STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455754	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Rehabilitation and Healthcare Center	603 Corinne St San Antonio, TX 78218

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interview, and record review, the facility failed to ensure residents had the right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 2 of 2 residents (Residents #46 and Resident #49) observed for physical restraints in that: 1. The facility failed to obtain a consent for Resident #46 to wear a wander guard. 2. The facility failed to obtain a consent for Resident #49 to wear a wander guard. This failure placed residents at risk of unnecessary restriction of their freedom of movement and diminished quality of life. The findings included: 1. Record review of Resident #46's admission record, dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), cognitive communication deficit, and generalized anxiety disorder. Record review of Resident #46's annual MDS assessment dated [DATE] revealed the resident had severely impaired cognition for daily decision making. Record review of Resident #46's comprehensive care, revision date [DATE], revealed the resident was an elopement risk related to resident wanders aimlessly, significantly intrudes on the privacy or activities, and had a Wandergaurd on her left lower leg. Interventions included check wanderguard placement, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate . Record review of Resident #46's Wandering/Elopement Risk Evaluation dated [DATE] indicated a high risk for elopement. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #46's Wandering/Elopement Risk Evaluation dated [DATE] indicated a low risk for elopement. Record review of Resident #46's physician's orders, dated [DATE] revealed: - Wander guard in place to assist in preventing the resident from exiting unaccompanied with an order date of [DATE] and no end date. -check wander guard to LLE for proper function every shift with a start date of [DATE]. Record review of the electronic health record revealed that Resident #46 did not have a consent for the use of the wander guard. During an observation and interview on [DATE] at 1:12 p.m. revealed Resident #44 had a wander guard on her left ankle. CNA I stated the wander guard could not be removed unless it was cut off. CNA I stated once it was cut off they would need a new one. The Resident was not able to be interviewed. During an interview on [DATE] at 10:44 a.m. the DON stated they did not get consent from the resident's or their representatives for a wander guard. The DON stated they obtain an order, care plan it, inform the resident or RP and do not document that they notified the family they would be placing a wander guard on the resident. During an interview on [DATE] at 9:11 a.m. an assistant for a potential legal guardian for Resident #46 stated they did not have legal guardianship of the resident and were in the investigation stage of obtaining guardianship and did not deal with any of the resident's consents at that time. During an interview on [DATE] at 9:52 a.m. an RP who was listed as an emergency contact for Resident #46 stated they had MPOA and the facility contacted them about trying to get the resident into a memory care unit, about other financial reasons, and insurance applications. The RP stated he had never been informed about a wander guard or attended a care plan meeting. The RP stated they had been to the facility as recent as a week ago and was never asked to sign any consents. The RP stated another family member might have more information and provided the contact information. During an interview on [DATE] at 9:52 a.m. Resident #46's family member stated he was not aware of any medications the resident was on, had not attended or been invited to any care plan meetings. The family member stated the facility did not inform or discuss a wander guard with him. The family member stated the facility had spoken to him about finding the resident placement in a locked facility. The family member stated they had no idea about the wander guard and thought it was odd, could understand if they felt they needed it for the resident, but if the resident was going to a locked facility why would they need that. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #49's admission record, dated [DATE] revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes.), cognitive communication deficit, vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain), schizophrenia (chronic mental disorder characterized by symptoms such as hallucinations, delusions, and cognitive challenges), and anxiety disorder. Record review of Resident #49's quarterly MDS assessment dated [DATE] revealed the resident had moderately impaired cognition for daily decision making. The wander guard was not mentioned in the MDS. Record review of Resident #49's comprehensive care, revision date [DATE], revealed the resident was an elopement risk/wanderer related to impaired safety awareness resident wanders aimlessly, and Wandergaurd on her right lower leg. Interventions included Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Elopement risk assessments to be completed per policy and prn. Monitor Wander Guard placement on RLE Qshift. Provide safe and secure surroundings that deter elopements. Record review of Resident #49's Wandering/Elopement Risk Evaluation dated [DATE] indicated a high risk for elopement. Record review of Resident #49's Wandering/Elopement Risk Evaluation dated [DATE] indicated a low risk for elopement. Record review of Resident #49's physician's orders, dated [DATE] revealed: - Monitor for placement every shift wander guard RLE Exp: ,d+[DATE] .Wander guard in place to prevent resident from exiting the facility unaccompanied. every shift for exit seeker, with an order date of [DATE], and no end date. -check wander guard to RLE for proper function every shift with a start date of [DATE]. Record review of the electronic health record revealed that Resident #49 did not have a consent for use of the wander guard. During an observation on [DATE] at 11:30 a.m. revealed Resident #49 had a wander guard on her right ankle. Resident #49's RP was contacted by phone on [DATE] at 9:27 a.m. and did not answer or return the call. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on [DATE] at 11:35 a.m. the DON stated they should notify the resident's family if they placed a wander guard on them. The DON stated they should put a note in about the discussion in the resident's medical record. The DON stated they recently updated the orders for Resident #46's and Resident #49's wander guard because they were expired and needed new ones put on. The DON stated they did not consider the wander guard a restraint because it only applied to the front door and the residents could go out the side doors if they wanted. The DON stated that was why the facility would try to find another locked facility for the resident to go if they had wandering behaviors. The DON stated both residents were aware they had a wander guard on that could not be removed and stated Resident #49 called it her ankle monitor. Record review of the facility's policy titled Wandering Residents-Wanderguard, no date, revealed, It is the policy of this facility to allow each resident as much physical freedom as safely possible in order to maintain the resident's optimum function. Procedures: 1. All appropriate residents shall be assessed within twenty-four (24) hours of any suspected wandering behavior and if necessary, the use of a protective device. (See Elopement Risk Assessment) 2. If assessment of the resident shows there is wandering potential creating a safety issue, the DNS or designee will discuss this issue with the family/responsible party. 3. Resident at risk for wandering shall have a Wanderguard(R). 4. The need for Wanderguard(R) shall be assessed a minimum of quarterly. The Wanderguard(R) is not a restraint and does not require a consent. 5. The family/responsible party shall be notified of the risk for wandering and that the Wanderguard(R) has been placed on the resident .

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on, interviews, and record review, the facility failed to ensure the residents had the right to formulate an advanced directive and determine the choice to receive or not receive CPR (cardiopulmonary resuscitation) for 1 (Resident #22) of 8 residents reviewed for accuracy and completeness of clinical records. The facility failed to ensure Resident #22's OOH DNR was signed by 2 witnesses. This failure could affect any residents who have medical records and could result in misinformation about professional care provided. Findings included: Record review of Resident #22's Admission Record, dated [DATE], revealed a [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of dementia without behavioral disturbance (a group of symptoms affecting memory, thinking, and social abilities, which interfere with daily life), dysphagia (difficulty swallowing), pneumonitis (when air sacs in the lungs become inflamed due to irritant substances and disturb the normal functioning of the lungs), anoxic brain damage (serious condition that occurs when there is a complete lack of oxygen supply to the brain. This can happen when oxygen levels drop to a dangerous level or when blood flow to the brain decreases to a threshold where brain cells begin to die. Brain cells begin to die after approximately four minutes of oxygen deprivation. Anoxic brain injury can cause permanent cognitive problem), and chronic kidney disease (a gradual loss of kidney function). The admission record did not specify the resident's code status. Record review of Resident #22's annual MDS assessment, dated [DATE], revealed the resident had severely impaired cognition for daily decision making. Record review of Resident #22's care plan, updated [DATE], revealed the resident had elected a DNR status with interventions of Do Not Resuscitate in the event of cardiac arrest, provide advanced directive education and support in directive completion, and update the resident's chart to reflect the elected code status, and staff must be aware of the code status election. Record review of Resident #22's order summary, dated [DATE], revealed an order for DNR with a start date of [DATE], and no end date. Record review of Resident #22's OOH DNR revealed it was signed by the legal guardian on [DATE], by 1 witness on [DATE], and the physician on [DATE]. A second witness signature was missing. During an interview on [DATE] at 11:24 a.m. the SW stated she was responsible for filling out the DNR forms or helping families to complete them. The SW stated she helped complete this form. The SW stated they forgot to get a 2nd witness signature on Resident #22's DNR. The SW stated the missing signature was a mistake and the DNR was not valid. The SW stated they may have to perform CPR if the resident needed it and would not honor the legal guardians wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:49 a.m. the DON stated Resident #22's DNR was not valid because it was missing 2 witness signatures. The DON stated Resident #22 would be full code until the form was completed accurately which was not honoring the resident's or representatives wishes to not be resuscitated. Record review of the facility's policy titled Advance Directives, dated ,d+[DATE], revealed, It is the policy of this facility that a resident's choice about advance directives will be recognized and respected .1. Prior to, upon, or immediately after admission, the Social Worker will ask residents, and/or their family members, about the existence of any advance directives. 2. Should the resident indicate that he or she has issued advance directives about his/her care and treatment, the facility will require that a copy of such directives be included in the medical record .b) Do Not Resuscitate -- Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health-care proxy, or representative (sponsor) have directed that no cardiopulmonary resuscitation (CPR) is to be attempted .4. Once the advance directive or information regarding resident preferences regarding treatment options is received by the facility, it will be confirmed in the resident medical record and communicated to members of the care plan team. The facility will also notify the attending physician of advance directives so that, if necessary, appropriate orders can be documented in the resident's medical record and plan of care .

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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 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** 39075 Based on observation, interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 19 residents (Resident #91) reviewed for assessments: Resident #91's admission assessment MDS dated [DATE] did not accurately reflect the resident could not be rated for incontinence since the resident required an indwelling urinary catheter. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #91's face sheet dated 3/20/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included urinary tract infection, obstructive and reflux uropathy (condition in which the normal flow of urine is blocked leading to kidney damage; uropathy refers to kidney damage caused by backward flow of urine from the bladder into the ureters and kidney), and chronic kidney disease stage 3 (moderate decrease in kidney function). Record review of Resident #91's admission MDS assessment, dated 3/10/25 revealed the resident was moderately cognitively impaired for daily decision-making skills and utilized an indwelling urinary catheter. Further review of Resident #91's admission MDS assessment revealed the resident was Occasionally incontinent (less than 7 episodes of incontinence) of bladder. Record review of Resident #91's Order Summary Report dated 3/20/25 revealed the following: - MONITOR INDWELLING CATHETER OUTPUT every shift, with order date 3/12/25 and no end date. Record review of Resident #91's comprehensive care plan with revision date 3/13/25 revealed the resident had an indwelling urinary catheter related to obstructive uropathy with interventions that included to provide catheter care every shift and as needed, measure urinary output, position catheter bag and tubing below the level of the bladder and away from entrance room door, and use enhanced barrier precautions. During an observation and interview on 3/18/25 at 10:47 a.m., revealed Resident #91 asked for help to go to the bathroom. Resident #91 was observed holding her indwelling urinary catheter bag by the tubing and was unaware she had an indwelling urinary catheter. During an observation and interview on 3/18/25 at 4:40 p.m., ADON B was in Resident #91's room assisting the resident to a sitting position. ADON B acknowledged Resident #91 had an indwelling urinary catheter and believed the resident had the indwelling urinary catheter since her admission on 3/3/25. ADON B stated, Resident #91 was confused and often asked to go to the bathroom. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/20/25 at 5:08 p.m., CNA E acknowledged Resident #91 utilized an indwelling urinary catheter since her admission to the facility. CNA E further stated the resident was confused and often asked to go to the bathroom. CNA E revealed she had provided catheter care to Resident #91 at least once during her shift. During a joint interview on 3/21/25 at 10:33 a.m., MDS Coordinator C and MDS Coordinator D acknowledged they were working collaboratively on completing MDS assessments. MDS Coordinator C acknowledged she was responsible for completing Resident #91's admission assessment which included the resident utilized an indwelling urinary catheter. MDS Coordinator C stated she incorrectly marked the resident was occasionally incontinent of bladder but should have marked Not rated, resident had a catheter. MDS Coordinator C stated she took full responsibility for the error. Both MDS Coordinator D stated, the purpose of the MDS assessment was to determine the kind of care the resident was supposed to receive based on the assessment and the information the assessment helped to complete the comprehensive care plan. During an interview on 3/21/25 at 1:01 p.m., the DON stated, Resident #91's MDS assessment identified the resident as being occasionally incontinent of urine but acknowledged it was incorrect because the resident utilized an indwelling urinary catheter which meant the resident was incontinent. The DON further stated the purpose of the MDS assessment was for billing purposes and to ensure billing was appropriate. The DON stated, the MDS drives the care plan and tells you how to care for the resident. It gives a true picture of the resident. A request on 3/21/25 at 1:01 p.m. for an MDS policy was made but a policy was not provided at the time of the exit. Record review of the CMS RAI Version 3.0 Manual, Section H: Bladder and Bowel, dated October 2024 revealed the following, .The intent of the items in this section is to gather information on the use of bowel and bladder appliances .Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment .and/or devices .and services to achieve or maintain as normal elimination function as possible .Urinary Continence .Coding Instructions .Code 9, not rated: if during the 7-day lool-back period the residnet had an indwelling bladder catheter .

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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 50760

Based on interviews and record review, the facility failed to identify a diagnosis of mental illness on the preadmission screening and resident review (PASRR) assessment for 2 of 2 residents (Resident #47 and Resident #90) whose records were reviewed for PASRR services.

The facility failed to recognize on the Level I PASRR screening that Resident #47 and Resident #90 had the mental illness diagnosis of bipolar disorder which would qualify Resident #47 and Resident #90 for a PASRR evaluation.

This deficient practice could place residents with mental illness at risk for not obtaining the services needed to treat their mental health diagnoses.

The findings included:

1. Record review of Resident #47's admission sheet, dated 8/25/23, noted the resident was admitted to the facility on [DATE] with a diagnosis of bipolar disorder on admission (8/25/23).

Record review of Resident #47's quarterly MDS assessment, dated 2/5/25, noted the resident's BIMS was 2, indicating severe cognitive impairment; mood indicators were present including feeling down, depressed, or hopeless with social isolation and behaviors of delusions and verbal behaviors towards others; and diagnoses of depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder (PTSD).

Record review of Resident #47's order summary from March 2025 indicated the resident received Depakote (an anticonvulsant) 125mg twice daily for mood.

Record review of Resident #47's care plan, revised on 1/15/25 noted the resident has the Potential for mood problem r/t Admission, Disease Process. One of the approaches was to Administer medications as ordered and Monitor/document for side effects and effectiveness.

Record review of Resident #47's PASRR screening dated 8/25/23, noted an answer of 0 (No) in section C0100 Mental Illness in response to the question, Is there evidence or an indicator this is an individual with a Mental Illness?

2. Record review of Resident #90's admission sheet, dated 2/7/25, noted the resident was admitted to the facility on [DATE] with a diagnosis of bipolar disorder on admission (2/7/25).

Record review of Resident #90's quarterly MDS assessment, dated 2/10/25, noted the resident's BIMS was 10, indicating moderate cognitive impairment; with no mood or behaviors present; and a diagnosis of bipolar disorder.

Record review of Resident #90's order summary from March 2025 indicated the resident received Olanzapine 20mg at bedtime related to bipolar disorder and Olanzapine 5mg at bedtime related to bipolar disorder.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #90's care plan, revised on 2/28/25 noted the resident has Anti psychotic medication use r/t bi-polar. One of the approaches was to Administer medication as prescribed-Olanzapine and Document side-effects: drowsiness, dry mouth, blurred vision, constipation, edema, extrapyramidal symptoms, urinary retention, stiff or tight muscles, tardive dyskinesia (a chronic movement disorder that can develop as a side effect of long-term use of certain medications, primarily antipsychotic drugs). Record review of Resident #90's, PASSR screening dated 2/7/25, noted an answer of 0 (No) in section C0100 Mental Illness in response to the question, Is there evidence or an indicator this is an individual with a Mental Illness? In an interview on 03/19/25 at 01:59 PM with MDS Coordinator C and MDS Coordinator D, MDS Coordinator D stated, When residents come here, they should have their PASRR included with their admission paperwork. MDS Coordinator D stated the facility uploads it and sends a copy to the local authority. MDS Coordinator D stated If the level one screening is negative the local authority acknowledges they receive it. MDS Coordinator D stated If the level one screening is positive, the local authority comes to the facility and assesses the resident, and attends the care plan meetings. MDS Coordinator D stated If it is negative there is no follow up. MDS Coordinator D stated If the facility notices a resident has a disability, they do another level one screening and repeat the process. MDS Coordinator D stated The clinical team suggests if a resident is showing signs of disability, and The clinical team would include staff who are hands on with the resident including the ADON, the social worker, and the activity director, and They would be the ones to suggest if the resident is showing signs of behaviors. MDS Coordinator D They rely on the PASSR screening from where the resident has been, like the hospital. When asked is it correct if the PASRR assessment should be left as 'No' if a resident has bipolar disorder, MDS Coordinator D stated Most of the time the PASRR says 'No', and they submit the hospital PASRR to the local authority and the MDS assessment. MDS Coordinator D stated in her experience if a resident had bipolar it wasn't enough to get services, because they don't have behaviors. When asked why Resident #90 was receiving an antipsychotic without behaviors, MDS Coordinator D stated Maybe in the past she had a behavior. MDS Coordinator D stated They are going to deny services for bipolar, MDS Coordinator D stated They have not submitted Resident #90's information to the local authority yet, and they have a 90 day period to do so. MDS Coordinator D stated she will submit the PASRR from the hospital to the local authority. When asked if the level one screening needed to be corrected before being submitted to the local authority MDS Coordinator D stated The PASRR from the hospital will not be updated. When asked what the risk to the resident was of putting 'No' on the level one screening if they have a mental illness, MDS Coordinator D stated she has never experienced a negative effect with a resident if they answer 'No' on the level one PASRR when the resident has a mental illness, because if they have behaviors they do mental screenings. When asked what the risk to the resident was if they don't mark 'Yes' to mental illness if a resident has bipolar disorder, MDS Coordinator D stated They have never had an issue with a resident because they have psych on the premises at the facility. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/19/25 at 04:22 PM with the DON, the DON stated she would talk to the MDS nurses about training since the residents have a mental illness diagnosis on admission but the hospital PASRR assessment is negative and is not getting updated before being sent to the local authority who is then not coming out to evaluate the resident. The DON stated she would educate them on getting the PASRR fixed moving forward especially if the residents are on medications. The DON stated, 'All residents get psych services, but moving forward they will make sure they take care of the PASRR correctly. The DON stated she wasn't sure what the risk to the resident was of a negative level one PASRR with evidence of a mental illness diagnosis, but stated The purpose of PASRR is to get residents services if they have a diagnosis of mental illness. Review of the facility policy, undated, titled Resident Assessment PASSAR Screening noted it is the policy of this facility to complete an accurate PASSAR screening for individuals with a mental disorder and individuals with intellectual disability.

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F 0689 Level of Harm - Minimal harm or potential for 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** 39075 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 24 residents (Resident #89) reviewed for accidents and hazards: The facility failed to ensure Resident #89 did not have a pair of scissors, a large pair of nail clippers, and a disposable razor in his room. This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: Record review of Resident #89's face sheet dated 3/19/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included gastro-esophageal reflux disease with esophagitis (a chronic condition where stomach acid frequently flows back into the esophagus causing inflammation and irritation), duodenitis without bleeding (inflammation of the first part of the small intestine without gastrointestinal bleeding), dysphagia, oropharyngeal phase (difficulty swallowing in the mouth and throat), and cognitive communication deficit (difficulties with communication caused by impairments in cognitive function such as attention, memory, problem-solving, and executive functioning.) Record review of Resident #89's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #89's comprehensive care plan with revision date 1/27/25 revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes, with interventions that included to use simple directive sentences when communicating with the resident. Record review of Resident #89's Functional Abilities assessment dated [DATE] revealed the resident needed Partial/moderate assistance with personal hygiene including shaving. During an observation and interview on 3/18/25 at 9:26 a.m., revealed Resident #89 was observed with a large a disposable razor on the bedside table. Further observation revealed a large pair of nail clippers under the left side of the resident's bed. Resident #89 stated, he last used the disposable razor to shave himself two days ago and would sometimes cut his own nails with the nail clippers. Resident #89 stated he last trimmed his fingernails about 10 days ago. Resident #89 stated he had purchased the disposable razor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/19/25 at 8:02 a.m., revealed Resident #89 was observed with a pair of yellow handle scissors, the same large nail clippers, and the disposable razor on the resident's bedside table. Resident #89 stated he used the large nail clippers to trim his own nails because sometimes they (staff) don't have nail clippers. Resident #89 stated he used the yellow handle scissors to trim his moustache. Resident #89 stated he last used the yellow handle scissors like a week ago. During an observation and interview on 3/19/25 at 8:07 a.m., CNA I stated when she usually came on shift, she would make rounds of the residents' rooms, including Resident #89, and ensure the residents were clean, the call light was within reach, ensure fall risk preventions were in place, and ensure there was nothing on the floor, no clutter. CNA I acknowledged Resident #89 had a yellow handle pair of scissors, a large pair of nail clippers, and a disposable razor on the resident's bedside table. CNA I stated, Resident #89 was not supposed to have the yellow handle pair of scissors, the large pair of nail clippers, and the disposable razor in his possession because he could cut himself. During an observation and interview on 3/19/25 at 8:16 a.m., LVN J acknowledged Resident #89 was not supposed to have the yellow handle pair of scissors, the large nail clippers, and the disposable razor. LVN J stated, the large nail clippers, the yellow handle scissors, and the disposable razor could cause the resident to cut himself and confiscated the items. During an interview on 3/19/25 at 4:09 p.m., the DON stated, for the residents' safety, and for residents who had dementia or were forgetful, items such as scissors, nail clippers, disposable razors, and medications were not supposed to be in the resident's possession. The DON further stated, residents needed to be supervised for their safety. The DON stated, the facility developed a system where facility management staff were assigned to make daily rounds to specifically look out for things like that. A request for a facility policy and procedure for Accidents/Hazards requested on 3/19/25 at 4:15 p.m. but was not provided at the time of exit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections for 2 of 5 residents (Resident #49 and Resident #91) reviewed for incontinent care: 1. The facility failed to ensure CNA I and CNA N properly cleaned Resident #31's vaginal area, catheter tube, and buttock area during incontinent care. 2. The facility failed to ensure Resident #91's indwelling urinary catheter bag was not on the floor. These deficient practices could place residents at-risk for infection and skin break down due to improper care practices. The findings included: 1. Record review of Resident #49's admission record, dated 3/20/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), hydronephrosis (when urine builds up in a kidney), obstructive and reflux uropathy (is when your urine can't flow (either partially or completely) through your ureter, bladder, or urethra due to some type of obstruction), and hypertension (high blood pressure). Record review of Resident #49's quarterly MDS assessment dated [DATE] revealed the resident had moderately impaired cognition for daily decision making. Section H showed the resident had an indwelling catheter and was always incontinent of bowel. Record review of Resident #49's comprehensive care plan, revision date 4/25/22 and 1/22/25, revealed the resident had has bowel/bladder incontinence related to muscle weakness, activity intolerance, impaired mobility, physical limitations and recent CVA with interventions to check as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. The resident had Foley catheter related to diagnosis of obstructive and reflux uropathy. Record review of Resident #49's physician's orders dated 3/18/25 revealed an order for catheter care every shift and monitor for urethral site for signs and symptoms of skin breakdown, pain/discomfort, usual odors, urine characteristics or secretions, catheter pulling causing tension every shift with a start date of 1/8/24, and no end date. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During on observation on 3//20/25 at 11:25 a.m. revealed CNA I and CNA N performed peri care and catheter care on Resident #49. CNA I handed CNA N a wipe and CNA N wiped the resident's upper pelvic area below her abdomen. CNA I then handed CNA N another wipe and CNA N then wiped from the front and down the resident's right side of her labia. CNA I then handed CNA N another wipe and CNA N then wiped the resident's urethral opening around the catheter tube with the crumpled wipe. CNA N then used the same crumpled wipe and cleaned the resident's catheter tube. CNA N did not clean the resident's left side of her labia. CNA N then had the resident turn to her side. CNA I then handed CNA N a wipe and CNA N wiped the resident's back/buttocks. CNA I handed CNA N another wipe and CNA N crumpled the wipe and wiped the resident's anus once and then again in the same area of the anus with the same part of the crumpled wipe. CNA N then removed the soiled brief from the resident and discarded it. CNA I and CNA N threw the brief in a trash bag. CNA I removed her gloves and sanitized her hands and put on new gloves. CNA N did not change her gloves or perform hand hygiene. CNA N then grabbed a bag with a clean brief and with the same gloves she used to clean the resident she put the clean brief on the resident. During a joint interview on 3/20/25 at 11:35 a.m. CNA N stated she needed 6 wipes to clean the resident's vaginal area. CNA I stated she did not hand CNA N 6 wipes to clean her vaginal area but thought CNA N used a folding technique where she used a new clean area of the wipe each time she wiped the resident. CNA N stated she thought she used the folding technique and did not notice if she crumpled the wipe or not. CNAN stated she forgot to change her gloves and should have changed them if they were soiled. CNA N stated they should not go from a dirty to a clean area to prevent germs from the soiled brief from getting on the new clean brief. During an interview on 3/20/25 at 5:30 p.m. the DON stated a wipe could be used once, flipped, and used again before being tossed. The DON stated crumpled wipes were messy and made it hard to know what part of the wipe had been used. The DON stated staff were expected to change their gloves and perform hand hygiene when handling a clean brief to prevent cross contamination from the dirty brief. 2. Record review of Resident #91's face sheet dated 3/20/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included urinary tract infection, obstructive and reflux uropathy (condition in which the normal flow of urine is blocked leading to kidney damage; uropathy refers to kidney damage caused by backward flow of urine from the bladder into the ureters and kidney), and chronic kidney disease stage 3 (moderate decrease in kidney function). Record review of Resident #91's admission MDS assessment, dated 3/10/25 revealed the resident was moderately cognitively impaired for daily decision-making skills and utilized an indwelling urinary catheter. Record review of Resident #91's Order Summary Report dated 3/20/25 revealed the following: - MONITOR INDWELLING CATHETER OUTPUT every shift, with order date 3/12/25 and no end date. Record review of Resident #91's comprehensive care plan with revision date 3/13/25 revealed the resident had an indwelling urinary catheter related to obstructive uropathy with interventions that included to provide catheter care every shift and as needed, measure urinary output, position catheter bag and tubing below the level of the bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/21/25 at 9:53 a.m., revealed CNA F and CNA G were in Resident #91's room in preparation for catheter/incontinent care. Resident #91 was observed lying in the bed placed in the lowest position, and the indwelling urinary catheter tubing was observed on the right side of the bed with the urinary catheter bag resting on the floor. During a joint interview on 3/21/25 at 9:57 a.m., CNA F and CNA G acknowledged Resident #91's indwelling urinary catheter bag was on the floor and should not have been. CNA F and CNA G stated they were responsible for ensuring the indwelling urinary catheter bag was kept off the floor because it could result in the resident getting an infection or the bag or tubing could be stepped on causing an injury. During an interview on 3/21/25 at 10:10 a.m., LVN H acknowledged Resident #91 utilized an indwelling urinary catheter and it was the responsibility of the CNAs to ensure the indwelling urinary catheter bag was emptied, that there were no kinks in the tubing, including ensuring the indwelling urinary catheter bag was not on the floor. LVN H stated, Resident #91's indwelling urinary catheter bag on the floor could result in the resident getting an infection and it was considered a break in infection control. LVN H further stated the CNA staff, the charge nurses, and the managers were supposed to make rounds which included checking to make sure the indwelling urinary catheter bags were kept off the floor. During an interview on 3/21/25 at 1:01 p.m., the DON stated, indwelling urinary catheter bags observed on the floor placed the resident at an increased risk of infection. Record review of the facility's policy titled Incontinent Care, dated 5/2007, stated Policy: t is the policy of this facility to: 1. Remove urine or feces from skin. 2. Cleanse and lubricate skin. 3. Provide dry, odor free perennial care system. Procedures: Equipment: disposable incontinent brief, pad or resident's own undergarment (as a plan of care), linen, as needed Washcloth/bath towel, soap and/or peri wash/and or peri wipes, lotion. 1. Assemble equipment. Explain procedure. Provide privacy by closing door and securing privacy curtain. 2. Assist resident to turn on side with back toward you. Expose buttocks area. Wash, using front-to-back strokes, rinses, and dry exposed skin surfaces. Apply lotion. Remove soiled linen and replace clothing/linen as necessary. 3. Cloth undergarments. 4. Remove garment by rolling resident. Disposable incontinent briefs: A. Open brief fully on a flat surface. Place the end with the tapes at the back of the resident's body. Place the brief on the resident so that the back is slightly higher than the front. Pull the brief up into the crotch so that the flexible gathers fit into the creases of the resident's legs at the groin. B. Smooth the back flaps of the brief over the front flaps. Fasten the leg tapes (bottom tapes) on each side first. (The leg fit should be comfortably snug, like underwear, but not too tight.) Fasten the waist tapes on each side. C. A change in the color of the brief (grayish) indicates wetness. Men ordinarily wet the front of the crotch first; women wet the back D. Cleanse perennial/rectal area and apply a new brief. E. Wash hands . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Catheter Care, no date, revealed, Policy: It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and PRN for soiling. Monitoring of leg strap and level of drainage bag as indicated. PURPOSE: To promote hygiene, comfort and decrease risk of infection for catheterized residents. PROCEDURES: Equipment: Soap, Water, (Disposable wipes may be used as a substitute for soap and water), Gloves, Clean washcloth and trash bag . 5. Position resident comfortably. Do not expose unnecessarily. 6. Wash hands or Sanitize. 7. Put gloves on. 8. Using disposable wipes, clean the catheter insertion in a downward motion (front to back). Use each disposable wipes for one cleansing motion. 9. Repeat the procedure using the wipes. 10.May secure the tubing with securement device PRN to prevent migration of catheter/ friction/ tension. 11. Keep tubing below level of bladder 12. Cover drainage bag with privacy bag 13. Remove gloves and wash hands or sanitize. 14. Make the resident comfortable. 45857

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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** 39075 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals, and preferences for 1 of 2 residents (Resident #9) reviewed for oxygen therapy: Resident #9's oxygen concentrator filters were covered in a thick white/gray substance. This failure could affect residents who received respiratory therapy and put them at risk for inadequate or inappropriate amounts of oxygen delivery. The findings included: Record review of Resident #9's face sheet dated 3/20/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure (a condition in which the respiratory system fails to provide adequate oxygen to the blood or remove carbon dioxide from the body), dementia (decline in cognitive function severe enough to interfere with daily life), and chronic obstructive pulmonary disease (progressive lung disease characterized by persistent airflow limitation and respiratory symptoms). Record review of Resident #9's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and required oxygen treatments. Record review of Resident #9's Order Summary Report dated 3/20/25 revealed the following: - CHANGE O2 TUBING & HUMIDIFIER BOTTLE every night shift every Sunday, ensure humidifier & all tubing are dated appropriately, with order date 9/11/24 and no end date - CHECK & RECORD O2 SATURATION every shift related to ACUTE AND CHRONIC RESPIRATORY FAILURE, with order date 2/22/24 and no end date - O2 at 2-5 L/MIN VIA NC to Maintain sats above 92% every shift for O2 Dependent with order date 6/25/24 and no end date Record review of Resident #9's comprehensive care plan with revision date 11/15/24 revealed the resident had altered respiratory status/difficulty breathing related to acute and chronic respiratory failure with interventions that included to provide oxygen as ordered. During an observation and attempted interview on 3/19/25 at 7:55 a.m., Resident #9 was in the bed with the oxygen concentrator operating via the nasal cannula. Resident #9 refused and was unwilling to answer any Surveyor questions. The resident's oxygen concentrator had two rectangular filters on the right and left side of the oxygen concentrator that appeared to be covered in a thick white/gray substance. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and attempted interview on 3/20/25 at 2:29 p.m., Resident #9 was in the bed with the oxygen concentrator operating via the nasal cannula. Resident #9 refused and was unwilling to answer any Surveyor questions. The resident's oxygen concentrator had two rectangular filters on the right and left side of the oxygen concentrator that appeared to be covered in a thick white/gray substance. During an observation and interview on 3/20/25 at 2:33 p.m., RN L stated she made room rounds of the residents assigned to her, including Resident #9 at the beginning of her shift beginning at 6:00 a.m. RN L acknowledged the resident received oxygen and had been using the oxygen concentrator. RN L was asked by the State Surveyor about the filters to Resident #9's oxygen concentrator and initially could not find them. RN L stated, I don't know if this concentrator has a filter. RN L then observed the two rectangular filters on the left and right side of the oxygen concentrator and stated, this is what he is using for his source of air, it looks like he could be breathing a lot of bacteria through his lungs, it's like dust and it's not good. That's why we change our filters at home. RN L stated she had never checked the oxygen concentrator filters and believed it was the responsibility of the Maintenance Director. During an interview on 3/20/25 at 2:52 p.m., the Maintenance Director stated, the oxygen concentrators were checked by assigned upper management referred to as ambassadors assigned to different halls. The Maintenance Director stated he was assigned to the D hall as an ambassador and one of the duties was to check the oxygen concentrators which included making sure the oxygen filters were clean, and the humidifier canister and tubing were dated. The Maintenance Director stated, if he saw a problem he was supposed to report it to the nurses. The Maintenance Director stated he had removed oxygen filters when dirty and washed them. The Maintenance Director stated the HR Manager was the ambassador for the B hall where Resident #9 resided. During an interview on 3/20/25 at 3:04 p.m., the HR Manager stated she had been assigned the ambassador for the B hall and one of the duties assigned to her was to check the oxygen concentrator and ensure the humidifier canister and the tubing were dated. The HR Manager stated she did not like touching the oxygen concentrator, but if something did not look right, she would report it to the nurse. The HR Manager stated, the Maintenance Director already came to me because you (The State Surveyor) already talked to him about it. I have never cleaned the (oxygen) filters. The HR Manager stated she had made ambassador rounds earlier that morning in the B hall, including Resident #9's room, but revealed she had only glanced at the room itself as the resident was not in the room at the time and probably at dialysis. The HR Manager stated the DON and the Administrator had assigned upper management as ambassadors. During an interview on 3/20/25 at 3:31 p.m., the DON stated it was her expectation that the upper management staff assigned as ambassadors, as part of their duties, should be checking the oxygen concentrator filters to ensure they were clean and if they were not, they were supposed to wash them. The DON further stated, if the tubing on the oxygen concentrators needed to be addressed, the ambassadors were not allowed to touch them because removing them could alter the oxygen settings on the concentrator. The DON stated, if the ambassador missed it (the dirty oxygen concentrator filters) the nurses should have caught it. The DON stated, dirty oxygen filters could alter the concentrator and could clog like an air conditioning unit. The DON further stated, if the oxygen concentrator did not work properly, it could cause the resident to lose oxygen saturation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy and procedure titled, Oxygen Equipment, with revision date 5/2007, revealed in part, .It is the policy of this facility to maintain all oxygen therapy equipment in a clean and sanitary manner and to use disposable pre-filled humidifiers, tubing, masks and cannulas for residents receiving oxygen. This equipment is to be discarded after use. The facility will maintain clean tanks, connectors, and concentrators .Oxygen concentrator filters will be cleaned with water and detergent every week or according to manufacturers recommendations .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 3 residents (Resident #9) reviewed for dialysis: The facility did not maintain communication, coordination, and collaboration with the dialysis facility for Resident #9. This deficient practice could affect residents who received dialysis treatments and place them at risk for complications and not receiving proper care and treatment to meet their needs. The findings included: Record review of Resident #9's face sheet dated 3/20/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included end stage renal disease (condition in which the kidneys have lost nearly all their function and can no longer effectively filter waste, excess fluids, and toxins from the blood, resulting in dialysis or a kidney transplant), cognitive communication deficit (refers to difficulty with communication that result from impairments in cognitive processes such as attention, memory, problem-solving, organization, and executive function), dementia (decline in cognitive function severe enough to interfere with daily life), and dependence on renal dialysis (medical treatment that performs the function of the kidneys when they are no longer able to filter waste, excess fluids, and toxins from the blood effectively). Record review of Resident #9's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and required dialysis treatments. Record review of Resident #9's Order Summary Report dated 3/20/25 revealed the following: - DIALYSIS COMMUNICATION FORM TO BE COMPLETED AND FILED/SCANNED IN CHART ON DIALYSIS DAYS, with order date 2/22/24 and no end date - HEMODIALYSIS 3 times per WEEK EVERY Tuesday, Thursday, and Saturday, with order date 5/17/24 and no end date Record review of Resident #9's comprehensive care plan with revision date 3/19/25 revealed the resident had end stage renal disease and received dialysis treatments with interventions that included for dialysis communication form to be completed and filed/scanned in chart on dialysis days. Record review of Resident #9's Renal Dialysis Communication Forms revealed the form had three sections. The top section of the Renal Dialysis Communication form, Facility Information Pre-Dialysis was supposed to be completed by the facility staff. The middle section of the form, Dialysis Center Information was supposed to be completed by the dialysis clinic while Resident #9 was at dialysis. The bottom portion of the form, Facility Information Post-Dialysis was supposed to be completed by the facility staff upon Resident #9's return from dialysis treatment. (continued on next page)

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F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of Resident #9's Renal Dialysis Communication Forms for March 2025 revealed the following:

- 3/1/25- not provided

- 3/4/25 - the dialysis center information and the facility information post dialysis sections were blank

- 3/6/25 - the dialysis center information and facility information post dialysis sections were blank

- 3/13/25 - not provided

- 3/18/25 - not provided

- 3/20/25 - the dialysis center information section was blank

An attempt at an interview with Resident #9 on 3/19/25 at 7:55 a.m., and 3/20/25 at 2:29 p.m. were unsuccessful as the resident refused or was unwilling to answer Surveyor questions.

During an interview on 3/21/25 at 11:47 a.m., RN L acknowledged Resident #9 went for dialysis treatments on Tuesday, Thursday, and Saturday. RN L stated she had provided Resident #9 with the Renal Dialysis Communication form on 3/20/25 and had filled in the top portion of the form. RN L stated, we have had issues with the dialysis clinic, because the sheets have been coming back blank. RN L further stated if the form was not filled out by the dialysis clinic or the form did not return with the resident, we would reach out to the dialysis clinic to get it. RN L stated, sometimes she would delegate the Medical Records Clerk to obtain the information from the dialysis clinic, and she believed ADON A also followed up on the Renal Dialysis Communication form. RN L acknowledged the Renal Dialysis Communication Form for Resident #9 provided on 3/20/25 was not filled out by the dialysis clinic and she gave ADON A the form to follow up with the dialysis clinic. RN A stated the importance of the Renal Dialysis Communication form was to determine if the resident had problems during dialysis or the dialysis clinic identified a change of condition or requested a medication adjustment or lab analysis. RN A stated, that should be communicated to us.

During an interview on 3/21/25 at 11:59 a.m., the Medical Records Clerk stated, she received the Renal Dialysis Communication Forms for every resident who received dialysis treatments. The Medical Records Clerk acknowledged the form had three sections; the nurses fill in the top part, the patient then takes the form with them, and then after dialysis they (the dialysis clinic) give the resident the form and when they get here (to the facility) the form is returned to the nurse. The Medical Records Clerk stated, when the received the form, it is not my responsibility to make sure they are filled out, but if I get one with missing information, I notify the nurse. The Medical Records Clerk further stated she collected the Renal Dialysis Communication Forms at the end of each month and was not aware the forms had to be uploaded as they come. I have never been told I had to do it daily, it's a lot of paperwork.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER: Northeast Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 603 Corinne St San Antonio, TX 78218	

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/25 at 12:41 p.m., ADON A acknowledged Resident #9 received dialysis treatments on Tuesday, Thursday, and Saturday. ADON stated, the nurses get busy and were aware the Renal Dialysis Communication forms had to be filled in completely, but she was available to help. ADON A stated, nurses are responsible, for when the sheets come back, they are responsible for getting the fax number and send (back) to the dialysis clinic to make sure it is completed. ADON A stated the Medical Records Clerk would be allowed to fax the Renal Dialysis Communication forms or call the dialysis clinic for the nurses but preferred the nurses complete that task. The ADON stated the believed the purpose of the Renal Dialysis Communication form was to track the resident's weight and follow up on new medication orders or other recommendations requested by the dialysis clinic. ADON A stated, this is a failure because the facility and the dialysis clinic are not on the same page and we should all be on the same page. If we don't get the clinic to fill it out (the Renal Dialysis Communication forms), how would I know if they dialyzed correctly or anything that might affect the resident physically. ADON A further stated she depended on the dialysis clinic to fill in their portion of the form because that's how I get monthly weights on the resident; we depend on the dialysis clinic to get us those weights. ADON A stated it was ultimately the nurse's responsibility to ensure the forms were filled out completely. During an interview on 3/21/25 at 1:09 p.m., the DON acknowledged Resident #9 received dialysis treatments and nursing was responsible for ensuring the Renal Dialysis Communication forms were completed. The DON stated, we can accept the missing information on the dialysis section (of the Renal Dialysis Communication form), but we have to contact the dialysis clinic to get them to provide their portion of the sheet. The DON further stated, obtaining the missing information had to be done as soon as possible. The DON stated, the ADON was responsible for following up on the completion of the Renal Dialysis Communication forms and the Medical Records Clerk was only responsible for uploading the forms into the electronic record, but if the forms were missing documentation the Medical Records Clerk was supposed to notify the nurse. The DON stated the Renal Dialysis Communication forms were important because it communicated the condition of the resident while at dialysis and it helped the facility to monitor weights for those residents who received dialysis. Record review of the facility policy and procedure titled, Dialysis (Renal), Pre- and Post-Care, with revision date 12/2023 revealed in part, .It is the policy of this facility to .Assess resident daily for function related to renal dialysis .Participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services .Collaboration and Communication of Care .The care of the resident receiving dialysis services will reflect ongoing communication, coordination, and collaboration between the nursing home and dialysis staff .Staff will immediately contact and communicate with the attending physician/practitioner, resident/resident representative, and designated dialysis staff .regarding any significant changes in the resident's status related to clinical complications or emergent situations that may impact the dialysis portion of the care plan .

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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 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39075

Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 3 nurse medication carts and 2 of 24 residents (Resident #89 and Resident #66) reviewed for storage of drugs and biologicals.

1. The facility failed to ensure Resident #89 did not have medications at the bedside when a large bottle of antacids was found at the resident's bedside.

2. The facility failed to ensure Resident #66 did not have medications at the bedside when a bottle of hemp gummies and a bottle of blood flow supplements were found at the resident's bedside.

3. The facility failed to ensure medication carts were locked and secured when LVN M left a medication unlocked and unsecured on 03/20/2025.

These failures could place residents at risk of medication misuse or drug diversion.

The findings included:

1. Record review of Resident #89's face sheet dated 3/19/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included gastro-esophageal reflux disease with esophagitis (a chronic condition where stomach acid frequently flows back into the esophagus causing inflammation and irritation), duodenitis without bleeding (inflammation of the first part of the small intestine without gastrointestinal bleeding), dysphagia, oropharyngeal phase (difficulty swallowing in the mouth and throat), and cognitive communication deficit (difficulties with communication caused by impairments in cognitive function such as attention, memory, problem-solving, and executive functioning.)

Record review of Resident #89's most recent quarterly MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills.

Record review of Resident #89's Order Summary Report dated 3/19/25 revealed the following:

- Maalox Max Oral Suspension 400-400-40 MG/5 ML, Give 30 ml by mouth every 6 hours as needed for indigestion, with order date 1/20/25 and no end date.

- Tums Oral Tablet Chewable 500 MG, Give 1 tablet by mouth three times a day for low calcium related to hypocalcemia (low calcium levels), with order date 2/19/25 and no end date.

Record review of Resident #89's comprehensive care plan with revision date 1/27/25 revealed the resident was at risk for impaired cognitive function/dementia or impaired thought processes, with interventions that included to use simple directive sentences when communicating with the resident.

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	455754	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Rehabilitation and Healthcare Center	603 Corinne St San Antonio, TX 78218

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/18/25 at 9:26 a.m., revealed Resident #89 was observed with a large bottle of antacid tablets on the bedside table. Resident #89 stated he received his medications from the nurses in the morning and evenings. Resident #89 stated the nurses gave him antacids yesterday but had his own antacids for when he had heartburn. During an observation and interview on 3/19/25 at 8:07 a.m., CNA I stated when she usually came on shift, she would make rounds of the residents' rooms, including Resident #89, and ensure the residents were clean, the call light was within reach, ensure fall risk preventions were in place, and ensure there was nothing on the floor, no clutter. During the observation with Resident #89, he was asked where the bottle of antacids was, and the resident pointed to the top drawer of his dresser. CNA I took the bottle of antacids from the resident's top drawer of the dresser and held them for the nurse. During an observation and interview on 3/19/25 at 8:16 a.m., LVN J acknowledged Resident #89 was not supposed to have the bottle of antacids. LVN J stated, if Resident #89 took too many of the antacids he could get sick and he had not been assessed to self-medicate. 2. Record review of Resident #66's face sheet dated 3/19/25 revealed an [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes (a chronic condition that affects how the body regulates blood sugar), acute respiratory failure (condition in which the lungs are unable to provide enough oxygen to the blood or remove enough carbon dioxide from the body), chronic obstructive pulmonary disease (a progressive lung disease that causes airflow obstruction, making it difficult to breath), hyperlipidemia (high levels of fats [lipids] such as cholesterol and triglycerides in the blood), hypertension (high blood pressure), and heart failure. Record review of Resident #66's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills. Record review of Resident #66's Order Summary Report dated 3/19/25 revealed the following: - Amiodarone tablet 200 MG, Give 1 tablet by mouth two times a day for abnormal heart rhythm with order date 2/6/25 and no end date - Apixaban Oral Tablet 2.5 MG, Give 1 tablet by mouth two times a day for blood clot with order date 2/6/25 and no end date - Atorvastatin Calcium Oral Tablet 40 MG, Give 1 tablet by mouth at bedtime for cholesterol with order date 2/6/25 and no end date - Clopidogrel Bisulfate Tablet 75 MG, Give 1 tablet by mouth one time a day for blood clot prevention with order date 2/6/25 and no end date - Insulin Glargine Solution 100 UNIT/ML, Inject 40 unit subcutaneously one time a day for diabetes with order date 3/7/25 and no end date - Insulin Lispro Injection Solution 100 UNIT/ML, Inject as per sliding scale before meals for diabetes with order date 2/6/25 and no end date (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #66's comprehensive care plan with revision date 2/28/25 revealed the resident had altered cardiovascular status related to acute chronic congestive heart failure with interventions that included to give all cardiac medications as ordered by the physician. Further review of the comprehensive care plan revealed the resident had diabetes with interventions to administer diabetes medications as ordered by the doctor. Observation on 3/18/25 at 2:46 p.m. revealed Resident #66 sleeping in bed and a bottle of hemp gummies and a bottle of blood flow supplements on the resident's bedside table to the right of the bed. Observation and interview on 3/19/25 at 8:22 a.m. revealed Resident #66 sitting up in bed. Resident #66 stated he had a sleeping disorder and had been prescribed melatonin (a sleep aid) by the physician, but it did not help. Resident #66 acknowledged the bottle of hemp gummies at the bedside and stated he purchased them to help with his chronic obstructive pulmonary disease. Resident #66 stated he took the blood flow supplement pills he purchased every morning for help with filtering the blood. Resident #66 stated he was not aware if staff knew he had the hemp gummies or the blood flow supplement pills, but will talk to my doctor about using them. During an observation and interview on 3/19/25 at 8:40 a.m., CNA F acknowledged Resident #66 had a bottle of hemp gummies and a bottle of blood flow supplement pills at the bedside. CNA F stated she came on shift at 6:00 a.m. and had made rounds of the resident rooms, including Resident #66's room. CNA F stated making round consisted of ensuring the residents were clean and fall interventions were in place. CNA F stated she was not aware of any residents being able to self-medicate, including Resident #66. CNA F stated there should not be any medications left at a resident's bedside because all medications should be prescribed by the doctor, and from my own understanding he (Resident #66) could overdose and not realize how much he is taking. During an observation and interview on 3/19/25 at 8:48 a.m., LVN K stated she had come onto her shift at 6:00 a.m. and made rounds of the resident's rooms, including Resident #66. LVN K acknowledged she had seen Resident #66 earlier that morning sitting up in bed and watching television and had administered Resident #66 his insulin. LVN K observed Resident #66 in bed and acknowledged the resident had a bottle of hemp gummies and a bottle of blood flow supplement pills at the bedside. LVN K stated Resident #66 should not have had medications at the bedside and any medications received by the resident were supposed to be prescribed by the doctor. LVN K stated, He (Resident #66) could have complications, interactions with other medications and he could overdose with some of these, it's a risk. During an interview on 3/19/25 at 4:09 p.m., the DON acknowledged the facility did not have any residents who had been assessed to self-medicate or had expressed any interest in doing so. The DON further stated, for the residents' safety, and for residents who had dementia or were forgetful, items such as scissors, nail clippers, disposable razors, and medications were not supposed to be in the resident's possession. The DON further stated, residents needed to be supervised for their safety. The DON stated, the facility developed a system where facility management staff were assigned to make daily rounds to specifically look out for things like that. During a follow-up interview on 3/19/25 at 4:15 p.m., the DON stated Resident #66 had often ordered things online and any medications he ordered were supposed to be kept for the resident until his discharge. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy and procedure, untitled and undated, revealed in part, .Medications . Residents and family are restricted from bringing medicine into the facility unless approved by the director of nursing in advance . 3. Observation on 3/20/25 at 4:48 p.m. revealed the nurse's medication cart was left unattended across from the laundry room entrance door and next to the nurse's station, facing out into the hall with the nurse's medication cart keys on the lock. LVN M was observed leaving the nurse's station and walked up to the unlocked nurse's medication cart, locked the cart, and took the keys. During an interview on 3/20/25 at 5:05 p.m., LVN M acknowledged she had left the nurse's medication cart unlocked, and unattended with the keys left in the lock. LVN M stated, leaving the nurse's medication cart unlocked and unattended was not acceptable because it was a safety issue, and anybody could get into the medication cart and obtain access to medications. LVN M stated she was summoned to the nurse's station to participate in an in-service training and forgot to lock the nurse's medication cart. During an interview on 3/20/25 at 5:28 p.m., the DON stated it was her expectation for the medication carts to remain locked when unattended as anybody could get in there, a resident could get in there, a family member, there are narcotics in there and patients could take the medications that did not belong to them. Record review of the facility policy and procedure titled, Medication Access and Storage, undated, revealed in part, .It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply [sic] accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access .

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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 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. 45857 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: 1. The facility failed to date a bag of whipped cream in the fridge. 2. The facility failed to keep dry food delivery off the floor. 3. The facility failed to take and log temperatures for alternate items prior to meal service. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: 1. During an observation on 3/18/25 at 9:19 a.m. a bag of whipped nondairy cream was in the fridge. The bag had no date and was soft. The label read, best if used 1 year frozen (unopened) and 14 days refrigerated. During an interview on 3/18/25 at 9:19 a.m. the DS stated someone had just moved the whipped cream from the freezer box that day to use for meal service. The DS stated they should have dated it when they took it out of the box that had a date. 2. During an observation on 3/18/25 at 9:23 a.m. there was a case of water, a tub of peanut butter, and a bottle of BBQ sauce on the floor outside the kitchen. During an interview on 3/18/25 at 9:23 a.m. the DS stated they had received the items that morning during a delivery. The DS stated they would deliver the items to the facility and slide them off a pallet onto the floor. The DS stated they used to have their own pallet to keep the items off the floor but the pallet was in the way, and they did not use it any longer. 3. During an observation on 3/20/25 between 4:31 p.m. and 4:43 p.m. the DS took temperatures of: puree vegetables- 160 F puree pork-204 F puree potatoes- 202 F mechanical texture pork-169 F carrots- 200 F (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potato wedges-202 F pork chops- 197 F gravy-184 F hamburger patties-194 F The DS did not take temperature for a container of green beans and a container of pasta on the service well. The DS did not immediately write down the temperatures. During an interview and observation on 3/20/25 at 4:46 p.m. the DS stated he could recall all the temperatures he took later when he wrote them down. The DS stated he did not take the temperatures for the alternate items because he knew they were hot, and the log did not contain an area for him to record alternate items. The DS stated he should take the temperature of all the items he would serve that day and then took the temperature for a container of green beans and a container of pasta. During an interview on 3/21/25 at 1:39 p.m. the Administrator stated kitchen deliveries were usually dropped off outside the kitchen, it could be difficult to simultaneously put everything away, and some items maybe on the floor until put away. The Administrator stated he believed staff should be taking temperature off all food prior to serving it and they could add to the temperature list if there was not a dedicated line on the form. Record review of an untitled document, dated March 2025, showed a list of items to record temperatures on daily for breakfast, lunch and dinner. The dinner area had rows to document the temperature of the meat, vegetables, starch, mechanical entree, puree entree, pureed vegetable, pureed starch, dessert, milk, and cooks initials. The temperature for dinner items on 3/20/25 were recorded as: Meat-174 F Vegetables-202 F Starch- 201 F Mechanical entree- none Pureed entree- 165 F Pureed vegetable- 173 F Dessert- 32 F Milk- 32 F The log did not contain any temperature for alternate items on any of the dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Food Storage, dated 8/2007, stated Policy: it is the policy of this facility that food storage areas shall be maintained in a clean, safe, and sanitary manner. Procedures .2. All foods or food items not requiring refrigeration shall be stored at least six (6) inches above the floor .on shelves, racks, dollies or other surfaces with facilitate thorough cleaning, in a ventilated room, not subject to sewage or wastewater backflow or contamination by condensation, leakage, rodent, or vermin. All packaged food, canned foods, or food items stored shall be kept clean and dry at all time. 3. Cold foods shall be maintained at temperatures of 40 F or below. Hot foods or potentially hazardous food shall leave the kitchen or steam table at 140 F or above .

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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 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** 39075 Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 3 of 3 residents (Residents #22, Resident #49, and Resident #147) reviewed for infection control. 1. The facility failed to ensure PTA O wore a gown while in providing care to resident #22 who was on EBP. 2. The facility failed to ensure CNA N performed hand hygiene and changed gloves during incontinent care on Resident #49. 3. The facility failed to ensure ADON B used appropriate infection control principles, including hand hygiene/glove changes during wound care. These failures could affect residents who required assistance with incontinent care and wound care treatments and could place residents at risk for cross contamination and infections. The finding included: 1. Record review of Resident #22's Admission Record, dated 03/19/25, revealed a [AGE] year-old female admitted on [DATE], and readmitted on [DATE] with diagnoses of dementia without behavioral disturbance (a group of symptoms affecting memory, thinking, and social abilities, which interfere with daily life), dysphagia (difficulty swallowing), pneumonitis (when air sacs in the lungs become inflamed due to irritant substances and disturb the normal functioning of the lungs), anoxic brain damage (occurs when there is a complete lack of oxygen supply to the brain), muscle weakness and chronic kidney disease (a gradual loss of kidney function). Record review of Resident #22's annual MDS assessment, dated 2/5/25, revealed the resident had severely impaired cognition for daily decision making. Record review of Resident #22's care plan, updated 10/18/25, revealed the resident had a colostomy with interventions to change colostomy bag and wafer as ordered and provide colostomy care every shift and as needed per MD orders. Record review of Resident #22's order summary, dated 3/18/25, revealed an order for enhanced barrier precautions: PPE required for high resident contact care activities. Indication: colostomy, with a start date of 10/14/24 and no end date. During an observation on 3/18/25 at 10:11 a.m. PTA O was in Resident #22's room brushing her hair and then transferred her to her wheelchair. There was a small sign outside of Resident #22's room that stated Resident #22 was on EBP. PTA O only had on gloves and no gown. During an interview on 3/18/25 at 10:19 a.m. PTA O stated she was unsure what the sign outside of Resident #22's room was for or what it meant. (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 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 3/19/25 at 4:23 p.m. the DON stated the signs outside the residents' rooms were for residents who were on enhanced barrier precautions to remind staff to wear a gown and gloves. The DON stated they would be required to wear a gown and gloves if they were providing direct care to a resident who had a colostomy, wound, catheter, picc line, etc. The DON stated she had training with all staff a few months ago to go over what the signs meant and what was required for EBP.

During a follow up interview on 3/21/25 at 11:57 a.m. PTA O stated the signs outside the residents' rooms were to indicate they were on EBP, and staff needed to use a gown and gloves. PTA O stated she forgot about the resident's colostomy when she was providing care and transferring Resident #22 on 3/18/25. PTA O stated she had never paid attention to the signs before because she already knew what residents were on EBP and required the gown and gloves. PTA O stated she was just getting Resident #22 into her chair on 3/18/25 and helped her brush her hair before leaving the room. PTA O stated not using a gown for a resident on EBP could place them at risk of infection.

Record review of a facility's Inservice titled Infection Control, dated 1/31/25, revealed one topic covered was Enhanced Barrier Precautions- dressing, bathing, transferring, brief changes, toileting, peg tubes, IVs, linen change, wound care. PTA O signed the in-service.

2. Record review of Resident #49's admission record, dated 3/20/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood), hydronephrosis (when urine builds up in a kidney), obstructive and reflux uropathy (is when your urine can't flow (either partially or completely) through your ureter, bladder, or urethra due to some type of obstruction), and hypertension (high blood pressure).

Record review of Resident #49's quarterly MDS assessment dated [DATE] revealed the resident had moderately impaired cognition for daily decision making. Section H showed the resident had an indwelling catheter and was always incontinent of bowel.

Record review of Resident #49's comprehensive care, revision date 4/25/22 and 1/22/25, revealed the resident had has bowel/bladder incontinence related to muscle weakness, activity intolerance, impaired mobility, physical limitations and recent CVA with interventions to check as required for incontinence, wash, rinse, and dry perineum, change clothing PRN after incontinence episodes. Resident had foley catheter related to diagnosis of obstructive and reflux uropathy.

Record review of Resident #49's physician's orders, dated 3/18/25 revealed an order for catheter care every shift and monitor for urethral site for signs and symptoms of skin breakdown, pain/discomfort, usual odors, urine characteristics or secretions, catheter pulling causing tension every shift with a start date of 1/8/24, and no end date.

During on observation on 3//20/25 at 11:25 a.m. CNA I and CNA N performed peri care and catheter care on Resident #49. Both aides worked to provide pericare to Resident #49 and remove her dirty brief. CNA I removed her gloves and sanitized her hands and put on new gloves, CNA N did not change her gloves or perform hand hygiene. CNA N then grabbed a bag with a clean brief and with the same gloves she used to clean the resident, she then put a clean brief on the resident.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Rehabilitation and Healthcare Center	603 Corinne St San Antonio, TX 78218

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a joint interview on 3/20/25 at 11:35 a.m. CNA N stated she forgot to change her gloves and should have changed them if they were soiled. CNA N stated they should not go from a dirty to a clean area to prevent germs from the soiled brief from getting on the new clean brief.

During an interview on 3/20/25 at 5:30 p.m. the DON stated staff was expected to change their gloves and perform hand hygiene when handling a clean brief to prevent cross contamination from the dirty brief.

3. Record review of Resident #147's face sheet dated 3/20/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included enterocolitis due to clostridium difficile (an infection and inflammation of the colon caused the bacterium C. difficile), Escherichia coli (an infectious bacteria commonly found in the intestines), and stage 2 pressure ulcer (a pressure injury that involved partial-thickness skin loss).

Record review of Resident #147's most recent comprehensive MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and was identified with a stage 2 pressure ulcer/injury.

Record review of Resident #147's Order Summary Report dated 3/20/25 revealed the following:

- cleanse wound with N/S and pat dry apply barrier cream to coccyx. LOTA one time a day for wound care, with order date 3/20/25 and no end date

Record review of Resident #147's comprehensive care plan with revision date 3/19/25 revealed the resident admitted to the facility with a stage 2 pressure ulcer to the sacral area with interventions that included to administer treatments as ordered and monitor for effectiveness and use Enhanced Barrier Precautions.

Observation on 3/20/25 at 10:30 a.m., during wound care treatment, ADON A washed his hands in Resident #147's bathroom sink, put on a gown and gloves, pulled the resident's privacy curtain to provide privacy, removed his gloves, did not wash, or sanitize his hands and put on a new pair of gloves. ADON A then pulled back the resident's bed sheets, helped unfasten the resident's brief, removed his gloves, did not wash, or sanitize his hands and put on a new pair of gloves. ADON A then provided Resident #147 with wound care, removed his gloves, went to the resident's bathroom sink to wash his hands and then used his left hand to turn off the water faucet instead of using a disposable towel. ADON A then returned to Resident #147's bedside, put on a pair of gloves, and completed wound care. ADON A then took the wasted supplies used during wound care and placed them in a trash bag. ADON A then removed his gloves, did not wash, or sanitize his hands and put on a new pair of gloves. ADON A then helped to reposition Resident #147 onto his back, fastened the resident's brief and pulled the blanket over the resident's lower extremities. ADON A then removed his gloves, and gown, went into Resident #147's bathroom and washed his hands. ADON A then turned off the faucet with his left hand instead of using a disposable towel.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER: Northeast Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 603 Corinne St San Antonio, TX 78218	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/25 at 10:52 a.m., ADON A stated he should have been sanitizing or washing his hands between glove changes to disinfect his hands and to get rid of organisms. ADON A further stated, he should not have touched the faucet after washing his hands because the faucet was dirty and should have used a towel instead. ADON A stated, it was important to practice proper infection control because you don't want to spread infection, and if cross contamination occurred it could cause the resident to get an infection and end up in the hospital or there was the possibility of spreading infection to other residents. During an interview on 3/20/25 at 5:34 p.m., the DON stated, washing hands before and after glove changes to disinfect the hands and get rid of organisms before putting on gloves was her expectation. The DON further stated, not practicing proper hand hygiene was a potential for spreading germs and risk of infection to the resident. The DON stated, when washing hands with soap and water, the faucet should not be touched because it was dirty and that would be a break in infection control. Record review of the facility's policy titled Infection Prevention and Control Program, no date, stated Policy Statement It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . transmission based precautions are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. 1. Standard Precautions- are group of infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions, and excretions (except sweat) may contain transmissible infectious agents. Proper selection and use of PPE, such as gowns and gloves, is one component of standard precautions, along with hand hygiene, safe injection practices, respiratory hygiene and cough etiquette, environmental cleaning, and disinfection, and reprocessing of reusable medical equipment. The use of PPE is based on staff interaction with residents and the potential for exposure to blood, body fluids, or pathogens (E. G., gloves are worn when contact with blood, body fluids, mucus membranes, non intact skin, or potentially contaminated surfaces or equipment are anticipated) .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 that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs maybe indirectly transferred from resident to resident during these high contact activities. Nursing home residents with wounds and indwelling medical devices are especially at high risk for both acquisition of and colonization of MDRO's. a. PPE: use of gown and gloves for high contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with: i. Wounds and/or indwelling medical devices regardless of the MDRO colonization as well as for residents ii. MDRO infection or colonization. B. Multi drug resistant organisms (MDRO) the MDROs for which the use of EBP applies are based on local epidemiology. At minimum, they should include resistant organisms targeted by the CDC and can also include other epidemiologically important MDROs .C. Examples of high contact resident care activities requiring gown and glove use for enhanced. Precautions include: i. Dressing, ii. Bathing poured flash showering, iii. Transferring, iv. Provide hygiene . 45857