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	07/31/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for two of seven residents (Resident # 41 and Resident #2) reviewed for privacy. 1.The facility failed to ensure MA B locked the computer, after he walked away and left the computer unattended, which exposed Resident #41's morning medication list. 2. The facility failed to ensure the privacy curtains in Resident #2's room were able to completely close around his bed to provide Resident #2 privacy during wound care. These failures could place residents at risk of having medical information exposed to others and of loss of personal privacy, causing residents to feel uncomfortable and disrespected. The findings include: 1.Record review of Resident # 41's face sheet dated 07/30/25 revealed an [AGE] year-old male admitted to the facility on [DATE]. Resident # 41 had diagnoses that included: Schizophrenia (is a severe and chronic mental disorder characterized by disruptions in thought processes, perceptions, emotional responses, and social interactions) , Chronic obstructive pulmonary disease (is a progressive lung disease characterized by persistent airflow limitation, making it difficult to breathe) and Anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness). Record review of Resident # 41's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 99 which indicated Resident # 41 was unable to complete the interview. Observation on 07/30/25 at 8:48 am, revealed that MA B prepared Resident's # 41's morning medication, walked away from the computer and did not lock the screen. During an interview on 07/30/25 at 8:55 am, MA B mentioned that he was not trained to lock the computer screen and believed that minimizing the screen was enough. He acknowledged that when he stepped away from the computer, Resident #41's private medical information may have been exposed. During an interview on 07/30/25 at 10:30 AM, the DON stated that she was not aware Resident #41's records were left open and unattended by MA B. The DON mentioned that it was her expectation for the facility nursing staff to uphold HIPAA (health insurance portability and accountability act) regulations and lock computer screens when they were away from them. She emphasized that all staff members were responsible for protecting residents' information. The DON stated leaving residents' electronic medical records unattended could lead to unauthorized access. Record review of the facility policy titled HIPAA Security Measures , 2005, revealed . All work stations that access electronic health information will have restricted access. 2. Record review of Resident #2's admission Record dated 07/30/2025 revealed he was a [AGE] year-old man with an admission date of 06/27/2025, and with diagnoses which included: Metabolic Encephalopathy (brain dysfunction resulting from systemic illness or organ problems causing chemical imbalances in the blood); and (Type 2 Diabetes Mellitus (chronic condition resulting in persistently high blood sugar levels) with foot ulcer (wound on foot). Record review of Resident #2's admission MDS dated [DATE] revealed he was unable to complete the Brief Interview for Mental Status and was assessed as having an unstageable pressure injury presenting as deep tissue injury, present upon admission. Record review of Resident #2's Order Summary dated 07/30/2025 revealed an order for R heel - Cleanse with normal saline or wound cleanser, pat dry, apply anasept [broad-spectrum antimicrobial gel] and collagen mixture, apply calcium alginate [type of special absorption dressing used for wounds], cover with dry protective dressing daily and PRN until resolved every day shift. Record review of Resident #2's Care Plan initiated 06/27/2025 revealed Focus areas that included:-risk for alteration in blood glucose due to diabetes mellitus-will be treated with dignity and respect while at the facility, which included a goal will have the right to privacy-has pressure ulcer to right heel - admitted with deep tissue injury. Observation on 07/30/2025 at 3:10 p.m. of wound care for Resident #2, revealed LVN-C attempted, but was not able to completely close the privacy curtain in front of Resident #2's bed, as the privacy curtain was tangled in the rungs where it hung from the ceiling, and would not completely extend the distance needed to block visual view from the door to middle curtain which divided the room. LVN-C positioned the curtain directly in front of the foot of his bed, covering the width of the bed, which left an approximately 2-foot opening between the curtains and entry door, and curtains to midline dividing curtains. Resident #2's roommate was also in room, on other side of the midline privacy curtain. LVN-C covered Resident #2's upper body and legs with a sheet, but Resident #2 pulled it off, exposing his incontinent briefs, which could have been seen by his roommate or anyone entering the room. During an interview on 07/30/2025 at 3: 41 p.m., LVN-C stated she was not able to completely close Resident #2's privacy curtain while providing wound care treatment to his right heel

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents had a right to a safe, clean, comfortable, and homelike environment for 2 (Residents #52 and #87) of 30 residents reviewed, in that: 1. The bathroom door facing the interior of the bathroom used by Resident #52 had scrape marks and the lower section of the door was unpainted. 2. The entrance to the bathroom used by Resident #87 had a 3inch rust area on the left door post and the toilet was not secured to the floor base. These failures could result in residents not having a safe, clean, homelike environment which could result in low self esteem and a diminished quality of life. The findings included:1. Record review of Resident #52's face sheet, dated 7/29/25, revealed the [AGE] year resident was originally admitted to the facility on [DATE] with diagnoses including: expressive language disorder(a condition that affects a person's ability to use language), essential hypertension(a condition characterized by high blood pressure), and dysphagia(a condition in which it is difficult to swallow). Record review of Resident #52's Quarterly MDS, initiated on 6/6/25, revealed a BIMS score of 0 which indicated severe cognitive impairment. Record review of Resident #52's's care plan, initiated 09/21/23, revealed resident had plan for long term care stay at the facility. 2. Record review of Resident #87's face sheet dated 7/29/25, revealed the [AGE] year old resident was originally admitted on [DATE] with diagnoses including: alcoholic cirrhosis of the liver(a condition in which the liver damage is related to alcohol use), unspecified protein-calorie malnutrition(a condition in which there is not enough protein and calories in the diet), and chronic pulmonary edema(a condition in which the lungs have fluids built up). Record review of Resident #87's Quarterly MDS, initiated on 6/27/25, revealed a BIMS score of 10 which indicated moderate intact cognition. Record review of Resident #87's care plan, initiated 5/3/24, revealed resident had plan for long term stay at the facility. Observation on 07/28/25 at 1:25 pm for Resident #52 revealed the lower third of the interior facing bathroom door was unpainted with multiple scratch mark on the door surface. Observation on 7/28/25 at 2:00pm for Resident# 87 revealed that the left side of the bathroom door entry post had an approximate 3 inch area of rust on the door entry surface. The toilet used by Resident #87 was not secured to the floor surface and manually moved in place. Interview on 7/28/25 at 2:05pm Resident #87 stated that the rusted area on the door post was visible for one month. Resident #87 stated the toilet moved while in use and he would like it to be repaired During an observation on 7/31/25 from 9:05am to 9:10am with the Administrator and Maintenance Director confirmed the interior facing bathroom door used by Resident #52 needed repair and the bathroom door entry post and toilet used by Resident #87 needed repair. During an interview on 7/31/25 at 9:15am the Maintenance Director stated that repairs in the bathrooms used by Residents #52 and #87 would improve the resident's homelike environment. During an interview on 7/31/25 at 9;20am the Administrator stated that repairs in the bathrooms used by Residents # 52 and #87 would improve the resident's perception of living in a homelike environment. Record review of the facility's policy entitled Preventative Maintenance Program reviewed on 7/25/25 revealed A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 facility in that: 1. The facility failed to replace dirty overhead ceiling tiles in the main kitchen area. 2. The facility failed to replace a light bulb fixture in the main kitchen area. 3. The facility failed to clean an overhead ceiling vent in the dish room. 4. The facility failed to repair a wall penetration and broken floor molding in the employee bathroom in the main kitchen area. These failures could place residents at risk for food borne illness. The findings included: Observation on 07/28/25 from 9:15am until 9:35am with the Food Service Director revealed the following: a. There were 6 ceiling tiles which each measured approximately 2x2 ft in the main kitchen area that had dirt particles on the surface and were stained.b. There was a missing florescent light bulb in a overhead ceiling light fixture which measured approximately 4x2 ft in length in the main kitchen area.c. There was a ceiling air vent which measured approximately 2 ft in diameter in the dish room that had rust on the vent blades.d. There was a section of missing floor molding measuring approximately 1x2.5 ft with a wall penetration that measured approximately 3 inches in diameter in the employee bathroom in the main kitchen area. During an interview on 07/28/25 at 9:40am, the Food Service Director stated that she had placed a work order for the dirty ceiling tiles to be replaced. The Food Service Director stated the areas which needed repair or cleaned would affect the cleanliness of the kitchen. During an interview on 7/28/25 at 9:45am the Administrator stated that all kitchen areas needing repaired or cleaned would affect the cleanliness of the kitchen During an interview with the Maintenance Director on 6/6/25 at 10:35am he stated he had received a work order to replace the 6 overhead ceiling tiles that were dirty. The Maintenance Director stated that areas needing repaired or cleaned in the kitchen would affect the cleanliness of the kitchen. Record review of facility policy entitled Sanitization dated 2001 in the Dietary Policy and Procedures Manual revealed The food service area shall be maintained in a clean and sanitary manner. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed in 1 of 2 garbage dumpsters to dispose of garbage and refuse properly. The facility failed to ensure the sliding doors on both sides of the dumpster were completely closed. This deficient practice could place residents at risk for exposure to germs and diseases carried by vermin and rodents.The findings were: Observation on 07/29/25 at 10:30am with the Food Service Director revealed the sliding door which measured approximately 4x4 ft on one of the two standing garbage bins was open. The garbage bin with the open sliding door was full of garbage bags. During an interview on 7/29/25 at 10:35am with the Food Service Director stated that she was aware that the garbage lid should have been closed for pest control prevention. During an interview on 07/29/25 at 11:25am with the Administrator stated he was not aware of the reason for the requirement to keep the garbage lids closed. The Administrator stated he agreed keeping the garbage lids closed would maintain pest control. Record review of facility policy Food-Related Garbage and Refuse Disposal dated 2001 revealed All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 5-501.113 Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the food establishment. 5-501.114 Using Drain Plugs. Drains in receptacles and waste handling units for refuse, recyclables, and returnables shall have drain plugs in place

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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 interview and record review, the facility failed to maintain clinical records that were complete and accurately documented for 1 (Resident #11) of 25 residents reviewed for clinical records, in that: Resident #11's Medication Administration Record, dated July 2025, had blank spaces on July 5, 2025 rather than documentation. This deficient practice could cause miscommunication among the resident's caregivers and result in improper care.The findings were: Record review of Resident #11's face sheet, dated 07/31/2025, revealed the resident was admitted on [DATE] with diagnoses including: Essential Primary Hypertension, Generalized Anxiety Disorder, and Type 2 Diabetes Mellitus. Record review of Resident #11's Quarterly MDS, dated [DATE], revealed a BIMS score of 15 which indicated intact cognition.Record review of Resident #11's care plan, revised 05/17/2024, revealed [Resident #11] receives anti-anxiety medications r/t anxiety. Administer ANTI-ANXIETY medications as ordered by physician. Observe for side effects and effectiveness Q-SHIFT. [Resident #11] receives pain medication therapy. Administer ANALGESIC medications as ordered by physician. Observe/document side effects and effectiveness Q-SHIFT. [Resident #11] has Potential for complication hypo-hyperglycemia r/t DM. Medications/blood sugar check as ordered and as needed. Record review of Resident #11's Order Summary, dated 07/31/2025, revealed, (sic) amLODIPine Besylate Oral Tablet 5 MG (Amlodipine Besylate) Give 1 tablet by mouth at bedtime related to ESSENTIAL (PRIMARY) HYPERTENSION, clonazePAM Oral Tablet 1 MG Give 1 tablet by mouth at bedtime for anxiety, ANTIANXIETY MEDICATION - MONITOR FOR DROWSINESS, SLURRED speech. DIZZINESS, NAUSEA, AGGRESSIVE/IMPULSIVE BEHAVIOR. Anxiety: Monitor for episodes of anxiousness (restlessness, nervousness, increased heart rate, sweating, trembling, concentration difficulties, sleeping difficulties, worrying, avoidance, etc.), PAIN SCALE Q SHIFT, ACCUCHECKS before meals and at bedtime for Diabetes. Record review of Resident #11's Medication Administration Record, dated 07/31/2025, revealed blank spaces rather than documentation on 07/05/2025 for medications and monitoring: (sic) amLODIPine Besylate Oral Tablet 5 MG (Amlodipine Besylate) Give 1 tablet by mouth at bedtime related to ESSENTIAL (PRIMARY) HYPERTENSION, clonazePAM Oral Tablet 1 MG Give 1 tablet by mouth at bedtime for anxiety, ANTIANXIETY MEDICATION - MONITOR FOR DROWSINESS, SLURRED speech. DIZZINESS, NAUSEA, AGGRESSIVE/IMPULSIVE BEHAVIOR. Anxiety: Monitor for episodes of anxiousness (restlessness, nervousness, increased heart rate, sweating, trembling, concentration difficulties, sleeping difficulties, worrying, avoidance, etc.), PAIN SCALE Q SHIFT, ACCUCHECKS before meals and at bedtime for Diabetes. Record review of Resident #11's progress notes for July 2025 revealed no notes regarding medication administration on July 5, 2025. During an interview with the HR Director on 07/31/2025 at 10:05 a.m., the HR Director stated that RN A was assigned to care for Resident #11 on 07/05/2025. During an attempted interview with RN A on 07/31/2025 at 10:18 a.m., RN A did not answer the telephone and there was no option for voicemail. During an interview with Resident #11 on 07/31/2025 at 10:36 a.m., Resident #11 stated she had no concerns regarding her medications and did not recall a time when she did not receive her medications. During an interview with the DON on 07/31/2025 at 2:00 p.m., the DON confirmed there were blank spaces where documentation should have been on Resident #11's Medication Administration Record for 07/05/2025. The DON stated it was her expectation that nursing staff document when a medication or ordered monitoring was provided to the resident or refused by the resident. Record review of the facility policy, Documentation in Medical Record, 06/06/2025, revealed, Each resident's medical record shall contain an accurate representation of the actual experience of the resident.through complete, accurate, and timely documentation.