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	05/23/2025

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 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** Based on interview, and record review, the facility failed to ensure resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 6 residents (Resident #2) reviewed for incontinent care. The facility failed to ensure Resident #2 was not left sitting in urine in a chair in the dining room on the evening of 05/18/2025. This failure could place residents at risk of skin breakdown and infection. Findings include: Record review of Resident #2's admission Record dated 05/23/2025 revealed she was admitted [DATE] with diagnoses which included: Moderate Intellectual Disability (a condition that limits intelligence, defined as IQ between 36-51 and disrupts ability necessary for independent living) and Anxiety Disorder (a group of mental health conditions that cause fear, dread and other symptoms that our out of proportion to the situation). Record review of Resident #2's admission and baseline care plan dated 05/16/2025 revealed diagnoses of Moderate Intellectual Disability and Anxiety Disorder, and she was assessed as being disoriented x3 at all times and of having communication concerns relating to difficulty understanding others and difficulty being understood. She was also assessed as being continent of bowel and bladder. Record review of Resident #2's Nursing note dated 05/18/2025 at 8:47 p.m. by RN -B revealed: family members visited resident. resident was in the dining hall. resident was wet with urine on the floor. family was upset how they found resident. nurse told cna to clean and change resident . (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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telephone interview on 05/21/2025 at 10:45 a.m. with Family Member #1 revealed Resident #2 was admitted to the facility on [DATE] and she and another family member went to visit her Sunday evening 05/18/2025. She stated when she arrived at the facility about 7:30p.m. that evening, Resident #2 was not in her room, so she started looking for her everywhere and found her in the TV room, sitting on a chair, with a table in front of her and a male staff member sitting nearby working on a computer. She stated she saw a big puddle of liquid on floor under Resident #2's chair with a white blanket on the floor. Family Member #1 stated she asked the male staff if that was water or urine on the floor under Resident #2's chair, and if she had urinated on herself. She stated she asked how long Resident #2 had been sitting wet like that, and the male staff person never answered her questions, only looked up and told her they would clean her up. She stated a CNA arrived a few minutes later to help change Resident #2. Family member #1 stated when Resident #2 was assisted to stand up, they noticed a balled up wet diaper around her ankle, and noted she was wearing pants. Family Member #1 stated she asked to speak to the Charge Nurse and was told that the male staff member that had been working on the computer in the dining room was the Charge Nurse. Record review of the facility Nursing Schedule for 05/18/2025 revealed that for the 2p-10p shift on the second floor, RN-B was the only male Nurse scheduled. During a telephone interview with RN -B on 05/22/2025 at 4:02 p.m., RN-B stated that on that Sunday evening, 05/18/2025 around 9:30 p.m., Resident #2 was sitting in a chair in the dining room, when her family came in and found her sitting on the chair with a puddle of urine on the floor under her. RN-B stated the family was upset to find her wet, and he asked the CNA to clean and change her. RN-B stated that when the family arrived, the CNA was doing check and change, and he had been checking blood sugars, giving medications, but was charting in the dining room when the family came in. RN-B stated he did not know how long Resident #2 had been sitting there wet and asked the CNA to change her as soon as the family brought it to his attention. Interview with CNA-C on 05/22/2025 at 4:51 p.m. revealed she was the CNA assigned to Resident #2 on the evening of 05/18/2025 and was in the process of check and change and getting all the residents ready for bed when Resident #2's family arrived awhile after dinner, and the family told her they found Resident #2 in the dining room sitting at the dining table wet. CNA-C stated she had last changed Resident #2 just prior to the evening meal and had assisted her to the dining room for her meal. CNA-C stated she did not work with Resident #2 after that until asked to clean and change her after the family arrived. She stated she did not know why Resident #2 was still in the dining room at that time, and stated she goes room to room working her way down the hallway after dinner performing check and change, and the dining room is at the end of the hallway. CNA-C stated Resident #2's pants were wet in the groin area, and she cleaned her with periwipes and changed her brief and clothes. Interview on 05/23/2025 at 2:31 p.m. with LVN-D, revealed she was the Admitting Nurse for Resident #2, and had completed Resident #2's admission and Baseline Care Plan Summary. LVN-D stated Resident #2 had an intellectual disability, spoke only Spanish and needed cueing to do tasks. LVN-D stated Resident #2 was continent, but needed cues, or reminders to use the toilet. (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 interview with the DON on 05/23/2025 at 3:11 p.m., the DON stated she was aware of the incident on 05/18/2025, and that she had spoken with RN-B on the night of the incident, and he had told her he was passing medications when the family arrived and found her sitting in urine. The DON stated it was not acceptable for Resident #2 to be sitting in urine, and in this instance, the expectation was for staff, if they were working with another resident, to finish with that resident then go and clean and change Resident #2, but if the RN was charting, the expectation would be for him to stop charting and immediately clean and change the resident sitting in urine. Record review of the facility policy titled Activities of Daily Living (ADL's), Supporting dated Qtr. 3, 2018, revealed Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Further review revealed Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care); .elimination (toileting) .

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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** Based on observations, interviews and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, maintaining medical records on each resident that are complete and accurately documented for 1 of 2 residents (Residents #1) reviewed for clinical records. The facility failed to ensure Resident #1's completion or refusal of prescribed wound care was accurately documented on her Treatment Administration Record (TAR) for 4 (4/11/2025, 4/18/2025, 4/29/2025 and 5/2/2025) of 14 treatment days between 04/01/2025 through 05/20/2025. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. Findings included: Record review of Resident #1's admission Record, dated 05/20/2025, revealed she was initially admitted on [DATE] and re-admitted on [DATE], with diagnoses which included: Chronic Systolic (congestive) Heart Failure (chronic condition where heart does not pump as well as it should); Type 2 Diabetes Mellitus with Diabetic Neuropathy (nerve damage caused by consistently high blood sugar levels); Lymphedema (swelling, most often in arm or leg caused by a lymphatic system blockage); and Peripheral Vascular Disease (condition where narrowed blood vessels reduce blood flow to limbs). 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 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 Care Plan revealed a focus area initiated 04/07/2023 for Altered skin integrity non pressure related to : BLE Vascular Wounds .frequent fungal infections, pruritis [irritating sensation that creates an urge to scratch] and dry skin with interventions which included Treatment as ordered. Record review of Resident #1's Order Summary Report for Active Orders as of 05/20/2025 revealed the following order: BLE-Cleanse with normal saline, pat dry, apply lotrisone cream [topical medication that combines an antifungal with a corticosteroid used to treat fungal skin infections], wrap with kerlix [brand of bulky gauze rolls used for wound care and bandaging], and wrap with ace bandage twice weekly and PRN until resolved every day shift every Tue, Fri. Record review of Resident #1's April and May 2025 Nurse Treatment Administration Records (TAR) revealed blanks which indicated the TAR was not initialed by a nurse as completed on the following designated wound care treatment dates: 4/11/2025, 4/18/2025, 4/29/2025 and 5/2/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #1 on 05/20/2025 at 10:28 a.m. revealed she was lying in a bariatric bed, and had both lower legs dressed (wrapped in ace wrap with visible gauze bandage underneath). The dressing on her right leg was dated 05/16/2025 and had the initials corresponding to LVN-A written next to the date. Resident #1 stated that she is supposed to receive wound care on Tuesdays and Fridays, but stated it wasn't always done when it was supposed to be done. She pointed to the label on her right leg dressing which documented a date of 05/16/2025 to show when was the last time her dressings were changed. This date indicated that her dressing had been changed that previous Friday, so would be due again today. Interview on 05/20/2025 at 12:50 p.m. with the DON revealed that the Treatment nurse was on leave today, so another Nurse attempted to provide wound care to Resident #1, but she refused. During an interview with Resident #1 on 05/20/2025 at 1:03 p.m., Resident #1 stated she wanted to have the wound care done the next morning to give them time to get all the supplies together. During an interview with LVN-A on 05/21/2025 at 03:58 p.m., LVN-A stated she was the Treatment Nurse and stated that Resident #1's TAR did contain blanks on 4/11/2025, 4/18/2025, 4/29/2025 and 5/2/2025. She stated Resident #1's orders were to receive prescribed wound care treatment on Tuesdays and Fridays. LVN-A stated she always completes Resident #1's wound care as ordered when she was at the facility, and that the blanks were due to either she was not at facility on those dates, or she did the treatment but forgot to document on the TAR. LVN-A stated if she was not available, then one of the Floor Nurses were supposed to provide the treatment. LVN-A stated that Resident #1 will often refuse or not let other Nurses do her wound care in her absence. In that case, the Nurse should document the refusal on the TAR. LVN-A stated that if treatment is not documented on the TAR, it would look like the treatment had not been done, and stated she needed to improve the accuracy and completion of her documentation. During an interview with the DON on 05/23/2025 at 1:20 p.m., the DON verified the presence of blanks on Resident #1's April and May 2025 TAR, and stated that if Resident #1 had refused treatment, that should be documented on the TAR with the correct code of 3, and that if wound care treatment was provided, it needed to be documented on the TAR. She stated that not documenting correctly on the TAR could be interpreted as the treatment was not done and it would make it hard to track how often she refused treatment. Record review of a facility policy titled Wound Care, dated Qtr 3, 2021, under the section labeled, Documentation, the policy stated The following information may be recorded in the resident's medical record, if applicable: 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 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.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 1 Maintenance and Housekeeping Office reviewed, in that: The Maintenance and Housekeeping Office, in which were stored tools and cleaning equipment, was observed with the door ajar and no staff in attendance. This deficient practice could result in residents, staff, or the public coming into contact with tools and cleaning equipment that were unsafe. The findings were: Observation on 05/21/2025 at 9:15 a.m. revealed the Maintenance and Housekeeping Office was located on the facility's second floor, was the first room of a hallway with resident room, was adjacent from the nurses' desk, and across the hall from a resident room. Further observation revealed the office door was ajar and no staff were in the office. Further observation revealed Housekeeper E was in the hallway between the Maintenance and Housekeeping Office and a resident's room. During an interview with Housekeeper E on 05/21/2025 at 9:15 a.m., Housekeeper E confirmed the office was unlocked and the door was ajar. She stated that the office was usually kept locked because it contained tools and cleaning equipment which were potentially unsafe for residents to handle. During an interview with the Maintenance Director on 05/21/2025 at 11:30 a.m., the Maintenance Director confirmed he had left the Maintenance and Housekeeping Office open and unattended. He stated that he had seen Housekeeper E in the hallway outside the office and believed it was safe to leave the office open due to her presence. The Maintenance Director confirmed that the office contained tools and cleaning equipment which were potentially unsafe for residents to handle. During an interview with the DON on 05/23/2025 at 3:30 p.m. the DON stated that her expectation was for the Maintenance and Housekeeping Office to be secured at all times when not in use by staff. The DON confirmed that was was potentially unsafe for residents to have access to tools and cleaning supplies. Record review of the facility policy, Hazardous Areas, Devices, and Equipment, revised July 2017, revealed, All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible.