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	05/06/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the resident's environment remained free of accidents and hazards as was possible and each resident received adequate supervision to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents.The facility failed to ensure Resident #1's fall mat was utilized per the comprehensive care plan.This failure could place residents at risk for accidents and injuries related to risk of falls.The findings included:Record review of Resident #1's face sheet dated 5/5/26 reflected an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia with behavioral disturbance, anxiety disorder, and history of falling.Record review of Resident #1's most recent admission MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills, required substantial/maximal assistance with mobility, and had reports of falls without injury.Record review of Resident #1's comprehensive care plan with revision date 3/12/26 reflected the resident had an ADL self-care deficit related to muscle weakness, poor endurance, and cognitive impairment with interventions that included the resident was dependent on staff with bed mobility, and transfers. Record review of Resident #1's comprehensive care plan reflected the resident had an actual fall with poor balance, poor communication/comprehension, unsteady gait with interventions that included the resident's bed placed in lowest position, a scoop mattress, room change closer to the nurse's station, and the use of fall mats.Record review of Resident #1's Fall Risk Evaluation dated 4/25/26 reflected the resident had a history of falls and had 3 or more falls in past 3 months, was disoriented at all times, chairbound, incontinent, and required the use of assistive devices. Record review of the facility document titled Ambassador/Guardian Angel Room Rounds dated 5/5/26 reflected Resident #1 looks good; fall prevention put in place.During an observation and interview on 5/5/26 at 9:09 a.m., Resident #1 was observed sitting up in a low bed, and a folded-up fall mat was observed propped up against the wall at the foot of the bed. Resident #1 stated he had never had any falls and denied needing help to get out of bed. Resident #1 stated he could show the State Surveyor that he was able to get out of bed without help and attempted to get up but was told not to. During an observation on 5/5/26 at 9:16 a.m. the call light to Resident #1's room was observed activated and at 9:22 a.m., the BOM entered the resident's room and asked the resident if he had activated his call light. The call light to Resident #1's room was turned off and the BOM exited Resident #1's room. The fall mat was observed folded up against the wall at the foot of the bed.During an observation on 5/5/26 at 9:31 a.m., CNA A was observed entering Resident #1's room and informed the resident she was going to change him. The resident's fall mat was folded up against the wall at the foot of the bed. CNA A closed the resident's door behind her.During an observation on 5/5/26 at 9:37 a.m., CNA A was observed exiting Resident #1's room with Resident #1 sitting up in a wheelchair. CNA A placed Resident #1 behind the nurse's station and returned to the resident's room.During an interview on 5/5/26 at 9:38 a.m., CNA A stated her shift began at 6:00 a.m. and she made rounds of the unit every two hours, and sometimes more often. CNA A stated she passed Resident #1's room often because the resident would try to get up out of bed by (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	himself. CNA A stated Resident #1 was supposed to have a fall mat in place while in bed, but she forgot to put the fall mat back in place after serving him breakfast. CNA A stated she went to help another resident on the unit and forgot to put the fall mat back for Resident #1. CNA A stated Resident #1 could have an injury if he should have a fall if the fall mat was not in place. CNA A stated she was aware Resident #1 was supposed to have the fall mat in place while the resident was on the bed and it was care planned. CNA A stated she was not the only person responsible for ensuring the resident's fall mat was in place, it was everybody's responsibility.During an interview on 5/5/26 at 9:51 a.m., the BOM stated she was part of a team assigned to resident rooms that consisted of making general rounds and checking on the residents to ensure their rooms were clean, the call lights were in place and asking the residents if they needed anything. The BOM stated nursing staff would often inform the staff regarding residents who were at risk for falls and interventions in place such as fall mats. The BOM stated Resident #1 was not on her rotation but was simply answering his call light. The BOM stated she was not aware if Resident #1 was a fall risk and did not notice the fall mat folded up against the wall at the resident's foot of the bed. The BOM stated, if Resident #1 was a fall risk and he had a fall mat, it should be utilized because if he should have a fall, the fall mat could help cushion the fall and prevent injury. During a joint interview on 5/5/26 at 10:36 a.m. with ADON B and ADON C, ADON B stated it was her expectation that fall mats that were implemented for a resident with a fall risk were supposed to be utilized because it helped to prevent injury. ADON B stated that the CNA staff and nursing staff should check for placement of the fall mat as well. ADON B stated she felt it was a Team effort to ensure safety, and we all do rounds to check on Resident #1. ADON C stated, staff were assigned to a unit to make rounds to ensure the residents were provided with hydration, to ensure the beds were in a safe low position, and the call lights were within the resident's reach. ADON C stated the routine for staff rounding the units was an established process and a check-off list was given to the assigned staff to complete while making rounds. ADON C stated the check-off list was reviewed by management during the morning meetings and were checked for any concerns made by a resident for items such as food requests or activity requests. Record review of the facility document titled Fall Management System with review date 10/25 reflected in part, .This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents.It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.Resident with high risk factors identified on the Fall Risk Evaluation will have an individualized care plan developed that includes measurable objectives and timeframes. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access for 1 of 5 Residents (Resident #2) reviewed for medication storage:The facility failed to ensure Resident #2 did not have a container of antifungal powder at the bedside.This deficient practice could affect residents who received medications in the facility and place them at risk for not receiving the correct medications, medication misuse or drug diversion.The findings included:Record review of Resident #2's face sheet dated 5/5/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included cellulitis of right lower limb, morbid obesity due to excess calories, bacterial infection, and age-related physical debility.Record review of Resident #2's comprehensive care plan with revision date 4/23/26 reflected the resident had fungal moisture associated skin damage under both breasts and abdominal folds with interventions that included to administer treatments as ordered.Record review of Resident #2's Order Summary Report dated 5/5/26 reflected the following:- Nystatin External Powder 100,000 Unit/GM, apply to groin topically two times a day for fungal infection for 7 days with order date 4/29/26 and end date 5/6/26During an observation and interview on 5/5/26 at 9:57 a.m., Resident #2 was observed on the bed wearing a hospital gown and her lower extremities were bandaged from her feet up to her ankles. Resident #2 stated she did not have any wounds on her buttocks and was not allowed to administer medications to herself because the facility did not allow the residents to administer their own medications. Resident #2 was observed with a 3-ounce bottle of antifungal powder at the bedside. The antifungal powder did not have a pharmacy label and indicated it was used for skin with a fungal infection. Resident #2 stated she had a fungus under her belly and was given the antifungal powder observed on the bedside by an unknown staff. Resident #2 stated, they left the antifungal powder at the bedside, but the staff applied it on her.During an observation on 5/5/26 at 2:06 p.m. Resident #2 was observed in the bed and the 3-ounce bottle of antifungal powder was observed at the bedside. During an observation and interview on 5/5/26 at 2:11 p.m., ADON C observed the 3-ounce bottle of antifungal powder at Resident #2's bedside and stated it was a stock bottle used by the nurse aides. ADON C stated, Resident #2 was not supposed to have the antifungal powder at the bedside because the resident could not treat herself. ADON C stated the resident required a physician's order and an assessment to show the resident could safely treat herself to keep the antifungal powder at the bedside. ADON C stated, Resident #2 could have an adverse reaction or further skin issues if the resident was trying to treat other areas of her skin. ADON C stated she would investigate who would have given Resident #2 the antifungal powder.During a follow-up interview on 5/6/26 at 7:54 a.m., ADON C stated she had interviewed CNA staff about providing Resident #2 with the antifungal powder and determined the CNA staff did not have access to antifungal powder and the medication was not part of their medication stock.During an interview on 5/6/26 at 8:22 a.m., RN D stated the CNA staff did not have access to topical medications other than moisturizers. RN D stated there were no residents in the facility who were allowed to medicate or treat themselves with medication. RN D stated residents would not be allowed to have medications at the bedside because they could be used improperly, consume it or other residents could wander into the room and take it. RN D stated the CNA staff were not even allowed to have barrier cream, and it had to be used on the residents, the nurse would have to apply it.During an interview on 5/6/26 at 9:33 a.m., CNA A stated she was not allowed to apply barrier cream or any other topical medication on the residents unless she was given permission by the nurse. CNA A stated fungal powder was not supplied to the CNA staff.Record review of the facility document titled Medication Access and Storage with revision date 5/2007 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected the following, .It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications.