STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455689	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Pedro Manor	515 W Ashby Pl 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which are complete; and accurately documented for 1 of 4 residents (Resident #1) reviewed for documentation. Resident #1's electronic medical record did not contain complete and accurate documentation regarding whether his falls on 5/28/25 and 7/12/25 were witnessed by nursing staff or unwitnessed. This failure could result in residents' records not accurately documenting interventions, monitoring, and information provided to the interdisciplinary team as to whether a resident fall was witnessed or unwitnessed. The findings were:Record review of Resident #1's face sheet, dated 7/17/25, reflected resident was a male aged 74 admitted on [DATE] and re-admitted [DATE] and discharged [DATE] (hospital) with diagnoses that included: nontraumatic intracranial hemorrhage (residual effects from a stroke), epilepsy (seizure disorder), abnormalities of gait and mobility (difficulty with ambulation), lack of coordination, and tinnitus (ringing in the ear). The RP was listed as: Guardian. Record review of Resident #1's quarterly MDS dated [DATE] reflected the resident's BIMS score was 1 which indicated severe cognitive impairment. The resident required set-up for transfer and had no impairments in range of motion. W/C was listed as an assistive device. Record review of Resident #1's fall risk score dated 7/12/25 reflected a score of 11 which indicated high risk for fall. Record review of Resident #1's Nurse Note dated 5/28/25 authored by LVN A reflected: resident had a witnessed fall without injury in the common area. Record review of Resident #1's CP dated 5/28/25 reflected witnessed fall with the new intervention of staff to be in-serviced, and optometry referral. Record review of Resident #1's Incident report authored by LVN A documented a conflict on whether the resident's fall on 5/28/25 was witnessed or unwitnessed. The incident report Box for fall was checked for unwitnessed. Record review of Resident #1's CP dated 7/12/25 reflected an unwitnessed fall with no injury; intervention was the placement of Dycem (adhesive) on the resident's W/C. Record review of Resident #1's Nurse Note dated 7/12/25 at 5:45 PM authored by LVN B reflected the fall was witnessed. Record review of the Resident's Incident Report dated 7/12/25 reflected the fall was not witnessed. Observation and interview of Resident #1 on 7/16/25 at 1:00 PM reflected, resident was in an ICU bed, alert and oriented to self. An O2 pulse meter was placed on the resident's head. His left elbow had multiple scratches and generalized bruising and was red in color. The resident could not recall any information regarding his falls on 5/28/25 and 7/12/25. The resident was able to state that he was not abused or neglected in the facility. The resident was unable to state any fall prevention measures that were in place at the nursing home. During an interview on 7/16/25 at 1:05 PM, the ICU RN stated: Resident #1 was admitted on [DATE] around midnight and given a CT scan at 2:00 AM. The CT scan revealed a small hemorrhagic contusion in the right frontal lobe (small bleeding in the front of the brain) not requiring a surgical intervention, The RN stated that the resident had dementia and was confused most of the time. The RN stated that the resident had a history of stroke in the year 2022. The RN stated the resident was scheduled to be transferred to a medical bed out of ICU on 7/16/25. Record review of Resident #1's ER report dated 713/25 at 26 minutes past midnight reflected: resident presented to ER from fall from his W/C on 7/12/25 around 10:20 PM. CT scan performed; no acute neurosurgical intervention was indicated at the time. The CT scan reflected a small hemorrhagic contusion in the anterior lateral inferior right frontal lobe (section of the brain involved in speech). Lab results reflected the resident had low potassium and high sodium [indicators of confusion]. Diagnoses included: hemorrhagic contusion after fall, history of CVA, and dementia. During an interview on 7/17/25 at 2:23 PM, LVN C (MDS) stated that: for the 5/28/25 fall there was a conflict in the incident report with the other documents (CP and Nurse Note). LVN C stated he could not explain the inaccurate documentation for the 5/28/25 fall. Regarding the fall incident on 7/12/25 at 5:45 PM, LVN C stated he could not explain why there was inaccurate documentation between the nurse note and the CP and the incident report. During an interview on 7/17/25 at 3:00 PM, the DON stated she was not aware of the inaccurate documentation for Resident #1's fall on 5/28/25. Regarding the inaccurate documentation on 7/12/25, the DON stated the MDS Nurse (LVN C) made an error in documentation that was immediately corrected on 7/17/25 [surveyor entered the facility on 7/16/25] which reflected that Resident #1's fall on 7/12/25 at 5:45 PM was witnessed. The DON stated that documentation required that the fall assessment, CP, and Kardex (nursing tool that summarizes resident information) were to be accurate. The DON stated the facility kept a binder of high-risk residents at the Nurse Station which captured the interventions for high fall risk residents. During a telephone interview on 7/17/25