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	01/10/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observations, interviews, and record review the facility failed to provide reasonable accommodation of resident needs and preferences for 3 of 37 residents (Residents #3, #6, and #8) reviewed for reasonable accommodations, in that: 1. Resident #3 had no access to her call light that was observed on the floor approximately four feet away from Resident #3. 2. Resident # 6 had no access to his call light that was observed on the floor behind the headboard of Resident #6's bed. 3. Resident #8 had no access to his call light that was observed on the floor approximately five feet away from Resident #8. This deficient practice could place residents not being able to use call lights for assistance in maintaining and/or achieving independent functioning, dignity, and well-being. Findings included: 1. Record review of Resident #3's undated face sheet revealed Resident #3 was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses that included anoxic brain damage (occurs when your brain loses oxygen and could cause serious, permanent brain damage), schizoaffective disorder (a chronic mental illness involving symptoms of schizophrenia and bipolar disorder and characterized by symptoms such as delusions, hallucinations, depression, and high-energy mood), bipolar disorder (a mental illness characterized by alternating periods of elation and depression), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities). Record review of Resident #3's quarterly MDS assessment, dated 11/26/2024, revealed a BIMS score of 5, indicating severe cognitive impairment. Section GG - Functional Abilities revealed Resident #2 required substantial to maximum assistance with toileting hygiene, bathing and dressing, and Resident #3 was dependent on staff for transfers. Section GG also revealed Resident #3 required partial to moderate assistance from staff for bed mobility. Section H- Bladder and Bowel revealed Resident #3 was always incontinent of bowel and bladder indicating Resident #1 would have required assistance from staff for incontinent care. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's comprehensive care plan revealed a care plan that stated, Resident will be treated with dignity and respect while at the facility, date initiated 09/11/2024. During an observation of Resident #3 on 01/08/2025 at 12:00 p.m., Resident #3 was lying in her bed asleep and Resident #3's call light was observed on the ground approximately four feet away from Resident #3 in front of her dresser. During an interview with PTA, 01/08/2025 at 12:02 p.m., PTA confirmed that he observed Resident #3's call light out of the reach of Resident #3. During an interview with CNA A on 01/08/2025 at 12:03 p.m., CNA A stated CNA A and CNA D were working B and C hall and stated resident call lights should be placed within reach of the resident when a resident was in their room. CNA A stated she had received training on call lights. CNA A stated she rounded on her patients at least every 2 hours. During an interview with CNA D on 01/08,2025 at 12:20 p.m., CNA D stated it was his second day working on the 1st floor and stated call lights should be within reach of the residents. He stated he made rounds during his shift by going up and down the halls checking on people and CNA D stated he had been answering call lights that morning when he was making rounds. During an interview with Resident #3 on 01/10/2025 at 2:50 p.m., Resident #3 stated that she used her call light to call for assistance and indicated that her call light was usually placed on her chest by pointing to her chest and stated here. 2. Record review of Resident #6's face sheet revealed Resident #6 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included lymphedema, (swelling due to the build-up of fluid in the body due to a problem with the lymphatic system, which is a network of tubes throughout the body that drains fluid), schizoaffective disorder (a chronic mental illness involving symptoms of schizophrenia and bipolar disorder and characterized by symptoms such as delusions, hallucinations, depression, and high-energy mood), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities). Record review of Resident #6's quarterly MDS assessment, dated 11/07/2024, revealed a BIMS score of 14, indicating no cognitive impairment. Section GG- Functional Abilities revealed Resident #6 was ambulatory and was independent with ADL's and transfers. Section H - Bladder and Bowel indicated Resident #6 had frequent bowel incontinence. Record review of Resident #6's comprehensive care plan revealed the following care plans: 1) [Resident #6] is at risk for falls r/t medications, occasional incontinence, insomnia, impaired cognition-schizophrenia, psych meds and psychosis, date initiated 03/15/2023. An intervention listed was be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance, date initiated 06/12/2021. 2) [Resident #6] has an ADL self-care performance deficit medication, psychological dx and needs set up to limited assist at times, date initiated 06/12/2021. An intervention listed was encourage the resident to use bell to call for assistance, date initiated 06/12/2021. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with Resident #6 on 01/08/2025 at 12:35 p.m., Resident #6's was observed sitting on the side of his bed eating lunch and Resident #6's call light was observed to be on the floor behind the head of Resident #6's bed. Resident #6 stated he did not place the call light behind his bed and stated staff usually place his call light on his bed. Resident #6 stated he did use his call light at times to call for assistance and stated he could not reach his call light from his seated position while eating lunch. 3. Record review of Resident #8's undated face sheet revealed Resident #8 was an [AGE] year old male who had an initial admitted [DATE], admitted [DATE], and admitted with diagnoses that included senile degeneration of brain (a term used to describe a cognitive decline, memory loss and difficulty learning, and problem solving in older adults), Alzheimer's disease (a progressive disease that affects memory and other important mental functions), legal blindness (a specific level of visual impairment that includes both people who are totally blind and those who have some vision but with significant limitations), depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities), and disorganized schizophrenia (disorganization of thought processes, behavior, and emotions). Record review of Resident #8's quarterly MDS assessment, dated 12/09/2024, revealed a BIMS score of 02, which indicated the resident was severely cognitively impaired. Section B- Hearing, Speech, and Vision revealed Resident #8 was sometimes able to make himself understood and express his ideas and wants and sometimes able to understand others. Section B also revealed Resident #8 had severely impaired vision. Section GG - Functional Abilities revealed Resident #8 required partial/moderate assistance with bathing and dressing and required supervision or touching assistance with bed mobility and transfers. Section H -Bladder and Bowel revealed Resident #8 was frequently incontinent of his bowel and bladder indicating Resident #8 would require staff assistance with incontinent care. Record review of Resident #8's comprehensive care plan revealed the following care plans: 1. [Resident #8] has an ADL self-care performance deficit r/t cognition and blindness, dated initiated 9/19/2017 and revised 6/07/2021. An intervention listed was encourage the resident to use bell to call for assistance, dated initiated 6/07/2021 and revised 6/15/2023. 2. [Resident #8 is at risk for falls r/t blindness, incontinence, medications, unsteady gait, and Parkinson's, date initiated 6/07/2021 and revised 9/09/2021. An intervention listed was be sure the resident's call light is within reach and encourage the resident to use it to call for assistance as needed. The resident needs prompt response to all requests for assistance, date initiated 6/07/2021. During an observation on 01/08/2025 at 1:16 p.m., Resident #8 was observed lying in bed asleep and Resident #8's call light was observed lying on the floor underneath a wheelchair approximately five feet away from Resident #8's bed. During an interview with RN C on 01/08/2025 at 2:35 p.m., RN C stated he was the Charge Nurse on the first floor and stated, I educate my staff about keeping the call lights in reach at all times. During an interview with the Administrator on 01/10/2025 at 1:48 p.m., the Administrator stated call lights should have been within reach of a resident when the resident was in their room. He stated it was important for the call light to be in reach so the resident can access the light whenever they need to meet their needs. The Administrator stated the facility staff had received training on call light placement and would receive additional training during an in-service scheduled for 1/17/2025. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 01/10/2025 at 2:28 p.m., the DON stated she ensured call lights were in reach of facility residents by rounding and made sure call lights were attached to the resident bed or wheelchair. The DON stated the call light should have been in reach of each resident and it was important for the call light to be in reach so the resident could call for help when needed. The DON stated when she started in her role 2 weeks ago, the DON rounded with staff in resident rooms to demonstrate observations each staff member should have made when rounding in rooms and that included call light placement. The DON also stated call light placement was a part of the skills competency check off trainings completed by direct care staff. Record review of a facility policy titled Call System, Resident, MED-PASS, Inc. (September 2022), revealed a policy heading that stated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Listed under, Policy Interpretation and Implementation, the policy stated, 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observations, interviews, and record review the facility failed to ensure residents had the right to personal privacy during personal care for 1 of 3 residents (Resident #3) reviewed for privacy, in that: CNA E and CNA J did not maintain privacy while providing incontinent care for Resident #3. This failure could place residents who require assistance with incontinent care at risk of being exposed. Findings included: Record review of Resident #3's undated face sheet revealed Resident #3 was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses that included anoxic brain damage (occurs when your brain loses oxygen and could cause serious, permanent brain damage), schizoaffective disorder (a chronic mental illness involving symptoms of schizophrenia and bipolar disorder and characterized by symptoms such as delusions, hallucinations, depression, and high-energy mood), bipolar disorder (a mental illness characterized by alternating periods of elation and depression), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities). Record review of Resident #3's quarterly MDS assessment, dated 11/26/2024, revealed a BIMS score of 5, indicating severe cognitive impairment. Section GG - Functional Abilities revealed Resident #2 required substantial to maximum assistance with toileting hygiene, bathing and dressing, and Resident #3 was dependent on staff for transfers. Section H- Bladder and Bowel revealed Resident #3 was always incontinent of bowel and bladder. Record review of Resident #3's comprehensive care plan revealed a care plan that stated, Resident will be treated with dignity and respect while at the facility, date initiated 09/11/2024. During an observation by Surveyor L on 01/09/2025 at 1:40 p.m., Surveyor L observed incontinent care provided to Resident #3 by CNA J and CNA E. Resident #3 was observed lying in the middle bed, Bed B, of a room with 3 residents. CNA J and CNA E were observed pulling the privacy curtain closed for bed A and for bed C to provide privacy for Resident #3 from her roommates. Surveyor L observed that Resident #3 did not have a privacy curtain on the track above her bed that would have provided Resident #3 privacy if a person opened Resident #3's bedroom door during care. During an interview with CNA J on 01/09/2025 at 2:01 p.m., CNA J told Surveyor L that CNA E made sure the other curtains were closed all the way during incontinent care and stated there was no curtain available for Resident #3. During an interview with CNA E on 01/09/2025 at 2:02 p.m., CNA E told Surveyor L that the windows and privacy curtains should be closed when providing incontinent care to residents. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Housekeeping Director on 01/09/2025 at 2:43 p.m., the Housekeeping Director told Surveyor K that he ordered privacy curtains and stated every resident room and bed should have a privacy curtain. The Housekeeping Director stated he made rounds daily to make sure privacy curtains were in place. The Housekeeping Director and Surveyor K entered Resident #3's room on 01/09/2025 at 2:46 p.m. , and the Housekeeping Director observed Resident #3's privacy curtain was missing and stated, I have been trying to order more hooks for the track. The Housekeeping Director stated the curtain had been down for about a month. The Housekeeping Director stated he would check the housekeeping and maintenance work order system to see if there was a work order for the missing privacy curtain. The Housekeeping Director stated it was important for each resident to have a privacy curtain to maintain their privacy. During an interview with the Housekeeping Director on 01/09/2025 at 3:15 p.m., the Housekeeping Director provided a work order and stated, based on the work order, the privacy curtain had been missing from Resident #3's bed since 2022. He stated, if anyone would have told me I would have added it and stated he had the parts and was going to install the privacy curtain. During an interview with the Administrator on 01/10/2025 at 1:48 p.m., the Administrator stated each resident should have a privacy curtain and the privacy curtain should be used to provide privacy to the resident during care and at the resident's request. The Administrator stated the use of privacy curtains were important so the residents felt dignified in their personal care and space and stated staff were trained on privacy during new hire orientation, competency checks, and resident rights training. During an interview with the DON on 01/10/2025 at 2:28 p.m., the DON stated the expectation for staff was to use the resident privacy curtain when providing incontinent care and the staff should have reported any issues with the privacy curtain to the Housekeeping Director. The DON stated it was important that each resident had a privacy curtain because we can provide the resident privacy during any treatment or care and so they have a curtain to close if they want the privacy in their own space. The DON stated staff were trained on resident privacy. During an interview with Resident #3 on 01/10/2025 at 2:50 p.m., Resident #3 stated she was happy with her new privacy curtain. Record review of a facility document titled CNA/Nurse Aide Orientation/Annual Sills Competency Checklist revealed a Skill/Task listed on the competency check off that stated Promotes and protects participant's dignity and privacy (knocks on doors, pulls curtains during care, and speaks respectfully to participants). Record review of a facility policy titled Resident Rights, 2001 MED-PASS, Inc. (Revised February 2021), revealed a policy statement that stated, Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation stated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; t. privacy and confidentiality. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Dignity, 2001 MED-PASS, Inc. (Revised February 2021), revealed a policy statement that stated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation stated, 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interviews, observations, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 11 residents (Resident #1) reviewed for accuracy of records, in that: The facility failed to ensure the treatment administration records (TAR) for Resident #1 accurately reflected the administration of the bilateral wound treatment on 01/03/2025 and 01/07/2025. This deficient practice could place residents receiving treatments at risk for not receiving appropriate care. The findings were: Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included congestive heart failure (a condition in which the heart doesn't pump blood as well as it should), type 2 diabetes (a condition that occurs when the body does not regulate or use sugar properly), bipolar disorder (a mental illness characterized by alternating periods of elation and depression), and lymphedema (swelling due to the build-up of fluid in the body due to a problem with the lymphatic system, which is a network of tubes throughout the body that drains fluid). Record review of Resident #1's annual MDS assessment, dated 12/15/2024, revealed a BIMS score of 14, Indicating no cognitive impairment. Section C - Cognitive Patterns revealed Resident #1 had difficulty focusing attention and had disorganized thinking, defined on the MDS as rambling or irrelevant conversation, unclear or illogical flow of ideas or unpredictable switching from subject to subject, and that these symptoms fluctuated in severity. Section E- Behavior revealed Resident #1 rejected care (e.g., bloodwork, taking medications, ADL assistance) 4 to 6 days a week. Section GG - Functional Abilities revealed Resident #1 used a wheelchair for mobility and had impaired range of motion on both sides of her lower extremities. Section GG also revealed Resident #1 was dependent on staff assistance for toileting, lower body dressing, putting on or taking off footwear, and chair/bed to chair transfers. Record review of Resident #1's comprehensive care plan revealed the following care plans [Resident #1] is at risk for pressure injuries due to impaired mobility, morbid obesity, dated 04/05/2023 and revised 04/29/2023. Altered skin integrity non pressure related to: BLE vascular wounds, dated 04/07/2023 and revised 05/04/2024. [Resident #1] has a behavior problem. She will refuse wound tx, refuse weekly wound measurements, refuse ADL assistance, say derogatory terms to staff, argue with roommate, dated 04/29/2023 and revised 09/09/2024. Altered skin integrity non pressure related to: vascular wound Lt lower leg circumferential, dated 07/24/2023 and revised 12/24/2024. Altered skin integrity non pressure related to: vascular wounds Rt lower leg circumferential, dated 07/24/2023 and revised 12/24/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 01/08/2025 at 10:49 a.m., of Resident #1's December TAR revealed the following orders scheduled for 6 a.m. to: A) Wound #1 right lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/10/2024. The TAR was initialed by the Wound Care LVN as completed on 12/24/2024 and coded 3- refused and initialed by the Wound Care LVN on 12/27/2024. B) Wound #1 left lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/10/2024. The TAR was initialed by the Wound Care LVN as completed on 12/24/2024 and coded 3- refused and initialed by the Wound Care LVN on 12/27/2024. The TAR revealed the following orders scheduled PRN: A) Wound #1 right lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/09/2024. The TAR revealed Resident #1 received a prn treatment, 12/23/2024 at 5:42 p.m. by Wound Care LVN. B) Wound #1 left lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/09/2024. The TAR revealed Resident #1 received a prn treatment, 12/23/2024 at 5:42 p.m. by Wound Care LVN. Record review, on 01/08/2025 at 10:49 a.m., of Resident #1's January TAR revealed the following orders scheduled for 6 a.m. to: A) Wound #1 right lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/10/2024. The TAR was not initialed by a nurse as completed on 01/03/2025 and 01/07/2025. B) Wound #1 left lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/10/2024. The TAR was not initialed by a nurse as completed on 01/03/2025 and 01/07/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review, on 01/09/2025 at 11:45 a.m., of Resident #1's January TAR revealed the following orders scheduled for 6 a.m. to: A) Wound #1 right lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/10/2024. The TAR is initialed as completed on 01/03/2024 and initialed with '19-other see progress note' by Wound Care LVN. B) Wound #1 left lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/10/2024. The TAR is initialed as completed on 01/03/2024 and initialed with '19-other see progress note' by Wound Care LVN. The TAR revealed the following orders scheduled PRN: A) Wound #1 right lower leg circumferential cleanse with wound cleanser, pat dry and appl zinc cream to the entire leg. Gauze may weave between toes and cap toes. Use ABD pad, Kerlix to heel. Compression wrap to the affected leg to apply compression wrap from the base of the toes to 2 finger length below the knee covering the heel. Every day shift every Tue, Fri for wound care, start date 12/09/2024. The TAR revealed Resident #1 received a prn treatment, 01/08/2024 at 12:35 a.m. by RN C. Record review of the facility wound care log, dated 01/03/2025, revealed Resident #1 had a venous wound to the right lower circumferential and a venous wound to the left lower circumferential. The log revealed Resident #1 admitted with the wounds on 12/22/2023 and the wounds measured 45 x 35 x 0.2cm. Record review of Resident #1's progress note, 12/27/2024 at 3:21 p.m. by Wound Care LVN, stated resident refused wound care. [physician group name] RN notified. No new orders. During an observation on 01/08/2025 at 11:25 a.m., Resident #1 was observed lying in bed with bilateral lower legs wrapped in compression wraps and toes were wrapped in gauze. The wraps and gauze were clean and intact and dated 01/08/2025 at 12:35 a.m. During an interview with RN B on 01/08/2025 at 2:20 p.m., RN B stated she worked with Resident #1 on the overnight shift of 01/07/2025. RN B stated RN C completed Resident #1's wound care and RN B stated she did not see the dates on Resident #1's bilateral dressings prior to RN C completing Resident #1's wound care. RN B stated Resident #1 refused care and refused for wound care to be completed at times but did allow RN C to complete wound care on the overnight shift on 01/07/2025. (continued on next page)

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	01/10/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN C on 01/08/2025 at 2:35 p.m., RN C stated he completed Resident #1's wound care on 01/08/2025 around 12:30 a.m. RN C stated he did Resident #1's wound care if Resident #1 refused wound care earlier in the day and was told by Wound Care LVN that Resident #1 had refused wound care during the day shift. RN C stated he did not document that he completed the wound care on the TAR. He stated he texted Wound Care LVN to notify the Wound Care LVN the wound care was completed and Wound Care LVN would document on Resident #1's TAR. RN C stated the TAR was only managed by the Wound Care LVN and RN C did not document on the TAR. RN C stated he can view the TAR to follow the treatment order and was notified when a treatment needed to be completed by the Wound Care LVN. RN C stated he did not pay attention to the date of the previous bandage on Resident #1's bilateral legs when he completed the treatment on 01/08/2025. He stated he could not remember the last time he was asked to complete Resident #1's wound care but stated her wounds looked the same in appearance as he had observed in previous observations. During an interview with Resident #1 on 01/09/2025 at 8:05 a.m., Resident #1 stated RN C completed Resident #1's bilateral leg treatments overnight on 01/08/2025. Resident #1 stated the Wound Care LVN would usually complete her dressing changes on Tuesdays and Fridays, but sometimes RN C will do it. Resident #1 stated she did not think her wound care had been completed since 12/23/2024 and stated, that is the date I remember Wound Care LVN doing it. Resident #1 denied refusing wound care or refusing dressing changes. Resident #1 stated she has had the bilateral venous wounds since 2008 and Resident #1 stated she had refused to be seen by the wound care physician at the facility for several months. During an interview with the Wound Care LVN on 01/09/2025 at 11:50 a.m., the Wound Care LVN stated she was responsible for providing wound care to Resident #1 and if she was not able to complete the wound care, Resident #1 refused or Wound Care LVN was not scheduled to work, Wound Care LVN would assign a nurse to complete wound care. Wound Care LVN stated she attempted to complete wound care on Resident #1 on 01/07/2025 in the afternoon and stated Resident #1 said she was not ready and did not want Wound Care LVN completing the wound care at that time. Wound Care LVN asked Resident #1 if RN C could do the wound care for Resident #1 later in the day and Resident #1 agreed. Wound Care LVN stated RN C let her know the following day that the wound care was completed and Wound Care LVN initialed 01/07/2025 with a 19- other see progress note and Wound Care LVN stated she added a late entry progress to document that she had asked RN C to complete the wound care. Wound Care LVN stated she educated RN C to document the treatment RN C completed on Resident #1's TAR on the prn orders for the bilateral wound care for 01/08/2025. Wound LVN C stated she also initialed Resident #1's TAR for bilateral wound care as completed on 01/03/2025 because I noticed I had not signed off on the TAR. Wound Care LVN stated Resident #1's bilateral venous wound measurements remain at 45 x 35 x 0.2 cm. Wound Care LVN stated she knew she completed the wound care because she would have entered a progress note for the refusal if Resident #1 had refused the treatment. She stated she had written it down in her personal notes and stated the wound size had not changed. Wound Care LVN stated she had been trained on documenting wound care in the TAR at the time of the wound care and stated it was important to document the treatments at the time they were completed to make sure the treatments are done and report any changes in a timely manner. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 01/10/2025 at 2:28 p.m., the DON stated missing documentation on the TAR was monitored by nursing managers who run a missing documentation report daily. The DON stated she ran the report on 01/08/2025 after having a conversation with RN C about RN C not documenting Resident #1's treatment on Resident #1's TAR. The DON stated RN C and Wound Care LVN were provided reeducation on 01/08/2025 regarding documentation of treatments on the TAR and documentation of treatments would be completed at the time the wound care was provided. The DON stated she reviewed Resident #1's January TAR with Wound Care LVN and stated Wound Care LVN stated she had completed the treatment on 01/03/2025. The DON stated documentation of wound care should occur right after the treatment has been completed and stated it was important to document timely because we are able to show that the treatment was done or that the treatment was refused and so the physician can see if the treatment is effective for the benefit of the patient. Record review of a facility document titled Licensed Nurse Orientation/Annual Skills/Competency Checklist for Wound Care LVN, dated 2/14/2024, revealed Wound Care LVN successfully completed Skill/Task #10. Review shift documentation process, requirements of obtaining physician orders (dx, location, parameters, monitoring, dose, freq, medication times, entering onto MAR/TAR, etc.). Record review of a facility document titled Competency Assessment Wound Care, signed by Wound Care LVN listed the date completed as 10/2024. The competency assessment revealed check marks indicating the competency had been demonstrated by Wound Care LVN for E. Documentation. The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any changes in resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason (s) why. 10. The signature and title of the person recording the data. Record review of a facility policy titled Wound Care, 2001 Med-Pass, Inc. Revised October 2010, under the section labeled, Documentation, the policy stated The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound car was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any changes in resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerates the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason (s) why. 10. The signature and title of the person recording the data.