STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455817	A. Building B. Wing	06/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on record review, interview, and observation, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility for 1 of 3 residents (Resident #1) reviewed for discharge rights, in that: The facility failed to ensure Resident #1's legal guardian was sufficiently prepared and oriented for Resident #1's transfer to hospital. This failure could place residents at risk of being discharged without preparation, causing a disruption in their care and services and denying them a voice regarding their treatment plan. The findings were: Record review of Resident #1's admission record, dated 06/29/24, reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include dementia (loss of thinking, remembering, and reasoning skills), schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors). Record review of Resident #1's MDS assessment (Nursing Home Comprehensive), dated 04/25/24, reflected she had a BIMS score of 10 out of 15, indicating moderately impaired cognition. Record review of Resident #1's care plan, dated 06/29/24, reflected Resident #1 had impaired cognitive function/dementia or impaired thought processes [related to] schizophrenia, dementia, initiated 04/19/24, with an intervention [Resident #1[needs supervision/assistance with all decision making. Record review of Resident #1's Letter of Guardianship, dated 01/24/24, reflected [Guardianship Program] was appointed as guardian of Resident #1, an incapacitated person. There was no record of a written discharge/transfer notice for Resident #1's legal guardian. There was no record of the facility making efforts to get an accurate state of the resident's condition while he was in the hospital. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/28/24 at 09:03 PM, Resident #1's legal guardian revealed he was not aware Resident #1 was not resident at this nursing home facility anymore. He revealed he was not told Resident #1 was transferred to a hospital so he was unable to follow up with resident. When he came to visit the facility on 06/24/24 at 01:30 PM, he found Resident #1 was not in the facility. He revealed ADON A did not know Resident #1's whereabouts at this time. The legal guardian further revealed he was unable to locate resident and filed a missing person's report to the local Police Department on 06/26/24 at 10:30 AM. During an interview on 06/29/24 at 11:15 AM, the Administrator revealed Resident #1 was anticipated to return to the facility and there was no reason for the facility to not take this resident back. She revealed they had communication with the hospital and the case manager there was finding placement for Resident #1. The Administrator revealed she assumed the hospital was working with Resident #1's legal guardian to ensure the guardian knew where Resident #1 would be discharged to, from the hospital. She further revealed another nursing home facility accepted Resident #1 to be admitted to their facility. There was no documentation of any of these actions being done. During a record review, interview, and observation on 06/29/24 at 04:18 PM, Resident #1 was observed at a different nursing home facility. He revealed he did not remember anything about the facility he was prior to hospitalization . He revealed he did not have a legal guardian and he was responsible for himself. Record review of his admission record at this second nursing home facility reflected Resident #1 was his own responsible party with no mention of a legal guardian. During an interview on 06/29/24 at 04:55 PM, Resident #1's legal guardian revealed he was not notified Resident #1 was discharged to a hospital on 06/07/24. He revealed he would have followed up with Resident #1 at the hospital. He further revealed he was not notified Resident #1 was at another facility. During an interview and record review on 06/29/24 at 06:26 PM, ADON A confirmed she spoke to the legal guardian about Resident #1 discharging to a hospital on 06/07/24 at 09:15 PM (per a nursing progress note authored by ADON A). She revealed she sent the hospital all pertinent paperwork, including Resident #1's admission record that listed legal guardian's contact information. She further revealed she expected and assumed the hospital would contact the legal guardian and discharge residents appropriately. Record review of grievances since January 2024 revealed no grievances regarding discharges. Record Review of facility's policy, Transfer or Discharge, Facility-Initiated, dated October 2022, reflected Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer . and Notice of Facility Bed-Hold and return policies are provided to the resident and representative within 24 hours of emergency transfer. 4. If the facility determines that the resident cannot return to the facility, the medical record will indicate the facility made efforts to: b. ascertain an accurate status of the resident's condition, which can be accomplished via communication between hospital and facility staff and/or through visits by facility staff to the hospital.