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	06/11/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, record review, the facility failed to ensure residents have a right to personal privacy for 1 of 6 residents (Resident #71) reviewed for privacy, in that: LVN A did not close Resident #71's privacy curtain while providing wound care on 06/10/2025. This deficient practice could place residents at-risk of loss of dignity due to lack of privacy. The findings included: Record review of Resident #71's face sheet, dated 06/10/2025, revealed an admission date of 03/19/2024 and, a readmission date of 10/08/2024, with diagnoses which included: Chronic kidney disease (gradual loss of kidney function), Aphasia (result of a Stroke or Brain injury, and affects a person's ability to communicate), Type 2 diabetes mellitus (high level of sugar in the blood), Hemiplegia (Paralysis of one side of the body), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Hypertension (High blood pressure) and, Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure). Record review of Resident #71's Quarterly MDS assessment, dated 04/29/2025, revealed the resident had a BIMS score of 11, indicating he was cognitively moderately impaired. Resident #71 was always incontinent of bladder and bowel and, required extensive assistance to total care with his activities of daily living. Resident #71 had two pressure ulcer (wound caused by prolonged pressure on the skin). Record review of Resident #71's care plan, dated 04/18/2024, revealed a problem of Skin integrity impaired r/t chronic sacral stage 4 pressure injury,, with a goal of will show s/s of healing wound by next review date. Observation on 06/10/2025 at 9:58 a.m. revealed LVN A did not completely close the privacy curtain while she provided wound care for Resident #71, exposing the resident's buttocks area during care. The resident's end of the bed was completely uncovered and anybody entering the room could have seen the resident. During an interview with LVN A on 06/10/2025 at 10:05 a.m., LVN A confirmed the privacy curtain was not completely closed while she provided care for Resident #71 but it should have been. She stated the resident had a right of privacy during care. She confirmed she received resident rights training within the year. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 06/11/2025 at 1:20 p.m., the DON confirmed privacy must be provided during nursing care and Resident #71's privacy curtain should have been closed completely to provide privacy and protect the dignity of the resident. He confirmed the staff had received training on resident rights within the year and the training was provided by the ADON and himself. They also checked the staff skills annually and as needed. Review of the facility's policy titled Resident Rights, dated October 3, 2022, revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: [.] privacy and confidentiality

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 20 residents (Resident #75) whose assessments were reviewed. The facility failed to indicate Resident #75's current tobacco use on his significant change MDS dated [DATE]. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #75's face sheet dated 06/08/2025 revealed the resident was admitted to the facility 02/10/2024 and readmitted on [DATE] with diagnoses that included: Hemiplegia and hemiparesis following cerebral infarction (paralysis or weakness on one side of the body following a stroke), chronic heart failure, schizoaffective disorder bipolar type (a mental health condition involving psychotic symptoms like hallucinations and delusions alongside mood episodes of mania and sometimes depression), and acute respiratory failure with hypoxia (a critical condition where the lungs cannot adequately oxygenate the blood, leading to low blood oxygen levels and potentially affecting other organs). Record review of Resident #75's significant change MDS assessment dated [DATE] revealed a BIMS score of 09/15, indicating moderate cognitive impairment. In Section J13.00, Current Tobacco Use, the code 0 for No was marked. Record review of Resident #75's comprehensive care plan dated 01/31/2025 revealed there was no focus area indicating the resident's use of smokeless tobacco. Observation on 06/09/2025 at 10:13 AM revealed five 1.2 oz. cans of smokeless tobacco on Resident #75's bedside table. During an interview on 06/09/2025 at 10:15 AM, RN E stated she was unaware Resident #75 used smokeless tobacco. During an interview on 06/09/2025 at 10:20 AM, Resident #75 stated he had used smokeless tobacco since he was nine years old. Of the five cans on his bedside table, three were empty and two contained some tobacco in them. He had used smokeless tobacco since his admission to the facility. He purchased the cans of tobacco from the nearby convenience store. During an interview on 06/09/2025 at 11:00 AM, the DON stated he was unaware Resident #75 used smokeless tobacco, and the resident's significant change MDS was not accurate and should have indicated Resident #75's use of tobacco. A possible reason for the error was this assessment was completed by the corporate RN who served as the interim MDS nurse between the departure of the previous MDS nurse and the hire of the present MDS nurse. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19. 11, October 2024 revealed, J1300: Current Tobacco Use. Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1, yes. DEFINITION: TOBACCO USE Includes tobacco used in any form.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to refer all residents with newly evident or possible serious mental disorder for level II resident review upon a significant change in status assessment for 1 (Resident #75) of 20 residents reviewed for resident assessments. The facility failed to refer Resident #75 for a level II resident review following a new diagnosis of schizoaffective disorder-bipolar type, added on 12/17/2024. This failure could place residents at risk of not having their mental health needs met by the facility and could place all residents at risk of harm by mentally unstable residents. Findings included: Record review of Resident #75's face sheet dated 06/08/2025 revealed the resident was admitted to the facility 02/10/2024 and readmitted on [DATE] with diagnoses that included: Hemiplegia and hemiparesis following cerebral infarction (paralysis or weakness on one side of the body following a stroke), chronic heart failure, schizoaffective disorder bipolar type (a mental health condition involving psychotic symptoms like hallucinations and delusions alongside mood episodes of mania and sometimes depression), and acute respiratory failure with hypoxia (a critical condition where the lungs cannot adequately oxygenate the blood, leading to low blood oxygen levels and potentially affecting other organs). Record review of Resident #75's quarterly MDS assessment dated completed on 04/07/2025, Section C, revealed a BIMS score of 09/15, indicating moderate cognitive impairment. Section I (Active Diagnoses) indicated Resident #75 had diagnoses including Psychotic Disorder (other than schizophrenia) and schizophrenia (e.g., schizoaffective and schizophreniform disorders). Section N (Medications) indicated Resident #75 was taking antipsychotic medications. Record review of Resident #75's care plan, dated 01/31/2025, revealed Resident #75 exhibits/reports mood problem related to mood disturbance and Psychosis. He was receiving the antipsychotic medication Seroquel, and the interventions included monitoring for increase in depression/anxiety and address accordingly and to reassure patient about the progress he is making towards goals. Record review of the documents in Resident #75's electronic health record revealed a PASRR 1 evaluation dated 02/10/2024 indicating the resident did not have a primary diagnosis of dementia, mental illness, intellectual disability or developmental disability. Record review of Resident #75's diagnosis report dated 06/11/2025 revealed a diagnosis of schizoaffective disorder, unspecified, with an onset date of 04/30/2024. This diagnosis was noted as resolved on 12/17/2024, and the diagnosis of schizoaffective disorder, bipolar type was noted with an onset date of 12/17/2024. Record review of Resident #75's physician order, dated 06/08/2025, revealed an order for, Quetiapine Fumarate Oral Tablet, 200 MG, give 1 tablet by mouth at bedtime related to schizoaffective disorder, bipolar type. Order date and start date was 04/05/2025. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #75's medical record from 02/10/2024 to 06/08/2025 revealed there was no referral to a local mental health authority regarding re-evaluation of PASRR due to the resident's new mental status (new diagnosis of schizoaffective disorder-bipolar type). During an interview on 06/10/2025 at 2:48 PM, the DON stated Resident #75's diagnosis of schizoaffective disorder should have triggered a referral to a local mental health authority for a Level II PASRR evaluation. The resident was diagnosed with schizoaffective disorder in December 2024 by the corporate MDS coordinator in the absence of the facility's MDS coordinator. This MDS coordinator did not inform the facility of this diagnosis and failed to submit the H&HS Form 1012 to determine whether Resident #75 needed further evaluation for mental illness. Record review of facility policy admission Criteria updated 12/2016 revealed, 8. Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-admission Screening and Resident Review program (PASRR) to the extent possible. Resident #75

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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** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, for 3 of 20 residents (Residents #52, #75 and #80) reviewed for comprehensive care plans. 1. The facility failed to develop a comprehensive person-centered care plan to address Resident #52's admission MDS assessment triggered care area. 2. The facility failed to develop a comprehensive, person-centered care plan to address Resident #75's use of smokeless tobacco. 3. The facility failed to ensure that Resident #80's comprehensive care plan was completed. These failures could affect residents who have care areas not addressed by the care plans by not having their needs met and putting them at risk of not receiving appropriate care. The findings included: 1. Record review of Resident #52's face sheet, dated 06/09/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Urinary tract infection (an infection in any part of the urinary system), Sepsis (blood poisoning), Type 2 Diabetes mellitus (high level of sugar in the blood), Chronic kidney disease stage 3 (gradual loss of kidney function), Hypertension (High blood pressure) and, Myocardial infarction (Heart attack). Record review of Resident #52's admission MDS assessment, dated 05/01/2025 and, completed 05/07/2025, revealed the resident had a BIMS score of 13, which indicated mild cognitive impairment. The resident required limited to moderate assistance with her activities of daily living. Further review revealed Resident #52 was occasionally incontinent of bladder and was frequently incontinent of bowel. Section V (care area assessment) coded for Resident #52 to be care planned for ADL functional/rehabilitation potential, Urinary incontinence and indwelling catheter, Nutritional status, Dehydration/fluid maintenance and, Pressure ulcer. Record review of Resident #52's Care Plan, dated 04/29/2025, revealed the resident was not care planned for any any of the care areas triggered by the MDS and was only care planned for activities. Record review of Resident #52's care plan dated 06/10/2025 revealed a comprehensive care plan had been completed on 6/10/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with MDS Nurse G on 06/11/2025 at 3:20 p.m., MDS nurse G stated Resident #52's comprehensive care was not written until 06/10/2025 and did not contained the area triggered by the care area assessment. MDS Nurse G confirmed a Comprehensive care plan must be done by day 21 after admission or 7 days after MDS admission. She stated the comprehensive care plan should have been done by 5/14/25 and was late. She stated the risk of having no comprehensive care plan or a late comprehensive care plan was for the resident to not receive appropriate care. She stated she used the RAI manual as a resource and could access it on her computer. Review of Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual Version 1.19.1 October 2024 revealed The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days). 2. Record review of Resident #75's face sheet dated 06/08/2025 revealed the resident was admitted to the facility 02/10/2024 and readmitted on [DATE] with diagnoses that included: Hemiplegia and hemiparesis following cerebral infarction (paralysis or weakness on one side of the body following a stroke), chronic heart failure, schizoaffective disorder bipolar type (a mental health condition involving psychotic symptoms like hallucinations and delusions alongside mood episodes of mania and sometimes depression), and acute respiratory failure with hypoxia (a critical condition where the lungs cannot adequately oxygenate the blood, leading to low blood oxygen levels and potentially affecting other organs). Record review of Resident #75's quarterly MDS assessment dated [DATE] revealed a BIMS score of 09/15, indicating moderate cognitive impairment. Record review of Resident #75's comprehensive care plan dated 01/31/2025 revealed there was no focus area indicating the resident's use of smokeless tobacco. Observation on 06/09/2025 at 10:13 AM revealed five 1.2 oz. cans of smokeless tobacco on Resident #75's bedside table. During an interview on 06/09/2025 at 10:15 AM, RN E stated she was unaware Resident #75 used smokeless tobacco. During an interview on 06/09/2025 at 10:20 AM, Resident #75 stated he had used smokeless tobacco since he was nine years old. Of the five cans on his bedside table, three were empty and two contained some tobacco. He had used smokeless tobacco since his admission to the facility. He purchased the cans of tobacco from the nearby convenience store. During an interview on 06/09/2025 at 11:00 AM, the DON stated he was unaware Resident #75 used smokeless tobacco in his room, and the resident's Comprehensive Care Plan should have a focus area indicating the resident's use of smokeless tobacco. A possible reason for this omission might be it was not carried over from a recent discharge and readmission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy, Care Plans, Comprehensive Person-Centered dated 10/02/2022 revealed, Policy Statement: Measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan will: Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems. 3. Record review of Resident #80's face sheet dated 06/09/2025, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: Alzheimer's Disease with Early Onset (destroy memory and other important functions), chronic kidney disease (kidneys are not filtering correctly) Record review of Resident #80's admission MDS dated [DATE] revealed a BIMS score of 02, indicating severely impaired cognition. Record review of Resident #80's comprehensive care plan, updated 04/23/2025, revealed the only area addressed was Preference to participate in group activities and Code status. The resident was not care planned for any of the care areas triggered by the MDS which included dental, discharge plans, diet, medication, specialized equipment, behaviors or ADLs. Record review of Resident # 80's care plan dated 06/11/2025 revealed a comprehensive care plan had been updated on 06/11/2025. During an interview on 06/11/2025 at 8:00 AM, with MDS Nurse G confirmed that a comprehensive care plan should be completed within 48 hours of returning from the hospital. MDS Nurse G said the comprehensive care plan should include everything that was required to take care of a resident. She confirmed that if a comprehensive care plan was not completed or filled out correctly things can be missed on how to take care of the resident. During an interview on 6/11/2025 at 10:00 AM DON confirmed that a comprehensive care plan should be completed within 48 hours of returning from the hospital . The DON confirmed the comprehensive care plan should include everything that was required to take care of a resident. He confirmed that if a comprehensive care plan was not completed or filled out correctly things can be missed on how to take care of the resident. Record Review of the facility's policy Care Plans, Comprehensive Person-Centered Policy dated 10/02/2022, revealed The comprehensive, person-centered care plan is developed within (7) days of the completion of the required comprehensive assessment (MDS) . Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' conditions change. When there has been a significant change in the resident's condition; b. When the desired outcome is not met. c. When the resident has been readmitted to the facility from a hospital stay, and d. At least quarterly, in conjunction with the required MDS assessment.

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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** Based on interview and record review, the facility failed to ensure a comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 20 residents (Resident #11) reviewed for care plans. The facility failed to revise Resident #11's comprehensive care plan to reflect the resident's refusal to have her weight taken. This deficient practice could cause confusion for staff members responsible for providing direct care for residents and result in staff not respecting residents' wishes regarding care. The findings were: 1. Record review of Resident #11's face sheet dated 06/09/2025 revealed the resident was an [AGE] year old female with diagnoses that included: cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die), cerebral palsy (a group of neurological disorders that affect movement, posture, and muscle coordination), schizophrenia (a serious mental health condition that affects how people think, feel and behave), epilepsy (a neurological disorder characterized by recurring seizures due to abnormal electrical activity in the brain) and dysphagia (difficulty swallowing foods or liquids). Record review of Resident #11's quarterly MDS assessment dated [DATE] revealed a BIMS of 03/15, indicating the resident had severely impaired cognition. She was incontinent of bowel and bladder and completely dependent on staff for all ADL care. Record review of Resident #11's comprehensive care plan, revised 05/17/2025, revealed Resident #11 had an ADL self-care performance deficit related to impaired mobility from a stroke. The resident required substantial/maximal assistance with toileting, bathing, dressing, personal hygiene, and mobility. Resident #11 at times refused medications, ADL care and showers (initiated on 11/04/2021). Resident #11 had an unplanned/unexpected weight loss related to diuretic use, poor intake, and dysphagia (initiated on 05/04/2023). Interventions included: Consulting the dietitian if consumption was poor for more than 48 hours; if weight decline persisted, contact the physician and dietitian immediately; observe and evaluate any weight loss by determining percentage lost and following facility protocol for weight loss. There was no indication in the comprehensive care plan Resident #11 refused to be weighed. Record review of Resident #11's Order Summary Report dated 06/09/2025 revealed the order, Weekly weight x4 on admission, then monthly, if gain/loss >3#, reweigh, notify MD. The start date of the order was 09/11/2024. Record review of Monthly Weight Report provided by the facility on 06/08/2024 revealed there were weight measurements for Resident #11 for 12/2024 (133.0 lbs.), 01/2025 (133.5 lbs.), 02/2025 (132.0 lbs.), no weight noted for 03/2025, a weight for 04/2025 (137.0 lbs.) and no weight measurements noted for 05/2025 and 06/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/10/2025 at 2:46 PM, CNA F stated she attempted to weigh Resident #11 on 06/03/2025 but the resident refused to be weighed. She noted the resident's refusal in the Tasks section of the resident's EHR. During an interview on 06/10/2025 at 3:00 PM, the DON stated Resident #11's occasional refusal to be weighed was not noted in the resident's comprehensive care plan and should have been noted. The EHR system used by the facility only allowed a 30-day look back. The procedure when a resident refused to be weighed was the CNA noted the refusal in the Tasks section of the resident's EHR. This triggered a nurse to note the refusal in the Weights section of the resident's EHR and alerted the MDS nurse to document this behavior in the resident's comprehensive care plan. Nursing staff failed to act on the information noted by the CNA, and more education was required to ensure it would not happen again. During an interview on 06/11/2025 at 3:20 PM, the MDS LVN stated she assumed the position on 05/01/2025 and was not aware of the missing weight measurements. Record review of facility policy, Care Plans, Comprehensive Person-Centered dated 10/02/2022 revealed, Policy Statement: Measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan will: j. Reflect the resident's expressed wishes regarding care and treatment goals; 15. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals will be documented in the resident's clinical record in accordance with established policies.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who needed tracheostomy care were provided such care, consistent with professional standards of practice, for 1 of 1 residents (Resident #76) reviewed for tracheostomy care. The facility failed to provide tracheal care and suctioning according to professional standards for Resident #76. These deficient practices could result in the resident's not receiving the care and services ordered by the physician and a decline in health status and respiratory infection. Findings included: Record review of Resident #76's face sheet, dated 06/10/2025, revealed an admission date of 07/25/2024 with diagnoses that included: Anoxic brain damage (damage caused to the brain due to a lack of oxygen), Contractures (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), Aphasia (result of a Stroke or Brain injury that affects a person's ability to communicate) and, Dysphagia (Difficulty swallowing). Record review of Resident # 76's Quarterly MDS assessment dated [DATE], revealed Resident #76 was non verbal. Resident #76 required extensive assistance for all of her activities of daily living. Resident #76 was coded as receiving tracheostomy (opening in the trachea (windpipe) to facilitate breathing) care. Record review of Resident #76's care plan, dated 08/12/2024, revealed a problem of has a tracheostomy and is at risk for respiratory distress, aspiration and infections. and, an intervention of Sterile Tracheostomy care as ordered and PRN to help prevent infection. Record review of Resident #76's physician orders for June 2025 revealed Tracheostomy care: Cleanse tracheostomy site with normal saline, pat dry; apply split tracheostomy gauze twice daily every shift-Start Date-01/22/2025. Observation on 06/10/25 at 11:25 a.m. revealed while providing tracheostomy care for Resident # 76, RN B placed the sterile field on the side table and positioned the box containing the normal saline and gauze used to clean the tracheostomy of the resident on the top of the sterile field. By doing so every time she reached for saline and gauze the non sterile part of her arms crossed over the sterile field, as a result breaking the sterile field. During an interview with RN B, on 06/10/2025 at 11:35 a.m., RN B confirmed breaking the sterile field but did not realize she was doing it. She stated she had received training for tracheostomy care and infection control with the year. (continued on next page)

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	455597	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON, on 6/11/25 at 1:20 p.m., the DON stated tracheostomy care should be done using sterile procedure and not maintaining sterile technique could result in respiratory tract infection. The DON stated crossing the sterile field with the non sterile part of the arms constitute breaking the sterile field. The RN was qualified to do tracheostomy care and her skills were checked annually by the DON. Record review of the facility policy, titled tracheostomy care, dated 10/03/2018, revealed Set up supplies on sterile field.[.] Maintaining sterile field, pour equal parts hydrogen peroxide and normal saline in one compartment of opened kit. Pour normal saline in another compartment. Review of Nursing Skills - 2e Copyright © 2023 by WisTech at https://wtcs.pressbooks.pub/nursingskills/chapter/4-4-sterile-fields/ revealed Open sterile kits away from your body first, touching only the very edge of the opening flap. Using the same technique, open each of the side flaps one at a time using only one hand, being careful not to allow your body or arms to be directly above the opened drape. Take care not to allow already-opened corners to flip back into the sterile area again.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure that nurses were able to demonstrate competency in skills and techniques to provide nursing and related services for 1 of 6 residents (Resident #76) by 1 of 3 nurses (RN B) reviewed for competent staff, in that: The facility failed to provide tracheal care and suctioning according to professional standards for Resident #76. The failure could place residents at risk for not receiving nursing services by adequately trained and licenses nurses and could result in a decline in health and infection. The findings included: Record review of Resident #76's face sheet, dated 06/10/2025, revealed an admission date of 07/25/2024 with diagnoses that included: Anoxic brain damage (damage caused to the brain due to a lack of oxygen), Contractures (shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement), Aphasia (result of a Stroke or Brain injury that affects a person's ability to communicate) and, Dysphagia (Difficulty swallowing). Record review of Resident # 76's Quarterly MDS assessment dated [DATE], revealed Resident #76 was non verbal. Resident #76 required extensive assistance for all of her activities of daily living. Resident #76 was coded as receiving tracheostomy (opening in the trachea (windpipe) to facilitate breathing) care. Record review of Resident #76's care plan, dated 08/12/2024, revealed a problem of has a tracheostomy and is at risk for respiratory distress, aspiration and infections. and, an intervention of Sterile Tracheostomy care as ordered and PRN to help prevent infection. Record review of Resident #76's physician orders for June 2025 revealed Tracheostomy care: Cleanse tracheostomy site with normal saline, pat dry; apply split tracheostomy gauze twice daily every shift-Start Date-01/22/2025 1800. Observation on 06/10/25 at 11:25 a.m. revealed while providing tracheostomy care for Resident # 76, RN B placed the sterile field on the side table and positioned the box containing the normal saline and gauze used to clean the tracheostomy of the resident on the top of the sterile field. By doing so every time she reached for saline and gauze the non sterile part of her arms crossed over the sterile field, as a result breaking the sterile field. During an interview with RN B, on 06/10/2025 at 11:35 a.m., RN B confirmed breaking the sterile field but did not realize she was doing it. She stated she had received training for tracheostomy care and infection control with the year. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON, on 6/11/25 at 1:20 p.m., the DON stated tracheostomy care should be done using sterile procedure and not maintaining sterile technique could result in a respiratory tract infection. The DON stated crossing the sterile field with the non sterile part of the arms constituted breaking the sterile field. The RN was qualified to do tracheostomy care and her skills were checked annually by the DON. Record review of the Facility's Licensed Nurse orientation/Annual Skills/Competency Checklist, dated 04/15/2025, revealed RN B met competency for tracheostomy care. Record review of the facility policy, titled tracheostomy care, dated 10/03/2018, revealed Set up supplies on sterile field.[.] Maintaining sterile field, pour equal parts hydrogen peroxide and normal saline in one compartment of opened kit. Pour normal saline in another compartment. Review of Nursing Skills - 2e Copyright © 2023 by WisTech at https://wtcs.pressbooks.pub/nursingskills/chapter/4-4-sterile-fields/ revealed Open sterile kits away from your body first, touching only the very edge of the opening flap. Using the same technique, open each of the side flaps one at a time using only one hand, being careful not to allow your body or arms to be directly above the opened drape. Take care not to allow already-opened corners to flip back into the sterile area again.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, 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 reviewed for kitchen sanitation. 1. The facility failed to store clean cups properly to allow for air-drying. 2. The facility failed to store a mop and a broom in a sanitary manner in the utility closet. These deficient practices could place residents who received meals and snacks from the kitchen at risk for food borne illness. The findings included: 1. Observation on 06/08/2025 at 11:52 AM in the dish room revealed there was one tray of 19 plastic mugs stored face-down on a wet tray. There were also two trays of ceramic mugs, each with approximately ten mugs, stored face down on a wet tray. There were no air-drying nets separating the plastic or ceramic mugs from the trays. During an interview on 06/08/2025 at 11:54 AM, the DM stated the trays were missing air-drying nets separating the bowls and cups from the trays. She had several such nets that were in use on other trays and needed to purchase more. It was important to ensure clean dishes were air-dried to prevent the potential accumulation of germs and bacteria which could lead to foodborne illness. 2. Observation on 06/08/2025 at 12:05 PM revealed a soiled mop and a broom were stored head-side down inside a plastic storage crate in the utility closet. The mop was not in use at the time of the observation. During an interview on 06/08/2025 at 12:05 PM, the DM stated she had just used the mop and should have stored it in an upright position on one of the hooks inside the utility closet to ensure it dried properly and did not harbor bacteria. Mop heads were sent to laundry for cleaning and sanitizing. Record review of the facility's policy Warewashing, undated, revealed, Procedures: 4. All dishware will be air dried and properly stored. Record review of the facility's policy, Cleaning Instructions, Cleaning Cloths, Pads, Mops and Buckets, undated, revealed, Policy: Cleaning tools will be maintained in clean, fresh, odor-free condition. Procedure: 4. Mop buckets and wringers will be washed out after each use and stored inverted to allow drainage. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 6-501.16 Drying Mops. After use, mops shall be placed in a position that allows them to air-dry without soiling walls, equipment, or supplies. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 of 1 residents (Resident #5) reviewed, in that: The facility failed to ensure food items stored in Resident #5's personal refrigerator was labeled and dated. This deficient practice could place residents at risk of foodborne illness due to consuming foods which might be spoiled. The findings included: Record review of Resident #5's face sheet, dated 06/09/2025, reflected the resident was an [AGE] year old female and was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: Schizoaffective Disorder a chronic mental illness that combines symptoms of both schizophrenia and a mood disorder, such as depression or mania), Muscle Weakness (loss of muscle tissue and strength), Dementia (group of symptoms that affect memory, thinking, and other cognitive functions, significantly impacting daily life), and Hypertension (high blood pressure). Observation and interview on 06/09/2025,at 10:00 AM in Resident #5's room revealed in her personal refrigerator there was a covered plastic container that was not labeled or dated. Cooked sausage was in the container. Resident #5 was unable to tell Surveyor how long it had been in there. There was also a disposable bowl with canned peaches in it, covered with clear plastic wrap. There was no label or date on the bowl. There was one peanut butter and jelly sandwich wrapped and labeled with the resident's name. There was no date. There were two pieces of bread wrapped in clear plastic. There was no date or label. There was a jar of dill relish that had a best by date of May 2025. Interview on 06/11/2025 at 11:18 am with the DON confirmed that the food in the resident's refrigerator should be labeled and dated. The DON was asked what could happen if someone ate spoiled or old food. He said they could get sick. The DON was asked who was responsible for checking temperatures and food being labeled and dated. He told me they have advocate rounds where the staff checked but that sometimes the resident will refuse to let staff open her refrigerator. Record review of the Facility's policy titled Food: Safe Handling for Foods from Visitors revealed 4. When food items are intended for later consumption, the responsible facility staff member will: Label foods with the resident name and the current date. 5. Refrigerators for storage of foods brought in by visitors will be properly maintained and daily monitoring for refrigerated storage duration and discard of any items that have been stored for more than 7 days.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed a to dispose of garbage and refuse properly for 1 of 2 Dumpsters (Dumpster #1) reviewed for garbage and refuse disposal. The facility failed to ensure Dumpster #1 had a drain plug. This deficient practice could place residents at risk for exposure to germs and diseases carried by vermin and rodents. The findings included: Observation on 06/08/2025 at 11:58 AM revealed Dumpster #1 did not have drainage plug. During an interview on 06/08/2025 at 11:58 AM, the DM stated she was unaware Dumpster #1 was missing a drain plug, and it was important for the dumpster to have one as it presented an unsanitary condition and an opportunity for the proliferation of rodents. During an interview on 06/11/2025 at 2:55 PM, the Maintenance Director stated the drain plug was missing from Dumpster #1 and he would ensure it was replaced. Dumpster #1 replaced the previous dumpster one month ago, and the previous dumpster did not require a drain plug. He was aware a plug was necessary to keep water and pests out of the dumpster. Record review of facility policy Food-Related Garbage and Refuse Disposal revised 10/17 revealed, Policy Statement: Food-related garbage and refuse are disposed of in accordance with current state laws. 5. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests. 7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 5-501.114 Using Drain Plugs. Drains in receptacles and waste handling units for refuse, recyclables, and returnables shall have drain plugs in place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, and record reviews, 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 2 of 6 residents (Resident #10 and 71) reviewed for infection control, in that: 1. While providing colostomy care for Resident #10, LVN C did not change his gloves or sanitize his hands after touching the privacy curtain and before starting the care. 2. a. While providing wound care for Resident #71, LVN A did not change her gloves or sanitize her hands after touching the privacy curtain and before starting the care. 2.b. While providing incontinent care for Resident #71, CNA D did not change his gloves or sanitize his hands during care. These deficient practices could place residents at-risk for infection due to improper care practices. These findings included: 1. Record review of Resident #10's face sheet, dated 06/10/2025, revealed an admission date of 05/28/2020, and a readmission date of 05/21/2025, with diagnoses which included: Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), Ileostomy status (surgery that makes an opening in the belly, or abdominal wall, for stool (poop) to leave the body), Malignant neoplasm of colon (Cancer of part of the intestine), Hypertension (High blood pressure), Hypothyroidism (under active thyroid), and Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood). Record review of Resident #10's MDS Quarterly assessment, dated 05/28/2025, revealed the resident had a BIMS score of 15, indicating no cognitive impairment. Resident #10 required extensive to total care with his activities of daily living, and had an indwelling catheter and an ostomy. Record review of Resident #10's care plan revealed a care plan initiated 06/14/2022 with a problem of requires the use of a Ileostomy.* at times res prefers to care for and manage his own ostomy care.and, an intervention of Provide ostomy care per order to prevent odors and keep ostomy (surgically created opening) patent. Observation on 06/10/25 at 10:45 a.m. revealed while providing colostomy care for Resident # 10, LVN C touched the privacy curtain to closed it with his gloved hands but did not change gloves and sanitized or washed his hands before starting to provide care for the resident. During an interview on 06/10/2025 at 11 a.m. LVN C stated he touched the privacy curtain and did not change his gloves afterward before starting care. He did not realize there was a risk of cross contamination. He confirmed receiving infection control training with the year. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #71's face sheet, dated 06/10/2025, revealed an admission date of 03/19/2024 and, a readmission date of 10/08/2024, with diagnoses which included: Chronic kidney disease (gradual loss of kidney function), Aphasia (result of a Stroke or Brain injury, and affects a person's ability to communicate), Type 2 diabetes mellitus (high level of sugar in the blood), Hemiplegia (Paralysis of one side of the body), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Hypertension (High blood pressure) and, Major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure). Record review of Resident #71's Quarterly MDS assessment, dated 04/29/2025, revealed the resident had a BIMS score of 11, indicating he was moderately impaired. Resident #71 was always incontinent of bladder and bowel and, required extensive assistance to total care with his activities of daily living. Resident #71 had two pressure ulcer (wound caused by prolonged pressure on the skin). Record review of Resident #71's care plan, dated 04/18/2024, revealed a problem of Skin integrity impaired r/t chronic sacral stage 4 pressure injury (deep, open wound that extends through the skin, underlying tissue, muscle, and bone at the base of the spine),, with a goal of will show s/s of healing wound by next review date. Further review revealed a problem of has potential for complications r/t bowel and bladder incontinence and, a goal of Resident will be free from complications r/t incontinence as evidence by intact skin, no rash or redness to pericare, no s/s of infection daily through next 90 day review. 2.a. Observation on 06/10/25 at 09:58 p.m. revealed while providing wound care for Resident # 71, LVN A touched the privacy curtain with her gloved hands and did not change her gloves or sanitized or washed her hands prior to start the wound care for the resident. During an interview on 06/10/2025 at 10:05 a.m. LVN A A stated she should have changed gloves and washed her hands because the privacy curtain was part of the resident's environment and was considered dirty and there was a risk for cross contamination. She stated she received training for infection control within the year. 2.b. Observation on 06/10/2025 at 12 p.m. revealed during incontinent care provided by CNA D for Resident # 71, CNA D did not change his gloves or sanitize his hands during the whole time he provided incontinent care to the resident. He did not changed his gloves after cleaning Resident #71's genital area and before cleaning the resident's buttocks. CNA D did not change his gloves after cleaning Resident #71's buttocks and before touching the clean brief. During an interview with CNA D on 06/10/2025 at 12:15 p.m. CNA D stated he did not change gloves and thought he did not need to. He stated he received Infection control training within the year. During an interview with the DON, on 06/11/2025 at 1:20 p.m., the DON stated the staff should change their gloves after touching the privacy curtain, which was considered dirty as part of the resident's environment. Further interview revealed the DON stated the CNA should have changed his gloves during incontinent care and washed or sanitized his hands to prevent cross contamination and infection. He revealed they provided training on infection control at least once a year and as needed. He revealed they checked the skills of the staff annually and as needed with the assistance of his ADONs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy. titled Hand washing/Hand hygiene, dated August 2019, revealed Before and after direct contact with resident, [.] before moving from a contaminated body site to a clean body site during resident care, [.] after contact with blood or bodily fluid [.] after contact with objects in the immediate vicinity of the resident.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and interview the facility failed to have an ongoing and effective pest control program for 1 of 4 halls (West hall) reviewed for pest control. The facility did not have an effective pest control program to eradicate the gnats in the facility. The facility failure placed residents at risk for infections and diminished quality of life. Findings included: Observation on 06/10/25 at 10:30 a.m. revealed while observing transfer care provided for Resident # 64 by CNA F, this surveyor observed 11-12 small flying black insects that looked like gnats on one of the side table in the room During an interview with CNA F on 06/10/2025 at 10:32 a.m., CNA F stated the flying black insect were present in the room and she added it happened often. She stated they reported to housekeeping every time they noted a problem with insects. During an interview on 06/10/2025 at 10:40 a.m., the DON stated the insects were present and alive in Resident #64's room. He added it was one of the thing they were working on and they were going to change the pest control company they were using. During an interview on 6/11/2025 at 2:55 p.m., the Maintenance supervisor stated the pest control company was coming every other week and as needed. He added the staff reported to housekeeping if they were seeing pest in the facility and housekeeping reported to him. He was made aware of the gnats and the pest control company came on the same day. He was told by the pest control company that gnats and flies were hard to treat because it was usually a sanitary issue and Resident #64 urinated all over the room and even in the AC vent. He stated they were trying to fix the problem by changing pest control company and he made rounds as often as he could. He was the only maintenance staff working at the facility. Further interview revealed the Maintenance Supervisor stated pests in the facility was a risk for infection. Record review of contracts, dated 11/01/2023, revealed the facility had a contract with a professional company for pest control, and they were contracted to come twice monthly and as needed if called. Record review of service log form for the last 6 months revealed the pest control company did a visit on 5/14/2025 but treated the facility for roaches and ants not gnats. Review of facility's policy, titled pest control, dated May 2008, revealed This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.