STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455969	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot Heights Health Care Center	5000 Fawn Meadow San Antonio, TX 78240

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 interview and record review, the facility failed to ensure that all allegations misappropriation were reported to the State Survey Agency no later than 24 hours after misappropriation was alleged for 1 of 8 residents (Resident #1) reviewed for misappropriation of resident property. The facility failed to report to HHSC when Resident #1's lost gold wedding ring, which was reported missing on [DATE], a replacement was provided on 04-09-2025 the facility did not report to HHSC within 24 hours. This failure could place residents at risk of misappropriation of money, possessions, and feelings of loss.The findings included:Record review of Resident #1's Face Sheet, dated [DATE], reflected a [AGE] year-old resident with an initial admission date of [DATE], with a most recent admission on [DATE], and diagnoses including Chronic Obstructive Pulmonary Disease (COPD; a group of lung diseases that block airflow and make it difficult to breathe), acute and chronic respiratory failure with hypercapnia (respiratory failure which leads to high volumes of carbon dioxide in the body), and type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). Further review reflected that Resident #1 expired on hospice at the facility on [DATE]. Record review of Resident #1's MDS Assessment, dated [DATE], reflected Resident #1 had a BIMS score of 7, indicating severe cognitive impairment. Record review of Resident #1's Comprehensive Person-Centered Care Plan, undated, reflected, [Resident #1] has age related cognitive decline and requires assistance and reminders at times to make needs known or complete tasks. Record review of Facility Grievance Resolution Form, for Resident #1 dated [DATE], reflected a summary statement of the grievance, Patient's [family member] reported she noticed residents' gold wedding band was missing from his hand when she went to wash his hands for lunch. With a Summary of Findings and Resolution, SW & wound care nurse searched residents' room & belongings. Maintenance director searched laundry services. SW spoke to CNA's who reported they had not seen the ring while providing care that morning. With corrective action, Checking in laundry and continuing to look for ring. Ordered a replacement ring. Outcome is satisfactory per spouse.Record review of Resident #1's Inventory of Personal Effects, dated [DATE], reflected that Resident #1 admitted with a gold wedding ring.Record review of email invoice dated [DATE] at 9:42 AM reflected that the Administrator bought a replacement ring for Resident #1. Record review of local police department incident report reflected that the Administrator reported to the local police department Resident #1's missing wedding ring on [DATE] at 12:34 PM. Interview on [DATE] at 12:42 PM, LSW stated that she was unsure of where Resident #1's ring went, but that Resident #1 had come back from the hospital 4 days prior to Resident #1's family member noticing his wedding ring was missing and they were uncertain if he was wearing his wedding ring when he was readmitted to the facility. LSW stated that she asked CNA's and Hospice Aides, who had visited earlier in the morning on [DATE] if they had seen Resident #1's ring. LSW stated no one had seen Resident #1's ring after Resident #1 had come back from the hospital. LSW stated that they did not think it needed to be reported, as Resident #1's family member made it seem as though it could possibly be at home, and they replaced the ring immediately which Resident #1's member was satisfied with. Interview on [DATE] at 2:34 PM, the DON stated the missing wedding ring was not reported to the State Survey Agency (Texas HHSC) because Resident #1's family member did not state the ring was stolen, only that she could not locate the ring and thought it was misplaced. The DON stated that the Administrator ordered a replacement and reported the missing ring to the local police department within 24 hours of the grievance describing that Resident #1's wedding ring was missing. The DON stated their expectation, as administration of the facility, was to report misappropriation of resident property to the state survey agency within the timeframe required. Interview on [DATE] at 9:15 AM, the Administrator stated that their top priority was finding the ring when the facility was notified it went missing, and once it was unable to be located, the next priority was providing Resident #1 with a replacement ring. The administrator stated it was not reported sooner due to Resident #1's family member not stating it was stolen, but only that she was unable to locate the ring. The Administrator stated his expectation was to report misappropriation to the state survey agency within 24 hours. Record review of Facility Policy, undated, titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment reflected, In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than twenty-four (24) hours if the events that cause the allegation does