

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455689	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/30/2026
NAME OF PROVIDER OR SUPPLIER  San Pedro Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to consult with the resident's physician and representative when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 of 8 residents (Resident #1) reviewed for resident rights. The facility failed to notify Resident #1's representative when staff reported a skin tear . This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition. The findings included: Record review of Resident #1's face sheet dated 4/28/26 revealed a [AGE] year-old male admitted to the facility on [DATE] and with diagnoses that included anxiety disorder ( persistent, excessive, and uncontrollable worry or fear that interferes with daily life) , Hypertension, (high blood pressure, is a chronic condition where the force of blood against artery walls is consistently too high) and Benign Prostatic Hyperplasia ( is a common, non-cancerous enlargement of the prostate gland). Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS of 12, which indicated moderate cognitive impairment. Record review of Resident #1's care plan, dated 4/2/2026, revealed: ST to left lateral shin, keep skin clean and dry . Review of facility incident and accident report from January 2026-April 2026 revealed Resident #1's name associated with the incident Skin Tear on 4/2/2026. Record review of Resident #1's physician's telephone orders, 4/2/26, revealed the following:Cleanse affected areas with normal saline, pat dry, apply skin prep, and xeroform to open areas, daily. Record review of Resident #1's progress notes from 4/2/26 , 2:20 PM ; written by LVN A revealed skin tear/abrasion noted to left lower shin; attempted to call daughter / POA; no answer noted. Record review of Resident # 1 electronic record progress notes from 4/3/2026, written by the treatment nurse, revealed this nurse was notified that Resident # 1 had a skin tear to the left lower shin, 8x6 CM. Interview with the RP on 4/29/2026 at 10:15 AM revealed she was never contacted by facility nursing staff; she was notified of the incident by Resident # 1 when she came to visit on 4/3/2026 and noted the skin tear to left lower shin. Interview with LVN A on 4/29/2026 at 10:30 AM revealed she called family but was unable to leave a voicemail, but was under the impression that the treatment nurse would call the family of Resident # 1. An interview with the treatment nurse on 4/29/2026 at 11:06 AM revealed that LVN A notified her of a skin tear for Resident #1 on 4/3/2026. The treatment nurse stated she called the MD, wrote orders, and did not contact family, as per the facility's culture; the charge nurse was responsible for contacting family. An interview with the DON on 4/29/2026 at 2:00 PM revealed that she became aware that the family was not notified of the skin tear that occurred on 4/2/2026, and that on 4/3/2026, when RP came to speak to her, an investigation was conducted. The DON stated that the RP should have been notified per the significant change policy. She said failure to notify the RP of an incident could lead to a breakdown of trust between RP and the facility. The DON stated both LVN A and the wound care nurse should have ensured the RP was contacted. The DON also stated her ADONs would be responsible for supervising compliance with this task, and she would monitor it by conducting random incident report checks Interview with the Administrator on 4/2/2026 at 2:30 PM (continued on next page)</p>		

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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