygen, in that: 1. The facility failed to ensure orders were in place to manage Resident #3's supplemental oxygen support devices. 2. The facility failed to ensure oxygen humidifier bottles were changed for Residents #12, #42, and #63 when empty. This deficient practice could place residents who received oxygen therapy at risk for an increase in respiratory complications. The findings were: 1. Record review of the Admission Record revealed Resident #3 was a [AGE] year-old female. Resident #3 was original admitted on [DATE]. Record review of Resident #3's quarterly MDS assessment, dated 4/03/2024, revealed Resident #3 had a BIMS summary score of 14, indicative of intact cognition. Resident #3's primary medical condition category that best described the primary reason for admission was coded as debility, cardiorespiratory conditions related to obstructive sleep apnea [characterized by recurrent episodes of complete or partial obstruction of the upper airway leading to reduced or absent breathing during sleep]. Other active diagnoses included asthma, chronic obstructive pulmonary disease, or chronic lung disease. Under section O, Special Treatments, Resident #3 received Oxygen therapy while a resident of the facility and within the last 14 days. Record review of Resident #3's Care Plan revealed a focus area of supplemental oxygen with the following interventions: monitor for complications; Monitor oxygen saturation levels; Oxygen for nasal cannula at 3 liters per minute; Oxygen tubing changed per facility protocol; date initiated 8/23/2023. Record review of Resident #3's order details revealed Resident #3 how to physicians' order to change oxygen tubing as needed for when visibly soiled with the start date of 4/01/2024. Record review of Resident #3's Treatment Administration Record for March 2024 printed 4/26/2024 at 11:26 AM revealed Resident #3 had the oxygen tubing, bottle, and clean filter changed every Sunday night on the following dates: 3/03/2024, 3/10/2024, and 3/17/2024. No further dates were indicated for tubing change in March 2024. Record review of Resident #3's Treatment Administration Record printed 4/26/2024 at 11:24 AM, for Resident #3 revealed no entries for the order Change Oxygen Tubing as needed for when visibly soiled for April 2024. (continued on next page)

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	04/26/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/23/2024 at 3:02 PM revealed Resident #3 was lying supine in bed with her eyes closed and the nasal cannula placed correctly and the oxygen concentrator running at 2.5 liters per minute. Resident #3 did not respond to verbal stimuli and could be heard softly snoring. In an observation and interview on 04/24/24 at 12:03 PM, Resident #3 removed her nasal canula and stated, no one here will change out the nasal cannula. I can not remember when it was last changed. The nasal canula prongs were a discolored yellow tint, whereas most of the tubing was transparent. Resident #3 stated she would like the nasal canula to be replaced now, but also, before it becomes yellow. Resident #3 stated she felt she should not have to ask for the nasal canula to be changed. 2. Record review of Resident #12's face sheet, dated 4/23/24, revealed a [AGE] year-old female admitted to the facility on [DATE], readmitted on [DATE] with the diagnosis that included: anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), Hepatic encephalopathy(is the deterioration of brain function that occurs in people with severe liver disease) and neuralgia (is a particular type of pain that often feels like shooting, stabbing or burning sensation). Record review of Residents #12's Physician monthly orders dated , April 2024 revealed an order start date of 10/17/22, Change oxygen tubing, humidifier bottle every week on Sunday. Record review of Resident #12's Quarterly MDS dated [DATE], revealed a BIMS score of 7 which indicated severe impairment. Record review of Resident #12's care plan, dated 8/25/23, revealed the resident required oxygen change 02 tubing and concentrator bottle weekly on Sunday. Observation on 4/23/24 at 10:35 a.m. revealed Resident #12 oxygen concentrator at the bedside, with the humidifier bottle empty, dated 4/14/24. During an interview with Resident #12 on 4/23/24 at 10:36 a.m., the resident was unable to respond to any questions by surveyor due to disease process. During an interview with LVN A on 4/23/24 at 10:55 a.m., it was revealed that oxygen tubing and humidifier bottles were changed and dated by the night shift. 3. Record review of Resident #42's face sheet dated, 4/23/24 revealed a [AGE] year-old male admitted to the facility on [DATE], readmitted on [DATE] with diagnosis that included: Heart Failure (a condition that develops when your heart does not pump enough blood for your body's needs), Benign prostatic hyperplasia, (a noncancerous enlargement of the prostate gland), and Type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Record review of Resident's #42's Physician monthly orders dated April 2024, revealed an order start date of 2/20/22. Change oxygen tubing, humidifier bottle every week on Sunday. Record review of Resident #42's Quarterly MDS dated [DATE] revealed a BIMS score of 11, indicating cognition was mildly impaired. (continued on next page)

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	04/26/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #42's care plan, dated 02/22/23, revealed the resident required oxygen change 02 tubing and concentrator bottle weekly on Sunday. Observation on 4/23/24 at 10:40 a.m. revealed Resident #42 was in bed wearing oxygen tubing on their nose and an oxygen concentrator at the bedside, with the humidifier bottle empty, dated 4/14/24. During an interview with Resident #42 on 4/23/24 at 10:42 a.m., the resident stated, I keep telling the nurse that my nose is dry, but no one listens around here. During an interview with LVN A on 4/23/24 at 10:55 a.m., LVN A stated oxygen tubing and humidifier bottles were changed and dated by the night shift. 4. Record review of Resident #63's face sheet dated 4/23/24 revealed a [AGE] year old female admitted to the facility on [DATE], with the diagnosis that included: Insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep), Schizophrenia (is a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and Epilepsy (is a brain condition that causes recurring seizures). Record review of Resident #63's Physician monthly orders dated April 2024 revealed an order start date of 6/01/23, Change oxygen tubing and humidifier bottle every week on Sunday. Record review of Resident #63's Quarterly MDS dated [DATE] revealed a BIMS score of 9, which indicated moderate cognitive impairment. Record review of Resident #63's care plan, dated 06/1/23, revealed the resident required oxygen change 02 tubing and concentrator bottle weekly on Sunday. Observation on 4/23/24 at 10:45 a.m. revealed Resident #63 in wheelchair sitting wearing oxygen tubing on their nose and an oxygen concentrator at the bedside, with the humidifier bottle empty, dated 3/19/24. During an interview with LVN A on 4/23/24 at 10:55 a.m., LVN A stated oxygen tubing and humidifier bottles were changed and dated by the night shift. During an interview with Resident #63 on 4/23/24 at 10:45 a.m., the resident was unable to respond to any questions by surveyor due to disease process. During an interview with the DON on 4/23/24 at 11:05 AM, the DON stated revealed Residents #12's, #42's, and #63's oxygen concentrator bottles should have been changed by the night shift weekly. The DON stated the facility currently used agency night shift nurses, and they must have forgotten to change the humidifier bottles on Residents #12, #42, and #63. The DON further stated the ADON oversaw this task. The DON stated Residents #12, #42, and #63 risked possible dry nasal passages due to having their oxygen humidifier bottles empty. Record review of the facility's policy titled, Respiratory Therapy, dated 2001 and revised November 2011, revealed: Change pre-filled humidifier when water becomes low. 46131

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	04/26/2024

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 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. 27923 Based on observations, interviews, 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, in that: 1. There were 10 slices of bread in the refrigerator that were not labeled or dated. 2. There was a box of 400 coffee creamers in the refrigerator that were not labeled or dated. 3. An ice cream freezer had an internal temperature of 70 degrees with 20 4 -ounce packets of melted ice cream. 4. A bag of 12 waffles in an outside freezer was not labeled or dated. 5. Three boxes of 3-gallon containers of apple juice concentrates in the storeroom were not labeled or dated. 6. The ceiling vent across from the dish machine had dirt and grease on the vent slats. 7. A Dietary Aide, DA D was observed in the kitchen not wearing a hair restraint. These deficient practices could place residents who received meals and snacks from the kitchen at risk for food borne illness from improper infection control, from a lack of food label date monitoring, from a lack of equipment maintenance, and improper sanitation in the kitchen area. The findings included: Observation on 04/23/24 from 9:20 a.m. to 9:50 a.m. during the kitchen tour with the Dietary Manager revealed the following: a. There was a bag containing 10 slices of bread in the refrigerator that was not labeled or dated. b. There was a box of 400 coffee creamers in the refrigerator that was not labeled or dated. c. There was a freezer in the kitchen that had an internal temperature of 70 degrees; it contained 20 4 ounce packets of ice cream that were melted. d. There were 3 boxes with each containing a 3 gallon container of apple juice concentrate in the store room that were not labeled or dated. e. There was a ceiling vent in the dish machine room measuring approximately 1x1 foot that had visible dirt particles and grease on the vent slats. (continued on next page)

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	04/26/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. There was a dietary aide, DA D, observed on 04/24/24 at 12:10p.m., in the kitchen not wearing a hair restraint. During an interview with the Dietary Manager on 04/23/24 at 9:55 a.m., the Dietary Manager stated it was important for food to be labeled and dated to know when it was out of date. She stated the ice cream freezer had been working and should have been functioning properly. The Dietary Manager stated that having the dish machine ceiling vent clean was important for kitchen sanitation purposes. During an interview with the Dietary Manager on 4/24/24 at 3:15 p.m., the Dietary Manager stated wearing hair restraints in the kitchen is important to keep hair from falling onto the floor. During an interview with the Maintenance Director on 4/25/24 at 8:10 a.m., Maintenance Director stated = he was not aware that the kitchen ice cream freezer was not operating properly and it had been taken out of service. He stated that he was not aware the dirty dish room ceiling vent and it had been cleaned. Record review of facility's Dining Services Policy and Procedure Manual Policy 018 for Food Storage Dry Goods dated 09/2017 stated all dry goods will be appropriately stored in accordance with the FDA food code. Record review of the facility's Dining Services Policy and Procedure Manual Policy 019 for Cold Foods dated 04/2018 stated all foods will be stored in covered container, labeled and dated. Record review of the facility's policy of Sanitation dated 11/2022 stated that the food service area was to be maintained in a clean and sanitary manner. Record review of the Food Code, U.S. Public Health Service, U.S. Food Drug Administration (FDA), 2017, U. S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (A) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. FOOD CODE - Commercially prepared food (B) Except as specified in (E) -(G) of this section, refrigerated, , ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (continued on next page)

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	04/26/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed 4-601.11 Equipment, Food-Contact Surfaces, Non-food-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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	04/26/2024

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 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 residents' refrigerators (refrigerators in resident room [ROOM NUMBER] and room [ROOM NUMBER]) reviewed in that: The personal refrigerators in residents' rooms [ROOM NUMBERS] 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 04/23/2024 at 10:02 a.m. revealed the personal refrigerator in resident room [ROOM NUMBER] contained scrambled eggs with cactus, which was unlabeled and undated. Observation in room [ROOM NUMBER] on 04/24/2024 at 10:32 a.m. revealed a container with scrambled eggs and cactus was still present. During an interview with CNA B on 04/23/2024 at 10:35 a.m., CNA B confirmed that the personal refrigerator in resident room [ROOM NUMBER] contained a container with scrambled eggs and cactus which was unlabeled and undated. Observation on 04/23/2024 at 10:44 a.m. revealed the personal refrigerator in resident room [ROOM NUMBER] contained a frozen meal which had thawed and was unlabeled and undated. Observation in room [ROOM NUMBER] on 04/23/2024 at 10:54 a.m. revealed the frozen meal which had thawed was still present. During an interview with CNA B on 04/23/2024 at 11:35 a.m., CNA B confirmed that the personal refrigerator in resident room [ROOM NUMBER] contained a frozen meal which had thawed and was unlabeled and undated. During an interview with the DON and ADON on 04/24/2024 at 11:47 a.m., the DON and ADON confirmed perishable food and drinks in residents' personal refrigerators should be labeled and dated to prevent residents from consuming spoiled foods. The DON stated the night shift nurses were responsible for overseeing this task and this was not being monitored. Record review of the facility's policy titled, Foods Brought by Family/Visitors, dated 2001 and revised March 2012, revealed, .Food brought to the facility by visitors and family is permitted. The nursing staff will discard perishable foods on or before the use by date .

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	04/26/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 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 2 residents (Resident #2) reviewed for infection control, in that: The Sharps container in Resident # 2's room was overfilled. These deficient practices could place residents at risk for infection due to improper care practices. The findings include: Record review of Resident #2's face sheet dated 4/26/24, revealed a [AGE] year old female admitted to the facility on [DATE], with diagnosis which included: Diabetes mellitus (is a disease of inadequate control of blood levels of glucose, Cerebral arteriosclerosis (is a disease that occurs when the arteries in the brain become hard, thick, and narrow due to the buildup of plaque inside the artery walls) and cerebral infarction (appears as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). Record review of Resident #2's Quarterly MDS, dated [DATE], revealed that the resident had a BIMS of 00, which indicated severe impairment. Further review revealed the resident was nonverbal, had memory problem and was severely impaired. Resident #2 required total care and was always incontinent of bowel and bladder. Observation during blood sugar check on 4/25/24 at 11:35 a.m. revealed LVN C checked Resident #2's blood sugar and could not dispose of used sharp supplies in the sharps container in the resident's room. During an interview with LVN C on 04/25/204 at 11:35 a.m., LVN C stated central supply was responsible for replacing sharps containers and nurses risked getting punctured by used equipment. During an interview with the DON on 04/25/2024 at 3:50 p.m., the DON stated all nurses had a key to the central supply room and had the ability to replace full sharps containers. The DON stated staff risked getting punctured by a sharps container being full. The DON stated she was responsible for overseeing infection control in the building. Record review of the facility's policy titled, Sharps disposal, dated 2001 and revised January 2012, revealed, Designated individuals will be responsible for sealing and replacing containers which are 75 % to 80 % full, to protect employees from puncture.

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	04/26/2024

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 41651 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for 1 (Main Dining Room) of 2 dining rooms reviewed and 1 (Hall 100) of 5 hallways reviewed for pests, in that: 1. Numerous flies were observed in a resident room on Hall 100. 2. Numerous flies were observed near a trash can and on Resident #53's food and drink in the Main Dining Room. This deficient practice could place residents at risk of residing in an environment with pests. The findings were: 1. Observation on 04/23/2024 at 10:30 a.m. revealed the presence of numerous flies in Resident #46's room on Hall 100. During an interview with Resident #46, at the same time as the observation, Resident #46 stated flies were in his room daily, often land on him, and stated, They drive me crazy. 2. Observation on 04/23/2024 at 12:50 p.m. revealed the presence of flies in and around a large trash can in the Main Dining Room. Further observation at 12:57 p.m. revealed flies landed on Resident #53's food and drink in the Main Dining Room. During an attempted interview with Resident #53 on 04/23/2024 at 12:50 p.m., at the same time as the observation, Resident #53 was unable to converse. During an interview with the Marketer on 04/23/2024 at 12:59 p.m., the Marketer confirmed the presence of flies on Resident #53's food and drink and stated she would replace the items. During an interview with the Administrator on 04/25/2024 at 4:30 p.m., the Administrator stated the facility should be free of pests and provided documentation of pest control service. Record review of the pest control provider's visit logbook revealed the provider serviced the facility three times during the month of April. Record review of the facility's policy titled, Pest Control, revised May 2008, revealed, Our facility shall maintain an effective pest control program.

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	04/26/2024

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 41651 46131 Based on observation, interview, and record review, the facility failed to establish and enforce policies regarding smoking for 1 of 1 facility reviewed for smoking, in that: Residents #43, #198, and #199 were observed smoking in the facility courtyard and all stated that they kept their own cigarettes and lighters in their rooms. This failure could place residents at risk of dwelling within an unsafe smoking environment. The findings were: Observation on 04/23/2024 at 12:05 p.m. revealed Residents #43, #198, and #199 were smoking in the facility courtyard. During interviews with Residents #43, #198, and #199, at the same time as the observation, Residents #43, #198, and #199 each stated that they keep their cigarettes and cigarette lighters in their rooms. Record review of Residents #43, #198, and #199's smoking assessments revealed they all have been assessed as safe to smoke independently. During an interview with the Administrator on 04/25/2024 at 4:30 p.m., the Administrator stated that while some residents had been assessed to safely smoke independently, none were meant to keep cigarettes or cigarette lighters in their possession. Record review of the facility policy, Smoking Policy - Residents, revised 2022, revealed, Residents who have independent smoking privileges are not permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession.