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	06/27/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review the facility failed to provide comfortable and safe temperature levels between a range of 71 to 81 degrees Fahrenheit for one of ten residents (Resident #2) reviewed for environment. The facility failed to ensure Resident #2's room remained at a comfortable temperature. This failure could place residents at risk of experiencing decreased comfort and could affect the well-being of residents. Findings include: Record review of Resident #2's MDS, dated [DATE], reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included hypertension (high blood pressure), anxiety disorder, and chronic obstructive pulmonary disease. Observation and interview on 06/25/24 at 10:40 AM with Resident #2 revealed he was in his room sitting in his bed. The resident said his room had been hot for a while and he had let the Maintenance Assistant know but the AC in his room had not been fixed. Observation of the thermostat on the wall of his room showed the temperature in the room was 80 degrees Fahrenheit. Resident #2 said he had a fan in his room but said it was not helping him keep cool. Observation on the following dates and times with an ambient thermometer in Resident #2's room revealed the following: 06/25/24 at 2:28 PM - 80 degrees 06/26/24 at 3:28 PM - 82 degrees Interview on 06/27/24 at 5:02 PM with the Maintenance Assistant revealed Resident #2 told him multiple times that his AC was not working, and one of those dates was 06/14/24. The Maintenance Assistant stated every time he checked Resident #2's AC, it was running good. The Maintenance Assistant said when he checked with his thermometer, the temperature out of the vent was 66 degrees. He stated he did not know why Resident #2's room was reading 80 degrees. The Maintenance Assistant further stated he told the Maintenance Director of Resident #2's AC but did not state when. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/27/24 at 5:02 PM with the Maintenance Director revealed he was made aware today, 06/27/24, that Resident #2's AC was not working. The Maintenance Director said they had just called in an AC repairman who was still at the facility and he would have Resident #2's AC checked out. Interview on 06/27/24 at 3:42 PM with the Operations Manager revealed she was not made aware Resident #2's AC was not working. She said risks of a hot room could cause the resident to feel uncomfortable in his room. Record review of the facility's, undated, policy titled Environmental Service reflected the following: It is the policy of this facility to maintain a clean and comfortable environment . 2. Temperatures in the common areas must remain between 70F-78F.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review the facility failed to implement written policies and procedures that prohibit, prevent abuse, neglect and exploitation of residents for three of three incidents (Resident #40, Resident #36, and Resident #9) reviewed for reporting. 1. The facility failed to follow their policy to report to the State Survey Agency when Resident #40 sprained his ankle when he got his foot caught in the van ramp while being pushed by the transportation driver. 2. The facility failed to follow their policy to report to the State Survey Agency when Resident #36 was found to have ant bites on her body. 3. The facility failed to follow their policy to report to the State Survey Agency when Resident #9 was given the wrong medications on 04/22/24. These failures could place residents at risk of lacking timely reporting of incidents. Findings include: 1. Record review of the facility's, undated, policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation, or Mistreatment reflected the following: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: .The State Survey Agency Record review of Resident #40's MDS, dated [DATE], reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included end stage renal disease (kidney failure), diabetes, osteoporosis, stroke, and seizure disorder. The MDS further reflected Resident #40 had a BIMS of 14, which indicated his cognition was intact. Resident #40 used a manual wheelchair. Record review of Resident #40's care plan, dated 08/29/23, reflected he had osteoporosis and interventions included to protect the resident from injury avoiding sudden bumps, jarring with transfers. The care plan further reflected Resident #40 attended dialysis Mondays, Wednesdays, and Fridays. Record review of Resident #40's progress note, dated 06/21/24, documented by LVN A, reflected the following: (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notified by 1st floor nurse that resident had an incident getting onto the transportation bus. This nurse went down to the 1st floor to assess the resident noted resident sitting in wheelchair, leaned over holding onto right foot, when assessed the right foot noted swelling to the right ankle, very sensitive to touch, able to wiggle toes and pedal pulse 3+. Took resident to his room, assisted him to bed, resident cannot bare weight on right foot . Resident stated 'driver of the van was pushing me onto the ramp but had to push me a little fast because there's a little bump to get over on the ramp when my foot got caught in the ramp and pushed my foot all the way back.' MD notified ordered STAT x-ray to right foot Asked resident pain level from 0-10 resident stated a 10, administered Acetaminophen-Codeine Tablet 300-30MG per resident request for pain. Record review of radiology results dated 06/21/24, reflected there were no fractures and no new orders given. Record Review of the Transportation Company's Accident/Incident Report Form, dated 06/21/24, reflected the following: Incident Information Incident Description [Resident #40] right ankle was injured while being rolled into the rear ramp of the wheelchair van by driver, [Driver]. As [Resident #40] crested the top of the ramp to enter the van, his right foot was not high enough, which caused his foot to roll under the leg. Driver took [Resident #40] back into the facility for examination by a nurse to determine the severity of his injury. Observation and interview with Resident #40 on 06/25/24 at 11:23 AM revealed when he was picked up for dialysis last Friday, 06/21/24, the transportation driver pushed him into the transportation van too fast and his foot got caught where the lift and the van connected. The resident said he immediately felt pain because it sprained his ankle. The facility ordered x-rays to ensure it was not broken due to the swelling. Observation of Resident #40's ankle revealed there was some swelling but there was no bruising noted at the time, but there was a pain patch on his ankle. The resident said he got some pain relief with the pain medications and pain patch. Resident #40 said the same transportation driver took him to dialysis on Monday, 06/24/24. Interview on 06/26/24 at 4:04 PM with LVN B revealed the transportation van arrived to pick up Resident #40 to take him to dialysis on 06/21/24, and they were loading the resident into the van. Shortly after, the transportation driver brought Resident #40 back into the facility and said as he was pushing the resident into the van, his foot got caught and twisted up on the ramp and Resident #40 immediately expressed pain. LVN B said she looked at the resident's ankle and noticed swelling on the outer side so she called to let his nurse, LVN A, know what had occurred. Interview on 06/26/24 at 2:51 PM with LVN A revealed she got a call from LVN B on 06/21/24, and said Resident #40 had hurt his ankle when the transportation driver was pushing him up the ramp into the van. When she was downstairs, she asked the resident what occurred and he said the transportation had pushed him faster to get onto the van, causing his foot to get stuck in the gap where the ramp meets the van and his foot had bent back. LVN A said she assessed the resident's ankle and noted swelling around it. Resident #40 told LVN A he was having pain to his ankle and he was medicated and they ordered x-rays to ensure it was not fractured. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 06/26/24 at 3:20 PM revealed she was told about Resident #40's incident and they called the doctor for x-rays to ensure his ankle was not broken. The DON stated she called the transportation company to find out what happened but said she had not heard back but would be calling them again for a statement. 2. Record review of Resident #36's, undated, Admission Record reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 had with diagnoses which included diabetes, stroke, and muscle wasting. Record review of Resident #36's quarterly MDS, dated [DATE], reflected a BIMS score of 11, which indicated moderate cognitive impairment. Her Functional Status reflected she required total assistance with all of her ADLs except eating and oral hygiene. Record review of Resident #36's care plan, dated 05/24/24, reflected the resident had behaviors of scratching and picking at her legs, and delusions involving staff and family. Record review of Resident #36's nursing notes reflected documentation on 05/12/24 resident with sugar ants all over her bed, moved resident to bed A temporarily, residents left arm with red raised itchy bumps. This Nurse notified MD new T.O.: Benadryl 25 mg PO PRN q8hours. DON was also informed. Interview on 06/25/24 at 10:28 AM revealed Resident #36 stated she had ants in her bed a few weeks ago, and she had ant bites all over her legs and arms. The facility treated her room, and she had no problems since then. Interview on 06/27//24 at 2:30 PM, the DON stated the incident with Resident #36 and the ants was not reported because the resident was able to tell them what happened. The DON did not feel reporting the injury to the resident was significant enough to rise to the level of reporting. Record review of the facility's pest control logs for January-June 2024 reflected the facility was treated for ants twice a month. 3. Record review of Resident #9's face sheet, dated 06/27/24, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #9's quarterly MDS, dated [DATE], reflected she had a BIMS score of 03, which indicated cognition was severely impairment. She had active diagnoses which included chronic obstructive pulmonary disease (lung disease), dysphagia (difficulty swallowing), gastro-esophageal reflux disease (acid reflux), type 2 diabetes mellitus (high blood sugar) with diabetic neuropathy (nerve damage) and essential hypertension (high blood pressure). Record review of Resident #9's care plan, revised on 05/07/24, reflected: Focus: [Resident #9] is taking medication for the management of GERD (Gastroesophageal Reflux Disease). Goal: Will remain free from discomfort, complications or s/sx related to dx of GERD through review date. Interventions: Give medications as ordered. Monitor/document side effects and effectiveness. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: [Resident #9] is on Pain medication Therapy r/t back, joint and muscle pain secondary to CVA (stroke) and DM (diabetic) Neuropathy. Goal: Will be free of any discomfort or adverse side effects from pain medication through the review date. Interventions: Administer medication as ordered. Record review of Resident #9's April 2024 MAR reflected: Pantoprazole Sodium Oral Tablet Delayed Release 40 MG (Pantoprazole Sodium) Give 1 tablet by mouth one time a day for GERD ***DO NOT CRUSH*** and traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours for Pain were held on 04/22/24 and to see nurses' notes. Record review of Resident #9's progress notes, dated 04/22/24 at 05:39 AM, by LNV A, reflected: Resident was given wrong medications, resident was supposed to be give PANTOPRAZOLE SOD DR 40 MG TAB, and TRAMADOL HCL 50 MG tablet for 6am medication. Instead, was given ALPRAZolam Oral Tablet 0.5 MG, and HYDROCODONE- ACETAMIN 10-325 MG. Resident has no known allergies to the medications. Resident lying in bed, eyes closed, respirations even and unlabored vitals within normal ranges BP 121/52, P 63, O2 97, R 18, T 97.5. Dr. [Name] notified wants patient monitored for any reactions to medications, DON notified as well. Interview on 06/25/24 at 2:55 PM with Resident #9 revealed he was doing well. Resident #9 did not appear to recall or know if he was given the wrong medication in April. Interview on 06/26/24 at 4:32 PM with LVN A revealed she administered Resident #9 the wrong medications the morning of 04/22/24. She stated she was giving morning medication pass and was prepping another resident medication when a staff went up to her to ask her a question, she got distracted and gave the medications to Resident #9 instead of the other resident. She stated she administered Resident #9 a narcotic pain pill and a Xanax. She stated she made the mistake of not double checking the resident and ended up giving the medication to Resident #9. She stated she realized the mistake and notified the doctor and the DON. She stated Resident #9 was monitored for 72 hours. She stated Resident #9 was not allergic to the medications and there were no side effects to the medications. She stated she was in-serviced the same day (04/22/24) on medication errors. She stated the risk of giving a resident the wrong medication could lead to side effects or resident being allergic to it. Interview on 06/27/24 at 2:02 PM with the DON revealed she could not recall all the details; however, LVN A administered Resident #9 the wrong medication back in April 2024. She stated LVN A contacted her right away and informed her she had given the wrong medication to Resident #9. She stated Resident #9 was placed on observation for 72 hours. She stated she in-serviced all the nursing staff on medication administration. The DON stated the risk of giving the wrong medication could lead to unconsciousness or an allergic reaction. The DON stated it was her and the Operational Manager responsibility to report any incidents to the state survey agency. She stated since there was no harm to Resident #9 and resident did not need to be sent to the hospital, they did not feel it needed to be reported to the state. Interview on 06/27/24 at 3:49 PM with the Operations Manager revealed she was the abuse coordinator, and it was her and the DON responsibility to report to the state survey agency. She stated she could not recall if she was notified that Resident # 9 was given the wrong medication. She stated she was unsure if it was something that needed to be reported to the state, she stated she would have to look into it. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44140

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review, the facility failed to ensure all alleged violations involving abuse, and neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately but not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury to the State Survey Agency in accordance with State law through established procedures for three (Resident #40, Resident #36, and Resident #9) of three incidents (Resident #40, Resident #36, and Resident #9) reviewed for reporting. 1. The facility failed to report to the State Survey Agency when Resident #40 sprained his ankle when he got his foot caught in the van ramp while being pushed by the transportation driver. 2. The facility failed to report to the State Survey Agency when Resident #36 was found to have ant bites on her body. 3. The facility failed to report to the State Survey Agency when Resident #9 was given the wrong medications on 04/22/24. These failures could affect place residents by resulting inat risk of a delay of identification of abuse or neglect and lack of timely follow-up on recommended interventions to prevent harm, or impairment. Findings included: 1. Record review of Resident #40's MDS dated [DATE] reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included end stage renal disease, diabetes, osteoporosis, stroke, and seizure disorder. The MDS further reflected Resident #40 had a BIMS of 14, whick indicated his cognition was intact, and used a manual wheelchair. Record review of Resident #40's care plan dated 08/29/23 reflected he had osteoporosis and interventions included to protect the resident from injury avoiding sudden bumps, jarring with transfers. The care plan further reflected Resident #40 attended dialysis Mondays, Wednesdays, and Fridays. Record review of Resident #40's progress note dated 06/21/24 documented by LVN A revealed the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notified by 1st floor nurse that resident had an incident getting onto the transportation bus. This nurse went down to the 1st floor to assess the resident noted resident sitting in wheelchair, leaned over holding onto right foot, when assessed the right foot noted swelling to the right ankle, very sensitive to touch, able to wiggle toes and pedal pulse 3+. Took resident to his room, assisted him to bed, resident can not bare [sic] weight on right foot Resident stated 'driver of the van was pushing me onto the ramp but had to push me a little fast because there's a little bump to get over on the ramp when my foot got caught in the ramp and pushed my foot all the way back.' MD notified ordered STAT x-ray to right foot Asked resident pain level from 0-10 resident stated a 10, administered Acetaminophen-Codeine Tablet 300-30MG per resident request for pain. Record review of radiology results dated 06/21/24 revealed there were no fractures and no new orders given. Record review of the Transportation Company's Accident/Incident Report Form dated 06/21/24 reflected the following: .Incident Information Incident Description [Resident #40] right ankle was injured while being rolled into the rear ramp of the wheelchair van by driver, [Driver]. As [Resident #40] crested the top of the ramp to enter the van, his right foot was not high enough, which caused his foot to roll under the leg. Driver took [Resident #40] back into the facility for examination by a nurse to determine the severity of his injury. Observation and interview with Resident #40 on 06/25/24 at 11:23 AM revealed when he was picked up for dialysis last Friday, 06/21/24, the transportation driver pushed him into the transportation van too fast and his foot got caught where the lift and the van connected. The resident said he immediately felt pain because it sprained his ankle. The facility ordered x-rays to ensure it was not broken due to the swelling. Observation of Resident #40's ankle revealed there was some swelling but there was no bruising noted at the time, but there was a pain patch on his ankle. The resident said he got some pain relief with the pain medications and pain patch. Resident #40 said the same transportation driver took him to dialysis on Monday, 06/24/24. Interview on 06/26/24 at 4:04 PM with LVN B revealed the transportation van had arrived to pick up Resident #40 to take him to dialysis on, 06/21/24, and they were loading the resident into the van. Shortly after, the transportation driver brought Resident #40 back into the facility and said as he was pushing the resident into the van, his foot had got caught and twisted up on the ramp and Resident #40 immediately expressed pain. LVN B said she looked at the resident's ankle and noticed swelling on the outer side so she called to let his nurse, LVN A, know what had occurred. Interview on 06/26/24 at 2:51 PM with LVN A revealed she got a call from LVN B, 06/21/24, and said Resident #40 had hurt his ankle when the transportation driver was pushing him up the ramp into the van. When she was downstairs she asked the resident what had occurred and he said the transportation had pushed him faster to get onto the van, causing his foot to get stuck in the gap where the ramp meets the van and his foot had bent back. LVN A said she assessed the resident's ankle and noted swelling around it. Resident #40 told LVN A he was having pain to his ankle and he was medicated and they ordered x-rays to ensure it was not fractured. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 06/26/24 at 3:20 PM revealed she was told about Resident #40 incident and they had called the doctor for x-rays to ensure his ankle was not broke. The DON stated she called the transportation company to find out what happened but said she had not heard back but would be calling them again for a statement. 2. Record review of Resident #36's, undated, Admission Record reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 had diagnoses which included diabetes, stroke, and muscle wasting. Record review of Resident #36's quarterly MDS, dated [DATE], reflected a BIMS score of 11, which indicated moderate cognitive impairment. Her Functional Status reflected she required total assistance with all of her ADLs except eating and oral hygiene. Record review of Resident #36's care plan, dated 05/24/24, reflected the resident had behaviors of scratching and picking at her legs, and delusions involving staff and family. Record review of Resident #36's nursing notes reflected documentation on 05/12/24 resident with sugar ants all over her bed, moved resident to bed A temporarily, residents left arm with red raised itchy bumps. This Nurse notified MD new T.O: Benadryl 25mg PO PRN q8hours. DON was also informed. Interview on 06/25/24 at 10:28 AM with Resident #36 revealed she had ants in her bed a few weeks ago, and she had ant bites all over her legs and arms. The facility treated her room, and she had no problems since then. Interview on 06/27//24 at 2:30 PM, the DON stated the incident with Resident #36 and the ants was not reported because the resident was able to tell them what happened. The DON did not feel reporting the injury to the resident was significant enough to rise to the level of reporting. Record review of the facility's pest control logs for January-June 2024 reflected the facility was treated for ants twice a month. 3. Record review of Resident #9's face sheet, dated 06/27/24, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #9's quarterly MDS, dated [DATE], reflected she had a BIMS score of 03, which indicated cognition was severely impairment. She had active diagnoses which included chronic obstructive pulmonary disease (lung disease), dysphagia (difficulty swallowing), gastro-esophageal reflux disease (acid reflux), type 2 diabetes mellitus (high blood sugar) with diabetic neuropathy (nerve damage) and essential hypertension (high blood pressure). Record review of Resident #9's care plan, revised on 05/07/24, reflected: Focus: [Resident #9] is taking medication for the management of GERD (Gastroesophageal Reflux Disease). Goal: Will remain free from discomfort, complications or s/sx related to dx of GERD through review date. Interventions: Give medications as ordered. Monitor/document side effects and effectiveness. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: [Resident #9] is on Pain medication Therapy r/t back, joint and muscle pain secondary to CVA (stroke) and DM (diabetic) Neuropathy. Goal: Will be free of any discomfort or adverse side effects from pain medication through the review date. Interventions: Administer medication as ordered. Record review of Resident #9's April 2024 MAR reflected: Pantoprazole Sodium Oral Tablet Delayed Release 40 MG (Pantoprazole Sodium) Give 1 tablet by mouth one time a day for GERD ***DO NOT CRUSH*** and traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours for Pain were held on 04/22/24 and to see nurses' notes. Record review of Resident #9's progress notes, dated 04/22/24 at 05:39 AM, by LNV A, reflected: Resident was given wrong medications, resident was supposed to be give PANTOPRAZOLE SOD DR 40 MG TAB, and TRAMADOL HCL 50 MG tablet for 6am medication. Instead, was given ALPRAZolam Oral Tablet 0.5 MG, and HYDROCODONE- ACETAMIN 10-325 MG. Resident has no known allergies to the medications. Resident lying in bed, eyes closed, respirations even and unlabored vitals within normal ranges BP 121/52, P 63, O2 97, R 18, T 97.5. Dr. [Name] notified wants patient monitored for any reactions to medications, DON notified as well. Interview on 06/25/24 at 2:55 PM with Resident #9 revealed he was doing well. Resident #9 did not appear to recall or know if he was given the wrong medication in April. Interview on 06/26/24 at 4:32 PM with LVN A revealed she administered Resident #9 the wrong medications the morning of 04/22/24. She stated she was giving morning medication pass and was prepping another resident medication when a staff went up to her to ask her a question, she got distracted and gave the medications to Resident #9 instead of the other resident. She stated she administered Resident #9 a narcotic pain pill and a Xanax. She stated she made the mistake of not double checking the resident and ended up giving the medication to Resident #9. She stated she realized the mistake and notified the doctor and the DON. She stated Resident #9 was monitored for 72 hours. She stated Resident #9 was not allergic to the medications and there were no side effects to the medications. She stated she was in-serviced the same day (04/22/24) on medication errors. She stated the risk of giving a resident the wrong medication could lead to side effects or resident being allergic to it. Interview on 06/27/24 at 2:02 PM with the DON revealed she could not recall all the details; however, LVN A administered Resident #9 the wrong medication back in April 2024. She stated LVN A contacted her right away and informed her she had given the wrong medication to Resident #9. She stated Resident #9 was placed on observation for 72 hours. She stated she in-serviced all the nursing staff on medication administration. The DON stated the risk of giving the wrong medication could lead to unconsciousness or an allergic reaction. The DON stated it was her and the Operational Manager responsibility to report any incidents to the state survey agency. She stated since there was no harm to Resident #9 and resident did not need to be sent to the hospital, they did not feel it needed to be reported to the state. Interview on 06/27/24 at 3:49 PM with the Operations Manager revealed she was the Abuse Coordinator, and it was her and the DON responsibility to report to the State Survey Agency. She stated she could not recall if she was notified that Resident # 9 was given the wrong medication. She stated she was unsure if it was something that needed to be reported to the state, she stated she would have to look into it. (continued on next page)

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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Pedro Manor	515 W Ashby Pl San Antonio, TX 78212

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's undated policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation, or Mistreatment reflected the following: Policy: It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment .Resident must not be subjected to abuse by anyone, including, but not limited to Facility staff, other resident representatives, consultants, or volunteers, staff of other agencies serving the resident representatives, families, friends, or other individuals. .Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: .The State Survey Agency . 44140

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility to ensure a new resident was not admitted with a mental disorder, unless the state mental health authority determined, based on an independent physical and mental evaluation performed by a person or entity other then the State mental health authority prior to admission for one of six residents (Resident #63) reviewed for Preadmission Screening and Resident Review (PASRR) screening . The Social Worker failed to ensure Resident #63's PL1 was accurate with the proper metal illness diagnosis when he was admitted . This failure could place residents at risk of not receiving specialized services. Findings included: Record review of Resident #63's MDS, dated [DATE], reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included schizoaffective disorder, schizophrenia and depression. Record review of Resident #63's care plan, revised on 11/27/24, reflected the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to schizoaffective disorder. Interventions included social services to provide psychosocial support as needed. Record review of Resident #63's PASRR Level 1 Screening, dated 10/19/23, reflected NO had been marked for the question if there was evidence or an indicator the individual had a mental illness. Interview on 06/26/24 at 3:15 PM with the Social Worker revealed she was responsible for looking at the PASSR Level 1 Screenings before residents were admitted . She stated she did not read through Resident #63's clinical records prior to being admitted so she did not see the resident had a diagnosis of schizophrenia. The Social Worker further said Resident #63 should have been referred to case management for a PASRR Evaluation because the resident could have been overseen for services from the Local Authority . Record review of the facility's policy titled PASRR, revised January 2022, reflected the following: .Policy: The facility will designate an individual to follow up on ALL residents that received a PASRR Level 1 screening. If Facility serves a resident with a positive PASRR Level 1 screening, the facility MUST obtain A PASRR Level II evaluation from the Local Authority or have documented attempts to follow up with the Local Authority to obtain PASRR Level II evaluation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 32227 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of three residents (Resident #40) reviewed for accidents. The transportation driver failed to ensure Resident #40 was safely transferred onto the transportation van on 06/21/24 when he was picked up for dialysis. The resident sprained his foot when it got caught in the van gap where the ramp met the van. This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life. Findings included: Record review of Resident #40's MDS, dated [DATE], reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included end stage renal disease (kidney failure), diabetes, osteoporosis, stroke, and seizure disorder. The MDS further Resident #40 had a BIMS of 14, which indicated his cognition was intact. Resident #40 used a manual wheelchair. Record review of Resident #40's care plan, dated 08/29/23, reflected he had osteoporosis and interventions included to protect the resident from injury avoiding sudden bumps, jarring with transfers. The care plan further reflected Resident #40 attended dialysis Mondays, Wednesdays, and Fridays. Record review of Resident #40's progress note, dated 06/21/24, documented by LVN A, reflected the following: Notified by 1st floor nurse that resident had an incident getting onto the transportation bus. This nurse went down to the 1st floor to assess the resident noted resident sitting in wheelchair, leaned over holding onto right foot, when assessed the right foot noted swelling to the right ankle, very sensitive to touch, able to wiggle toes and pedal pulse 3+. Took resident to his room, assisted him to bed, resident cannot bare weight on right foot .Resident stated 'driver of the van was pushing me onto the ramp but had to push me a little fast because there's a little bump to get over on the ramp when my foot got caught in the ramp and pushed my foot all the way back.' MD notified ordered STAT x-ray to right foot .Asked resident pain level from 0-10 resident stated a 10, administered Acetaminophen-Codeine Tablet 300-30MG per resident request for pain. Record review of radiology results, dated 06/21/24, reflected there were no fractures and no new orders given. Record review of the Transportation Company's Accident/Incident Report Form, dated 06/21/24, reflected the following: .Incident Information (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Incident Description [Resident #40] right ankle was injured while being rolled into the rear ramp of the wheelchair van by driver, [Driver]. As [Resident #40] crested the top of the ramp to enter the van, his right foot was not high enough, which caused his foot to roll under the leg. Driver took [Resident #40] back into the facility for examination by a nurse to determine the severity of his injury. Observation and interview with Resident #40 on 06/25/24 at 11:23 AM revealed when he was picked up for dialysis last Friday, 06/21/24, the transportation driver pushed him into the transportation van too fast and his foot got caught where the lift and the van connected. The resident said he immediately felt pain because it sprained his ankle. The facility ordered x-rays to ensure it was not broken due to the swelling. Observation of Resident #40's ankle revealed there was some swelling but there was no bruising noted at the time, but there was a pain patch on his ankle. The resident said he got some pain relief with the pain medications and pain patch. Resident #40 said the same transportation driver took him to dialysis on Monday, 06/24/24. Interview on 06/26/24 at 4:04 PM with LVN B revealed the transportation van had arrived to pick up Resident #40 to take him to dialysis on, 06/21/24, and they were loading the resident into the van. Shortly after, the transportation driver brought Resident #40 back into the facility and said as he was pushing the resident into the van, his foot had gotten caught and twisted up on the ramp and Resident #40 had immediately expressed pain. LVN B said she looked at the resident's ankle and noticed swelling on the outer side so she called to let his nurse, LVN A, know what had occurred. Interview on 06/26/24 at 2:51 PM with LVN A revealed she got a call from LVN B on, 06/21/24, and said Resident #40 had hurt his ankle when the transportation driver was pushing him up the ramp into the van. When she was downstairs she asked the resident what had occurred and he said the transportation had pushed him faster to get onto the van, causing his foot to get stuck in the gap where the ramp meets the van and his foot had bent back. LVN A said she assessed the resident's ankle and noted swelling around it. Resident #40 told LVN A he was having pain to his ankle and he was medicated and they ordered x-rays to ensure it was not fractured. Interview with the DON on 06/26/24 at 3:20 PM revealed she was told about Resident #40's incident and they had called the doctor for x-rays to ensure his ankle was not broken. The DON stated she called the transportation company to find out what happened but said she had not heard back but would be calling them again for a statement. Record review of the facility's policy titled Transportation to and from an off-site certified dialysis facility revised November 2017 reflected the following: POLICY: It is the policy of this facility to assist residents in arranging transportation to/from an off-site dialysis facility.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review, the facility failed to ensure a resident who was fed by enteral means, received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding, including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers for one of four residents (Resident #19) reviewed for enteral feeding. The facility failed to ensure nursing staff provided g-tube (a tube into the stomach that delivers formula for nutrition) care for Resident #19 per physician orders. This failure could result in the spread of resident infections. Findings included: Record review of Resident #19's face sheet, dated 06/27/24, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #19's quarterly MDS, dated [DATE], reflected she had a BIMS score of 03, which indicated her cognition was severely impaired. She had active diagnoses which included dysphagia (difficulty swallowing) following nontraumatic intracerebral hemorrhage (stroke), cognitive communication deficit, and hydrocephalus (fluid in the brain). The MDS assessment Section K - Nutritional approaches reflected Resident #19 had a feeding tube and was also on a mechanically altered diet. Record review of Resident #19's care plan, revised on 05/07/24, reflected Focus: [Resident #19] requires tube feeding PRN r/t poor PO intake secondary to intracranial hemorrhage. Goal: Feeding Tube insertion site will be free of s/sx of infection through the review date. Interventions: Bolus Feeding Of: Glucerna 1.5 at 237 cc if patient does not consume 50% of meal. Flush with 120mL of H20 with each bolus feeding in pt . eats less than 50%. Provide local care to Feeding Tube site as ordered and monitor for s/sx of infection. Record review of Resident #19's physician order, dated 09/15/23, reflected: Cleanse G-tube stoma with NSS, Pat dry and apply dry dressing every day shift. Record review of Resident #19's physician order, dated 09/15/23, reflected: Enteral Feed Order every shift Inspect and monitor gastrostomy stoma for signs and symptoms of local infection [NAME] as: redness; pain; tenderness; unusual odor, drainage; or discharge; hypergranulation of tissue surrounding stoma. Notify MD if S/S noted. Record review of Resident #19's June 2024 MAR/TAR reflected Resident #19 was provided with her g-tube care/treatment on 06/26/24 and 06/27/24. Observation and interview on 06/25/24 at 3:29 PM revealed Resident #19 sitting in the dining area. Resident #19 stated she was doing well. Resident #19 stated she had a g-tube; however, Resident #19 was unable to respond to further questions. Resident #19 was not a good historian. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/27/24 at 11:53 AM of Resident #19's g-tube stoma with LVN revealed gastric tube insertion site revealed no dressing was in place, yellow exudate noted to site. No redness noted and Resident #19 denied any pain or discomfort. Interview on 06/27/24 at 11:47 AM with LVN F stated she was the nurse assigned to Resident #19. LVN F stated Resident #19 had a g-tube; however, the resident did not utilize her g-tube since the resident was able to eat and took medications by mouth. LVN F stated she was unsure if Resident #19 had orders for g-tube care. LVN F reviewed Resident #19 orders and stated Resident #19 had orders to clean g-tube stoma; however, she had not done it since being employed. LVN F stated she had been employed for 4 weeks and today (06/27/24) was her second day working by herself. Follow-up interview on 06/27/24 at 12:22 PM, LVN F stated she was the nurse assigned to Resident #19 yesterday (06/26/24) and did not provide g-tube care. LVN F stated she was aware Resident #19 had a g-tube but since Resident #19 ate by mouth the g-tube was not prioritized. She stated she documented on the resident MAR/TAR that she completed the treatment even though she did not. LVN F stated she overlooked the order and clicked that she completed the treatment. LVN F stated the risk of not providing g-tube care could lead to an infection. Interview on 06/27/24 at 1:44 PM with the ADON revealed she was the ADON assigned for the third floor. She stated she was not aware Resident #19's g-tube stoma had not been cared for until today (06/27/24). The ADON stated Resident #19's g-tube was not being utilized unless the resident ate less than 50% of a meal then the resident required a bolus feeding. She stated it was the nurse's responsibility to follow physician orders. The ADON stated if the residents g-tubes were not being cared for it could lead to an infection. Interview on 06/27/24 at 2:02 PM with the DON revealed her expectations were for her nurses to follow physician orders. She stated they had a system in place were once a week every Tuesday the ADONs were responsible to check residents g-tubes. She stated she was unaware Resident #19's g-tube had not been cared for. She stated the risk of not providing g-tube care could lead to infection. Follow-up interview on 06/27/24 at 2:22 PM with the ADON revealed once a week on every Tuesday she was responsible to complete rounds and check residents g-tubes were being cared for. She stated she could not recall if she observed Resident #19's g-tube on Tuesday (06/25/24). The ADON stated it was her responsibility to follow-up and ensure g-tube care were being provided to residents. Record review of LVN F's Licensed Nurse Comprehensive Clinical Competency Review -Skills Checklist reflected LVN F completed Confirm placement of feeding tubes, Enteral Feedings-Safety Precautions on 06/15/24. Record review of the facility's Gastrostomy Tube policy, revised May 2007, reflected the following: It is the policy of this facility to provide proper care and maintenance of a gastrostomy tube. Daily checklist for gastrostomy tubes: Check the following each day. This information covers: PEG , Surgical, Balloon, and Low-profile gastrostomy tubes. (continued on next page)

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	455689	A. Building B. Wing	06/27/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Daily, all stoma sites will be cleaned with NS , pat dry with dry clean 4 x 4, apply protective ointment If indicated (some resident will require Anti-fungal Protective Ointment). Apply sterile dressing. Flextrak (optional) anchoring device may to be used to anchor G-tube to prevent tugging effect.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 4 residents (Resident #9) reviewed for pharmacy services. LVN A failed to administer the correct physician ordered medication (Pantoprazole Sodium Delayed Release 40 mg tablet and Tramadol HcL 50 mg tablet), and she instead administered Alprazolam Oral Tablet 0.5 mg (anti-anxiety medication), and Hydrocodone-Acetaminophen 10-325 mg (narcotic pain medication), which was another resident's medication on 04/22/24. This failure could place residents at risk for significant medication errors and jeopardize the resident health and safety. Finding included: Record review of Resident #9's face sheet, dated 06/27/24, reflected the resident was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #9's quarterly MDS, dated [DATE], reflected she had a BIMS score of 03, which indicated his cognition was severely impaired. Resident #9 had active diagnoses which included chronic obstructive pulmonary disease (lung disease), dysphagia (difficulty swallowing), gastro-esophageal reflux disease (acid reflux), type 2 diabetes mellitus with diabetic neuropathy (nerve damage) and essential hypertension (high blood pressure). Record review of Resident #9's care plan, revised on 05/07/24, reflected: Focus: [Resident #9] is taking medication for the management of GERD (Gastroesophageal Reflux Disease). Goal: Will remain free from discomfort, complications or s/sx related to dx of GERD through review date. Interventions: Give medications as ordered. Monitor/document side effects and effectiveness. Focus: [Resident #9] is on Pain medication Therapy r/t back, joint and muscle pain secondary to CVA (stoke) and DM (diabetic) Neuropathy. Goal: Will be free of any discomfort or adverse side effects from pain medication through the review date. Interventions: Administer medication as ordered. Record review of Resident #9's April 2024 MAR reflected: Pantoprazole Sodium Oral Tablet Delayed Release 40 MG (Pantoprazole Sodium) Give 1 tablet by mouth one time a day for GERD ***DO NOT CRUSH*** and traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours for Pain were held on 04/22/24 and to see nurses' notes. Record review of Resident #9's progress notes, dated 04/22/24 at 5:39 AM, by LVN A, reflected: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was given wrong medications, resident was supposed to be give PANTOPRAZOLE SOD DR 40 MG TAB , and TRAMADOL HCL 50 MG TABLET for 6am medication. Instead, was given ALPRAZolam Oral Tablet 0.5 MG, and HYDROCODONE- ACETAMIN 10-325 MG. Resident has no known allergies to the medications. Resident lying in bed, eyes closed, respirations even and unlabored vitals within normal ranges BP 121/52, P 63, O2 97, R 18, T 97.5. Dr. [Name] notified wants patient monitored for any reactions to medications, DON notified as well. Interview on 06/25/24 at 2:55 PM of Resident #9 revealed he was doing well. Resident #9 did not appear to recall or know if he had been given the wrong medication in April. Resident #9 stated he had no concerns regarding his medications. Interview on 06/26/24 at 4:32 PM with LVN A revealed she administered Resident #9 the wrong medications the morning of 04/22/24. She stated she was giving morning medication pass and was prepping another resident's medication when a staff came up to her to ask her a question, she got distracted and gave the medications to Resident #9 instead of the other resident. She stated she administered Resident #9 a narcotic pain pill and a Xanax. She stated she made the mistake of not double checking the resident and ended up giving the medication to Resident #9. She stated she realized the mistake and notified the doctor and the DON. She stated Resident #9 was monitored for 72 hours, she stated resident slept throughout the day. She stated Resident #9 was not allergic to the medications and there were no side effects to the medications. She stated she was in-serviced the same day (04/22/24) on medication error. She stated the risk of giving a resident the wrong medication could lead to side effects or the resident being allergic to it. Interview on 06/27/24 at 1:44 PM with the ADON revealed she was made aware of Resident #9's medication error. She stated LVN A realized right away she had given Resident #9 the wrong medications. She stated LVN A notified the doctor and the DON immediately. She stated all nurses were in-serviced on medication administration. She stated the risk of giving the wrong medication could be an allergic reaction. Interview on 06/27/24 at 2:02 PM with the DON revealed she could not recall all the details; however, LVN A administered Resident #9 the wrong medication back in April 2024. She stated the LVN A contacted her right away and informed her she had given the wrong medication to Resident #9. She stated Resident #9 was placed on observation for 72 hours. She stated she in-serviced all the nursing staff on medication administration. The DON stated the risk of giving the wrong medication could lead to unconsciousness or an allergic reaction. Record review of In-service Education Record Medication Errors, dated 04/22/24, reflected LVN A and 21 other nursing staff were in-serviced on 04/22/24. Record review of the facility's policy titled Care and Treatment, Medication & Treatment Orders, revised on May 2007, reflected the following: It is the policy of this facility that medications and treatments are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe . .6. Residents shall be identified prior to administration of a medication or treatment . .8. Documentation of the Medication Order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Each medication order is documented in the resident's medical order with the date, time, and signature of the person receiving the order. The order is recorded on the physician order sheet, or the telephone order sheet if it is a verbal order and the medications Administration Record (MAR).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, the medical record was maintained on each resident that were complete and accurately documented for 1 of 4 residents (Resident #19) records reviewed for treatment documentation. The facility failed to ensure LVN F accurately documented Resident #19's g-tube (a tube into the stomach that delivers formula for nutrition) care. This failure could affect any resident, placing them at risk of inaccurate information and resulting inappropriate care. Findings included: Record review of Resident #19's face sheet, dated 06/27/24, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #19's quarterly MDS, dated [DATE], reflected she had a BIMS score of 03, which indicated her cognition was severely impaired. She had active diagnoses which included dysphagia (difficulty swallowing) following nontraumatic intracerebral hemorrhage (stroke), cognitive communication deficit, and hydrocephalus (fluid in the brain). The MDS assessment Section K - Nutritional approaches reflected Resident #19 had a feeding tube and was also on a mechanically altered diet. Record review of Resident #19's care plan, revised on 05/07/24, reflected: Focus: [Resident #19] requires tube feeding PRN r/t poor PO intake secondary to intracranial hemorrhage. Goal: Feeding Tube insertion site will be free of s/sx of infection through the review date. Interventions: Bolus Feeding Of: Glucerna 1.5 at 237 cc if patient does not consume 50% of meal. Flush with 120mL of H20 with each bolus feeding in pt. eats less than 50%. Provide local care to Feeding Tube site as ordered and monitor for s/sx of infection. Record review of Resident #19's physician order, dated 09/15/23, reflected: Cleanse G-tube stoma with NSS , Pat dry and apply dry dressing every day shift. Record review of Resident #19's physician order, dated 09/15/23, reflected: Enteral Feed Order every shift Inspect and monitor gastrostomy stoma for signs and symptoms of local infection [NAME] as: redness; pain; tenderness; unusual odor, drainage; or discharge; hypergranulation of tissue surrounding stoma. Notify MD if S/S noted. Record review of Resident #19's June 2024 MAR/TAR reflected Resident #19's was provided with her g-tube care/treatment for 06/26/24 and 06/27/24 by LVN F. Observation and interview on 06/25/24 at 3:29 PM revealed Resident #19 sitting in the dining area. Resident #19 stated she was doing well. Resident #19 stated she had a g-tube; however, Resident #19 was unable to respond to further questions. Resident #19 was not a good historian . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/27/24 at 11:53 AM of Resident #19's g-tube stoma with LVN revealed the gastric tube insertion site revealed no dressing was in place, yellow exudate noted to site. No redness noted and Resident #19 denied any pain or discomfort. Interview on 06/27/24 at 11:47 AM, LVN F stated she was the nurse assigned to Resident #19. LVN F stated Resident #19 had a g-tube; however, the resident did not utilize her g-tube since the resident was able to eat and take medications by mouth. LVN F stated she was unsure if Resident #19 had orders for g-tube care. LVN F reviewed Resident #19 orders and stated Resident #19 had orders to clean the g-tube stoma; however, she had not done it since being employed. LVN F stated she had been employed for 4 weeks and today (06/27/24) was her second day working by herself. Follow-up interview on 06/27/24 at 12:22 PM, LVN F stated she was the nurse assigned to Resident #19 yesterday (06/26/24) and did not provide g-tube care. LVN F stated she was aware Resident #19 had a g-tube but since Resident #19 ate by mouth the g-tube was not prioritized. She stated she documented on the resident MAR/TAR she completed the treatment even though she did not. LVN F stated she overlooked the order and clicked that she completed the treatment. LVN F stated the risk of documenting something that was not provided could lead to her getting in trouble and other nurses not knowing if something was done or not. Interview on 06/27/24 at 1:44 PM with ADON revealed she was the ADON assigned for the third floor. She stated she was not aware Resident #19's g-tube stoma had not been cared for until today (06/27/24). The ADON stated Resident #19's g-tube was not being utilized unless the resident ate less than 50% of the meal then the resident required a bolus feeding. She stated it was the nurse's responsibility to follow physician orders. She stated she reviewed Resident #19's MAR and it was documented the care was provided. The ADON stated by not accurately documenting was considered falsification. Interview on 06/27/24 at 2:02 PM with the DON revealed her expectations were for her nurses to follow physician orders and document accurately. She stated everyday she reviewed the MAR report and she checked for any missed medications, any holes/refusals and ensured it was documented in the residents' charts. She stated if nurses documented the medications or treatment were provided, she would be unable to know if it was accurate. She stated they had a system in place were once a week every Tuesday the ADONs were responsible to check residents g-tubes. She stated she was unaware Resident #19's g-tube had not been cared for. According to the DON by not accurately documenting was considered falsification. Record review of the facility's policy titled Care and Treatment, Medication & Treatment Orders revised on 05/2007, reflected the following: It is the policy of this facility that medications and treatments are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe . 8. Documentation of the Medication Order. - Each medication order is documented in the resident's medical order with the date, time, and signature of the person receiving the order. The order is recorded on the physician order sheet, or the telephone order sheet if it is a verbal order and the medications Administration Record (MAR).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview and record review, the facility failed to establish and 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 diseases and infections for 2 (Residents # 57 and # 185) of 8 residents reviewed for infection control. Staff failed to don appropriate Personal Protective Equipment (PPE) while providing care to Resident #57, who had a colostomy, and Resident #185, who had a catheter. This failure could place residents at risk of contracting an infection from residents on Enhanced Barrier Precautions (EBP). Findings included: Record review of Resident #57's undated Admission Record reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #57 had diagnoses which included spinal bifiida (birth defect causing the spinal cord to not develop), paraplegia (paralysis below the waist), and bowel impairment requiring a colostomy (bag for collecting stooll, attached to the abdomen). Record review of Resident #57's quarterly MDS, dated [DATE], reflected a BIMS score of 12 which indicated she was cognitively intact. Her Functional Status reflected she was dependent on staff for all of her ADLs except eating and hygiene. Her Bowel and Bladder Assessment indicated she was always incontinent and had a colostomy. Record review of Resident #57's care plan, dated0 4/15/24, reflected she had an alteration in her gastro-intestinal status related to colostomy. It also indicated she was incontinent of bladder related to her paraplegia. Observation on 06/25/24 at 110:17 AM Resident revealed #57 had signage outside her room which indicated she was on EBP and staff should wear a gown and gloves while providing care. CNA C entered the resident's room to empty the resident's colostomy bag. CNA C donned gloves only, no gown, and provided the care to Resident #57. CNA C continued to care for other residents after completing Resident #57's care. Record review of Resident #185's undated Admission Record reflected he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included stroke, diabetes, and high blood pressure. Record review of Resident #185's admission MDS, dated [DATE], revealed a BIMS score of 4 indicating severe cognitive impairment. His Bowel and Bladder assessment indicated he was admitted with an indwelling catheter. Record review of Resident #185's baseline care plan revealed he had a self-care deficit, and had an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/27/24 at 10:54 AM of peri care and catheter care provided by LVN D and CNA E revealed both donned gloves, but no gowns. Care was provided appropriately with proper hand hygiene observed. Per facility policy, the resident also required EBP due to the catheter. Interview on 06/27/24 at 11:00 AM both LVN D and CNA E stated they were in-serviced on infection control recently. Neither one of them could say why they did not don the appropriate PPE based on the signage on the door. LVN D stated PPE was available on the nurse cart as well as the linen cart on the hall. Interview on 06/27/24 at 11:20 AM the Infection Preventionist stated she performed an in-service on Infection Prevention on 06/19/24 at the All Staff meeting. She stated there was no reason the staff should not know the appropriate use of PPE between her in-service and the signage posted outside the resident's room. The Infection Preventionist stated the risk of not wearing the appropriate PPE was spreading infection to other residents. Interview on 06/27/24 at 12:15 PM the DON stated there was no cause for the staff not to use PPE when needed. She stated staff were in-serviced frequently on infection control, but were obviously not retaining the knowledge. She stated the risk of not wearing appropriate PPE was spreading infections. Record review of the facility's policy IPCP Standard and Transmission-Based Precautions, dated December 2023, reflected: .3. Enhanced Barrier Precautions (EBP) expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities .(e.g., residents with wounds and indwelling medical devices .)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 6 residents (Resident #8) reviewed for safe and functional equipment. The facility failed to ensure Resident #8's bed was in proper working condition. This failure could place residents at risk for skin tears, injury, falls and discomfort during transfers. Findings included: Record review of Resident #8's face sheet, dated 06/27/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #8's quarterly MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated cognition was intact. Resident #8 had active diagnoses which included biliary cirrhosis (chronic liver disease), chronic pain syndrome, fibromyalgia (pain and tenderness all over the body). Resident #8 required the use of a wheelchair and required assistance of 2 or more helpers with bed mobility, toileting, transfers and dressing. Record review of Resident #8's care plan, revised on 05/07/24, reflected: Focus: ADL Self Care Performance Deficit r/t generalized weakness. Goal: Will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene with modified independence through the review date. Interventions: Bed Mobility (Roll Left And Right, Sit To Lying, Lying To Sitting On Side Of Bed): Requires staff participation to reposition and turn in bed. Focus: [Resident #8] has Liver Disease r/t Biliary Cirrhosis. Focus: Will be free from s/sx of liver complications, including infection, abnormal or unexplained bleeding, malnutrition, anemia, cognitive decline or mental status changes through review date. Interventions: Monitor/document/report to MD s/sx of complications: Malaise (discomfort), Fatigue (tiredness), Anorexia (eating disorder), Weight loss, Edema (fluid buildup), Nosebleeds, Bleeding gums, constipation or diarrhea, Ascites (fluid in abdomen, Altered LOC (level of consciousness), Confusion/disorientation. Observation and interview on 06/25/24 at 10:18 AM revealed Resident #8 sitting in her wheelchair. She stated she was doing well. Resident #8 stated she had been at the facility for 3 months and her bed had not been fixed. She stated her bed did not go up or down. Observed Resident #8 use the bed remote to adjust the end of the bed, however, it would only make a noise and would not move. She stated she would like to be able to elevate her legs at night due to her edema while lying in bed. She stated she needed her bed to work. Resident #8 stated she told the staff and a maintenance person but could not recall names. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/27/24 at 1:50 PM with CNA G revealed she was the CNA assigned to Resident #8. She stated a couple of weeks ago Resident #8 mentioned to her that her bed was not working. She stated she notified the Maintenance Director and she believed the Maintenance Director looked at it but she was unsure if he fixed it. She stated when Resident #8 went to bed they elevated her legs with pillows. Interview on 06/27/24 at 2:42 PM with RN H revealed Resident #8 had not mentioned anything to her regarding her bed not working. She stated Resident #8 was able to voice her needs and the resident was known to report any concerns to management. She stated she had not noticed Resident #8's bed not working, she stated they elevated Resident #8 legs with pillows at night. She stated there was no risk to the resident since the resident legs were being elevated with pillows. She stated as far as she knew the bed was working last week. Interview on 06/27/24 at 2:50 PM with the DON revealed she was not aware Resident #8's bed was not working. She stated staff had not mentioned anything to her regarding Resident #8's bed. She stated they had an online system where they log any maintenance concerns and they choose the priority. She stated all staff were responsible to notify maintenance. Interview on 06/27/24 at 3:51 PM with the Operations Manager revealed Resident #8 had not mentioned anything to her regarding her bed. She stated all staff were responsible to notify maintenance of any environmental concerns. She stated they had an online system staff used to input work orders and maintenance staff were responsible to review the report. She stated all staff had access to it. She stated she had not seen anything regarding Resident #8 bed. Interview on 06/27/24 at 4:48 PM with the Maintenance Director revealed about a month ago Resident #8 mentioned something about her bed not working. He stated he went to check the bed and the head of the bed was working properly. He stated he was unaware the end of the bed was the part that was not working. He stated they had an online system where staff were able to input any work order s and he reviewed it daily . Record review of facility Work Orders from 04/01/24 - 06/21/24 revealed no orders pertaining Resident #8's bed. Record review of the facility's, undated, policy titled Environmental Service reflected the following: It is the policy of this facility to maintain a clean and comfortable environment .3. When a maintenance issue arises, the resident, staff member or family member must put in a work order at the front desk with the receptionist. 4. The maintenance department will complete the work order or find a resolution within 72 hours from the time it was reported.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on observation, interview and record review, the facility failed to maintain an effective pest control program so the facility was free of pests and rodents for 1 of 1 facility kitchen and 1 (Resident #36) of 5 residents reviewed for pest control. 1. Resident #36 repored her bed was infested with ants and she had numerous bites to her arms and legs. 2. There were multiple gnats observed in the kitchen food preparation area, storage area room, dishwasher room and floor drain This failure could place residents at risk of a decreased quality of life and cross contamination of food. Findings include: 1. Record review of Resident #36's, undated, Admission Record reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 had with diagnoses that which included diabetes, stroke, and muscle wasting. Record review of Resident #36's quarterly MDS, dated [DATE], reflected a BIMS score of 11, which indicated moderate cognitive impairment. Her Functional Status reflected she required total assistance with all of her ADLs except eating and oral hygiene. Record review of Resident #36's care plan, dated 05/24/24, reflected the resident had behaviors of scratching and picking at her legs, and delusions involving staff and family. Record review of Resident #36's nursing notes reflected documentation on 05/12/24 resident with sugar ants all over her bed, moved resident to bed A temporarily, residents left arm with red raised itchy bumps. This Nurse notified MD new T.O.: Benadryl 25mg PO PRN q8hours. DON was also informed. Interview and observation on 06/25/24 at 10:28 AM revealed Resident #36 stated she had ants in her bed a few weeks ago, and she had ant bites all over her legs and arms. The facility treated her room, and she had no problems since then. Observed Resident #36 extremities and had no visible bite marks. Interview on 06/27//24 at 2:30 PM, the DON stated the incident with Resident #36 and the ants was not reported because the resident was able to tell them what happened. The DON did not feel reporting the injury to the resident was significant enough to rise to the level of reporting . Record review of the facility's pest control logs for January- June 2024 reflected the facility was treated for ants twice a month. 2. Observation of kitchen area on 06/25/24 at 8:43 AM revealed several gnats in the kitchen food prep area, storage area room and dishwasher room. No food was observed in the prep area. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Follow-up observation of kitchen area on 06/25/24 at 10:33 AM revealed staff prepping for lunch, staff were waving their hands in the air to move the gnats. Food was observed on the steam table; however, the food was covered. Interview on 06/25/24 at 11:28 AM with [NAME] revealed they have had an issue with gnats for a couple of months however, it had gotten better. He stated pest control went out about once or twice a month and was treating them. He stated they tried to always keep the kitchen clean to reduce the gnats. He stated the risk of having pests in the kitchen was it could get in the residents' foods. Interview on 06/25/24 at 11:23 AM with the Dietary Supervisor revealed pest control service went by yesterday (06/24/24) to treat the gnats. She stated the gnats used to be worse, and they come and go. She stated maintenance had been addressing the gnats and ensuring pest control services went out. She stated the risk of having pests in the kitchen would be pests getting in the resident's food. Interview on 06/25/24 at 11:36 AM with the Maintenance Supervisor revealed pest control service went out twice a month or as needed. He stated they had a drip system in place where they pour a chemical in the dishwasher room drains. He stated they were responsible to treat and notify the pest control service company when needed. He stated he had not had any complaints regarding pests in the facility . Record review of Pest Control Service Invoices, for 03/04/24 through 06/24/24, reflected evidence of treatment for pests in the kitchen. Record review of the facility's Physical Environment policy, revised May 2007, reflected the following: It is the policy of this facility to provide an environment free of pests. 1. The facility will have a pest control contract that provides frequent treatment of the environment for pests. 2. The pest control visits will occur at least monthly. 3. It will allow for additional visits when a problem is detected. 4. Monitoring of the environment will be done by the facility's staff. 5. Pest control problems will be reported promptly to the administrator.