

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455762	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER San Antonio Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE One Heartland Dr San Antonio, TX 78247	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520</p> <p>Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 6 Residents (Resident #48) reviewed for dignity.</p> <p>CNA F walked into Resident #48's room without knocking and while Surveyor and Resident #48 were having a discussion about his medical concerns.</p> <p>This deficient practice could affect any resident and contribute to residents feeling like their feelings, privacy or dignity does not matter.</p> <p>The findings were:</p> <p>Record review of Resident #48's face sheet, dated 11/8/24, revealed he was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus with Diabetic Neuropathy and Major Depressive Disorder, recurrent, moderate,</p> <p>Record Review of Resident #48's annual MDS, dated [DATE] revealed his BIMS was 14 reflecting minimal cognitive impairment, he did not have mood or behavior problems and for activities it reflected Resident #48 found it very important to chose how to spend his days and what activities were important to him.</p> <p>Observation and interview on 11/07/24 at 03:26 PM revealed Resident was sitting in a wheelchair and was talking about the rash on his upper body, hands and legs. Further observation revealed CNA F walked into Resident #48's room without knocking. He had a container of water in his hand. Surveyor and Resident #48 both quit talking. Resident #48 commented, it's like we're not Important and I don't even matter. It's my room. Resident #48 stated he wished staff would knock before they entered his room.</p> <p>Interview on 11/08/24 at 04:42 PM with CNA F revealed he stated he did not knock on Resident #48's room yesterday while he and Surveyor were talking. He stated he stepped out to get Resident #48 water and the Resident knew he was returning. Surveyor proposed CNA F a question: how would you like it if someone walked into your living room without knocking? CNA F stated he would not like it. CNA F apologized and stated he would not do it again.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/08/24 at 04:55 PM with the DON revealed CNA F told her about walking into Resident #48's room without knocking. She stated it was a dignity/privacy issue and she expected all staff to knock before entering a Resident's room. The DON stated the charge nurses should be watching out for any incidents.</p> <p>Record review of a facility policy, Resident Rights, revised 8/2020, read in relevant part: The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The Facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the Facility. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on observation, interviews, and record reviews the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay for 1 of 8 residents (Resident #4) reviewed for grievances.</p> <p>The facility failed to create a greience for Resident #4 who made a grievance to LVN D, LVN C, CNA A, and The BOM alleging she did not receive medications on Sunday 10/27/2024.</p> <p>This failure could place residents at risk for not having their grievances heard and or resolved.</p> <p>The findings included:</p> <p>A record review of Resident #4's quarterly MDS assessment dated [DATE] revealed Resident #4 was an [AGE] year-old female admitte d on 09/19/2022 for long term care and assessed with a BIMS score of 12 out of a possible 15 which indicated moderate cognitive impairment. Further review revealed Resident #4 was assessed as medically complex with diagnoses which included generalized pain, osteoarthritis, atrophy (weaking) of the eyes complicated by Presbyopia (not able to see close), Hypermetropia (only having the ability to see objects far away) and glaucoma (a condition where the eye's optic nerve, which provides information to the brain, is damaged). Resident #4 was assessed as dependent - helper does ALL of the effort to complete the activity for the following: Toileting and Bathing and was assessed without the ability to stand or walk.</p> <p>A record review of Resident #4's care plan conference dated 07/25/2024 revealed, (Resident #4) is here for LTC (long Term Care). She was discharged from (name of hospice care) hospice in June for stability. She remains on her pain management. She is bed bound and doesn't like to do therapy or get out of bed. (family) visits often. She is able to make her needs known. She prefers in room activities. She remains DNR (do not resuscitate) and regular diet.</p> <p>During an observation and interview on 11/05/24 at 10:39 AM revealed Resident #4 laying in her bed. Resident #4 stated she had not received medications and stated, you could have them give me my meds. Resident #4 continued to explain on 10/27/2024 she had not received her medications and she had complained to (name of family relative) and nurse that day (LVN D). Resident #4 detailed she believed she did not receive her medications and the next morning 10/28/2024 she made the same complaint to her CNA, CNA A, and then again to the BOM. Resident #4 stated no one gave her a report regarding her grievances. Resident #4 stated she did not fill out a grievance report and no one had assisted her in filling out a report.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/24 at 01:40 PM CNA A stated she recalled sometime last week - on a Monday Resident #4 made a complaint she had not received her medications that weekend, Sunday (10/27/2024). CNA A stated on Monday 10/28/2024 while she recovered Resident #4's breakfast tray Resident #4's ambassador the BOM entered the room to check in with Resident #4. CNA A stated she then introduced the BOM to Resident #4's complaint. CNA A stated she was a long-term employee of the facility and was not aware of the facility's grievance policy and or procedures. CNA A stated she had not assisted Resident #4 to fill out a grievance form.</p> <p>During an interview on 11/07/24 at 11:45 AM the Administrator stated he had provided the survey team all the grievance forms for the past months of May through November.</p> <p>A record review of the facility's grievance logbook revealed grievances for the time between May 2024 and November 2024 and no grievances were revealed for Resident #4's grievance made on 10/27/ 2024 and 10/28/2024.</p> <p>During an interview on 11/07/24 at 12:00 PM the BOM stated she was the ambassador for Resident #4 and on the Morning of 10/28/2024 she visited with resident #4 who stated she had a suspicion she did not receive her medications Sunday yesterday (10/27/2024). The BOM stated she checked with Resident #4's nurse that day Monday 10/28/2024 LVN C. LVN C reviewed Resident #4's medication administration record for 10/27/2024 and revealed LVN D had documented Resident #4 received her medications. The BOM stated she had not assisted Resident #4 to fill out a grievance form. The BOM stated she had not considered Resident #4's complaint of not receiving her medications as a grievance which needed to be documented since the record revealed she had received her medications.</p> <p>During an Interview on 11/07/2024 at 12:54 PM LVN D stated on 10/27/2024 Resident 4's (family member) called the nurses station and reported her (Resident #4) had alleged she had not received her morning medications. LVN D stated he reported to Resident 4's (family member) he had administered the medications also Resident #4 was a little sleepy that morning and may have not remembered. LVN D stated he did not document the report in any notes and had not generated a grievance report nor reported the allegation of neglect to his superior because he did not recognize the allegation of neglect because he had direct knowledge of the medication administration.</p> <p>During an interview on 11/07/2024 at 4:00 PM the DON stated she expected all the staff to assist residents document grievances made and to submit those grievances to the administrator. The DON stated she was surprised because the staff have been in-serviced on grievances and the facility had many grievances documented and resolved. The DON stated she would follow up with CNA A and LVN D.</p> <p>During an interview on 11/07/2024 at 04:10 PM the administrator stated he was the grievance officer and had not received a grievance report on behalf of Resident #4 regarding her suspicion of not receiving her medications and expected LVN D and the BOM to have generated a grievance report once the administrator received the surveyors report detailing the events on 10/27/2024 and 10/28/2024.</p> <p>A record review of the facility's policy dated August 2020, revealed, Purpose: To ensure that residents, family members, and representatives know about the procedure for filing grievances and complaints.</p> <p>Policy</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility advises residents and their representatives (including family, legal representatives, and advocates) of their right to file grievances without discrimination or reprisal, and of the process for filing grievances or complaints. and ensures that there is a prompt review, investigation and response to and resolution of grievances and complaints. The disposition of all resident grievances and/or complaints is recorded in the Facility's Resident Grievance/Complaint Log. Grievances and/or complaints may be submitted orally or in writing and can be made anonymously through the Compliance Hotline. Individuals will use Facility complaint forms or may use Resident Grievance/Complaint Form to submit written grievance reports. VI. Duties and Obligations of Staff; A. When a Facility Staff member overhears or receives a complaint from a resident, a resident's representative, another interested family member or visitor of a resident concerning the resident's medical care, treatment, food, clothing, or behavior of other residents, etc., the Facility Staff member is encouraged to advise the resident/concerned party that they may file a complaint or grievance without fear of reprisal or discrimination, and will assist the resident, or person acting on the resident's behalf, in filing a written complaint with the Facility. C. Staff members inform the resident or the person acting on the resident's behalf where to obtain a Resident Grievance/Complaint Form and where to locate the procedures for filing a grievance or complaint (e.g., posted on the consumer bulletin board).</p> <p>D. All alleged abuse, mistreatment, neglect, injuries of unknown source, and misappropriation of property will be reported to the Administrator immediately. See Policy Abuse Prevention Program. F. The Facility will inform the resident or his or her representative or concerned party of the findings of the investigation and any corrective actions recommended in a timely manner. IX. Grievance Complaint Log A. The disposition of all written grievances and/or complaints is recorded on the Resident Grievance/Complaint Log.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41937</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 2 of 3 patios reviewed for entrapment and lack of supervision.</p> <ol style="list-style-type: none"> 1. The secured enclosed patio by the 100-300 hall dining room was accessed by a door that would allow residents, staff, and the public to exit to the secured enclosed patio but would lock behind anyone and would prevent access back into the dining room. 2. The secured enclosed patio by the 400-600 hall dining room was accessed by a door that would allow residents, staff, and the public to exit to the secured enclosed patio but would lock behind anyone and would prevent access back into the dining room. <p>This failure could place residents, staff, and the public at risk for entrapment.</p> <p>The findings included:</p> <p>During an observation of the facility during initial rounds on 11/05/2024 from 09:00 to 06:00 PM revealed 3 secured patios. One enclosed secured patio was located by the 100-300 hall dining room. One enclosed secured patio was located by the 400-600 hall dining room. One secured enclosed patio was located within the memory care secured unit.</p> <p>During an observation on 11/05/24 at 05:30 PM revealed staff and residents gathered at the 100-300 hall dining room. Staff assisted some residents to their tables and other independent residents self-ambulated to the dining room and sat themselves at dining room tables and awaited the dinner meal. Approximately 20 residents were observed in the dining room. Further observation revealed Resident #16 walked in the dining room with his rollator walker and sat down for the dinner meal service. The surveyor observed the door at the end of the dining room which was used to access the adjacent enclosed secured patio. The surveyor exited the door and walked out into the patio. Further observation of the patio revealed a large patio with a concrete patio and walkways around a garden and shrubbery. The walkway led to a fenced in yard secured by a six-foot wooden privacy fence with a secured magnetically locked gate which could not be opened. The surveyor walked back to the door to the facility's 100-300 hall dining room to discover the door had locked behind the surveyor when the surveyor exited the door. Residents and staff could be visualized through the glass locked door. The door presented with a numbered push pin lock. The door presented without any signage to reveal a phone number and or access code. The surveyor had to knock on the glass door to gain the attention of staff. ADON E answered the knock and opened the door.</p> <p>During an interview on 11/05/2024 at 05:40 PM ADON E stated the door was free to exit and would lock behind anyone who would exit. ADON E stated staff would escort residents out to the patio for outdoor activities. ADON E stated there was a code for the door, but it was not posted. ADON E stated Resident #16 could exit to the secured patio and was not aware of the code. ADON E stated Resident #16 had no history of going outside without staff. ADON E stated some residents were aware of the code to enter back into the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 11/06/2024 at 12:36 pm revealed the enclosed secured patio located by the 300-600 hall dining room. The patio could be accessed by residents, staff, and the public through a glass metal door. The surveyor observed the door needed no code to exit but the door locked behind whoever exited the facility into the garden patio. The patio presented with concrete patios and walkways and features a six-foot privacy wooden fence which was electronically magnetically locked and could not be unlocked. The door back into the facility presented without any signage to advertise an access code and or facility phone number.</p> <p>During an interview on 11/07/2024 at 11:20 AM the Maintenance Director stated the doors to the secured enclosed patios by the 100-300 and 400-600 dining rooms had locks designed to allow anyone out but locked behind anyone who exited and could only be unlocked from the inside or by using a code from the outside. The Maintenance Director stated someone who did not know the code could be locked out of the facility and could not get out of the patio unless someone unlocked the door from the inside. The maintenance director stated he was in the process of removing the locks. The Maintenance Director stated the facility leadership met and decided to remove the locks on 11/07/2024 and provide a handle which would allow free movement in and out.</p> <p>During an interview on 11/8/2024 at 04:00 PM the Administrator stated the doors to the enclosed secured patios by the dining rooms had been locked and were now free to allow exit and entrance to the facility. The locks were changed yesterday 11/07/2024. the administrator stated the decision was made to improve supporting resident's rights of free movement and access to the patios.</p> <p>A record review of the facility's safe environment policy was requested on 11/08/2024 at 09:26 AM via email.</p> <p>A record review of the email dated 11/08/2024 time 09:31 authored by the administrator revealed, the policy was not provided.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure each resident received, and the facility provided food prepared in a form designed to meet individual needs for 1 of 8 residents (Resident #16) reviewed for mechanical soft diet needs.</p> <p>1. The facility failed to follow the physicians' orders and the Speech Language Pathologist's (SLP) recommendations for Resident #16's mechanical soft diet and served Resident #16 potato chips on 11/05/2024 for lunch.</p> <p>2. The facility failed to follow the physicians' orders and the Speech Language Pathologist's (SLP) recommendations for Resident #16's mechanical soft diet and served Resident #16 potato chips on 11/05/2024 for dinner.</p> <p>This failure could place residents at risk for harm by aspiration of food into the lungs due to swallowing difficulties.</p> <p>The findings included:</p> <p>A record review of Resident #16's admission record dated 11/05/2024, revealed an admitted [DATE] with diagnoses which included dysphagia oropharyngeal phase (swallowing difficulties), dementia (A group of symptoms that affects memory, thinking and interferes with daily life), and intellectual disabilities.</p> <p>A record review of Resident #16 quarterly MDS assessment dated [DATE] revealed Resident #16 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 10 out of a possible 15 which indicated moderate cognitive impairment. Resident # 16 was assessed with signs and symptoms of possible swallowing disorder coughing or choking during meals or when swallowing medications. And required a mechanically altered diet, require change in texture of foods or liquids.</p> <p>A record review of Resident #16's physicians orders dated 11/06/2024 revealed the physician ordered for Resident #16 to receive a regular diet with a mechanical soft texture, with thin liquids.</p> <p>A record review of Resident #16's care plan dated 11/06/2024 revealed Resident #16 was at risk for falls and had interventions for fall preventions, the resident needs a safe environment with: even floors free from spills and or clutter; adequate glare free light; . (Resident #16) has potential nutritional problem r/t (related to) dementia, dysphagia, GERD (gastroesophageal reflux disease) . provide serve diet as ordered</p> <p>A record review of Resident #16's SLP (Speech Language Pathologist) Recert, Progress, Report & Updated Therapy Plan dated 09/05/2024, revealed a new goal for Resident #16 as Patient will demonstrate ability to safely swallow mechanical safe foods and thin liquids using compensatory strategies in 95% of opportunities to maintain adequate nutrition / hydration.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident #16's lunch meal ticket dated 11/05/2024 revealed . Notes: Send only peanut butter and jelly sandwich and chips on plate; cottage cheese, dessert</p> <p>During an observation on 11/05/2024 at 12:16 PM revealed Resident #16 seated in the dining room and was served a lunch plate which included a peanut butter sandwich accompanied by potato chips. Continued observation revealed Resident #16 consumed the meal.</p> <p>During an interview on 11/05/2024 12:20 PM with the facility's SLP and the Dietician, the SLP stated she did not believe potato chips were consistent with a mechanical soft diet. The dietician disagreed and stated Resident #16 was fine with potato chips and bread.</p> <p>A record review of Resident #16's dinner meal ticket dated 11/05/2024 revealed . Notes: Send only egg salad sandwich and chips; cottage cheese, ice cream</p> <p>During an observation on 11/05/2024 at 05:46 PM revealed Resident #16 seated in the dining room and was served a dinner plate which included an egg salad sandwich accompanied by potato chips. Continued observation revealed Resident #16 consumed the meal.</p> <p>During an interview on 11/05/2024 at 05:50 PM the ADON E stated Resident #16 was served [potato chips and was assessed a needing a mechanical soft diet texture. The ADON E stated she needed to confirm if potato chips were consistent with a mechanical soft diet.</p> <p>During an interview on 11/08/2024 at 04:00 PM the DON stated she did not believe potato chips were consistent with a mechanical soft diet and would ask Resident #16's physician for a new SLP evaluation and potential swallow study. The DON stated the risk for a Resident with needs for a mechanical soft diet not receiving mechanical soft foods was aspiration and potential lung infections.</p> <p>A record review of the facility's Dental Soft (Mechanical Soft) Diet policy dated 2022 revealed, Indications for Use: The Dental Soft (Mechanical Soft) Diet is for individuals with limited or difficulty in chewing regular consistency foods. If a Mechanical Soft Diet is ordered, the Dental Soft (Mechanical Soft) Diet would be appropriate if there is a chewing/dentition problem. This diet may also be used by a Speech Language Pathologist (SLP) in the treatment of dysphagia with individualization per recommendations by the SLP. This diet may be used for those experiencing mouth irritation and dentition problems including lack of teeth or poor fitting dentures. Individualization for specific food tolerances is required. For individuals that have any swallowing problems or dysphagia, it is recommended that a SLP be consulted and one of the Dysphagia Level Diets may need to be implemented. General Principles & Guidelines: . 3. The diet consists of food of nearly regular textures but excludes very hard, sticky, crunchy or hard to chew foods. Foods should be moist and fork tender. 10. Hard crisp fried potatoes and potato skins are excluded. Food Guide: . not allowed: . Hard crisp fried potatoes</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44020</p> <p>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 observed.</p> <p>The facility failed to ensure dietary staff used proper hand hygiene during meal preparation.</p> <p>This failure could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <p>Observation on 11/07/2024 at 12:08 p.m. revealed the DA carried a bag of hamburger buns from the pantry, placed them on the counter, after she placed the bag down, pulled back plastic wrap from a sandwich on a plate reached up, grabbed a knife by the blade from the magnetic knife holder on the wall, cut the sandwich in half and then placed the plastic wrap back over the sandwich. The DA did not stop to remove gloves and wash her hands or change gloves.</p> <p>Observation on 11/07/2024 at 12:12 p.m. revealed the DA while wearing gloves she went into the pantry, brought back a loaf of bread, opened the bread removed the bread from the bag placed it on a plate, then got a slice of cheese from a zip lock bag, placed the cheese on the bread with her gloved hands and placed the sandwich on the griddle to grill the cheese sandwich. The DA did not stop to remove gloves and wash her hands or change gloves.</p> <p>Observation on 11/07/2024 at 12:16 p.m. revealed the DNS when the DA left kitchen to take items to dish room. The DNS reminded the DA to remove her gloves and wash her hands. The DA then removed her gloves, washed her hands and returned to the kitchen and put on new gloves.</p> <p>During an interview on 11/07/2024 at 1:42 p.m. the DA stated she should have washed her hands once she returned from the pantry and put on new gloves before taking the bread and cheese out to cook the sandwich. The DA stated by not washing her hands and changing her gloves it could cause cross contamination and could cause a resident to get sick. The DA further stated she had been trained on handwashing and cross contamination.</p> <p>During an interview on 11/07/2024 at 1:49 p.m. the DNS stated the DA should have removed her gloves and washed her hands after getting the bread from the pantry before preparing the sandwiches. The DNS further stated the staff had been trained on handwashing, cross contamination and the use of gloves. The DNS stated this practice could cause cross contamination and could cause a resident to get sick.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455762	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER San Antonio Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE One Heartland Dr San Antonio, TX 78247	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility's policy Dining Services Standards, revised 12/2022, read Policy: The facility staff will ensure the prevention of infection in the food service department to ensure the residents are provided with a positive meal experience, Procedure: A. Personnel: 4. Nutrition and Food Services personnel in direct contact with food will wear plastic or vinyl disposable gloves. Gloves should be removed upon leaving the work area and hand hygiene performed. Hand hygiene should be performed when returning to the work area and new gloves should be worn. Gloves should be changed, and hands washed with soap and water whenever the gloves are contaminated by touching potentially soiled surfaces such as cashier surfaces, floors, waste cans, cardboard boxes, etc.</p>