

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Patriot Heights Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 13 Residents (Resident #4) whose MDS records were reviewed for accuracy.</p> <p>The facility failed to ensure Resident #4's quarterly MDS assessment, dated 06/17/2024, accurately reflected the resident had a significant weight loss.</p> <p>This failure could place residents at risk for inadequate care due to inaccurate assessments.</p> <p>The findings included:</p> <p>Record review of Resident #4's electronic face sheet, dated 07/31/2024, reflected the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #4's diagnoses included: urinary tract infection (bladder infection), protein-calorie malnutrition (the state of inadequate intake of food as a source of protein, calories, and other essential nutrients), kidney failure (kidneys stop working), hypokalemia (below normal in potassium), and dementia (a group of symptoms affecting memory, thinking and social abilities).</p> <p>Record review of Resident #4's quarterly MDS assessment with an ARD of 06/17/2024 reflected the resident scored an 1/15 on his BIMS which signified the resident had severe cognitive impairment, and weight loss (loss of 5% or more in the last month or loss of 10% or more in last 6 months) in the section K (Swallowing/Nutritional status) was marked as No or unknown.</p> <p>Record review of Resident #4's comprehensive care plan revised on 06/10/2024 reflected [Resident #4] has unplanned/unexpected weight loss related to recent hospitalization on [DATE] - significant weight loss to 17.3 pounds (11%) for 6 months and for interventions Labs as ordered. Report results to physician and ensure dietician is aware, Med pass 120 milliliters by mouth two times a day added, monitor and evaluate any weight loss, and monitor and record food intake at each meal.</p> <p>Record review of Resident #4's weight log revealed the resident weighed 157.3 pounds on 12/06/2023 and 140.0 pounds on 06/03/2024 which the resident had a -11.00% significant weight loss for 6 months.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #4's nutrition assessment, dated on 04/15/2024, revealed At risk of dehydration due to dementia; offer fluids frequently. Weight loss related to inadequate oral intake as evidenced by weight loss for two weeks. Goal - gradual, non-significant weight gain towards ideal body weight. Recommendation - discontinue Renal diet restrictions and add Med Pass 120 milliliters two times a day.</p> <p>Record review of Resident #4's MAR, dated from 07/01/2024 to 07/31/2024, revealed Resident #4 received Med Pass 120 milliliters two times a day as ordered.</p> <p>Interview with the MDS nurse RN A on 07/31/2024 at 5:14 p.m. confirmed Resident #4 had a -11.00% significant weight loss from 12/06/2023 to 06/03/2024, and the quarterly MDS assessment with an ARD of 06/17/2024's weight loss in the section K (Swallowing/Nutritional status) should have been marked as Yes to Loss of 5% or more in the last months or loss of 10% or more in last 6 months. The MDS nurse RN A stated she did not know the reason it was marked No.; it was mistake because the MDS nurse RN A started working as a MDS nurse four months ago and was still on learning processes about MDS. Further interview with the MDS nurse RN A stated the potential harm was Resident #4 might have more weight loss because of no interventions by inaccurate MDS.</p> <p>Record review of the facility's policy, titled Nursing Administrative, undated, revealed To complete a comprehensive assessment of the resident's needs which are based on the State's specific Resident Assessment Instrument and the facility's interdepartmental assessment form, To assess the resident's capability to perform daily functions and significant impairments on function capacity, and this facility will assure the completion of the resident assessment process enabling the development of an individualized comprehensive care plan for residents.</p> <p>Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, for 1 of 2 residents (Residents #11) reviewed for respiratory treatment in that:</p> <p>Resident #11's nebulizing mask and tubing were observed on 07/28/2024, and it was covered in a plastic bag but dated on 05/12/2024.</p> <p>This failure could affect residents who received nebulizing treatment by placing them at risk for respiratory infections.</p> <p>The findings included:</p> <p>Record review of Resident #11's electronic face sheet, dated 07/31/2024, reflected the resident was admitted to the facility on [DATE] with diagnoses included: cerebral infarction (damage to tissues in the brain), dementia (a group of symptoms affecting memory, thinking and social abilities), atherosclerotic heart disease (damage or disease in the heart's major blood vessels), asthma (a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe), and sleep apnea (potentially serious sleep disorder in which breathing repeatedly stops and starts).</p> <p>Record review of Resident #11's quarterly MDS assessment with an ARD of 04/27/2024 reflected the resident scored an 10/15 on his BIMS which signified the resident had moderately cognitive impairment, and the resident needed to have supervision or touching assistance to all activities of daily living such as eating, dressing, showering, and transferring.</p> <p>Record review of Resident #11's physician orders, dated 05/11/2024, reflected Ipratropium-Albuterol Solution 0.5 - 2.5 (3) mg/3 ml - 3 milliliters inhale orally every 4 hours as needed for short of breathing or wheezing through nebulizer.</p> <p>Observation on 07/28/2024 at 11:43 a.m. revealed Resident #11's nebulizer was on the nightstand connected to a tubing and mask, and the tubing and mask were covered in a plastic bag. The plastic bag was dated on 05/12/2024.</p> <p>Interview on 07/28/2024 at 11:48 a.m. with RN B saw Resident #11's tubing and mask and confirmed the tubing and mask connected to Resident #11's nebulizer were covered in a plastic bag, and the bag was dated on 05/12/2024. RN B stated Resident #11 used sometimes the nebulizer and mask for breathing treatment. Further interview with the RN B confirmed per the facility policy nurses should have changed a tubing and mask for breathing treatment weekly, and RN B did not know what reason nurses did not change them weekly. The potential harm was Resident #11 might have respiratory infection due to old tubing and mask.</p> <p>Interview on 07/31/2024 at 5:42 p.m. with DON stated facility nurses should have changed Resident #11's tubing and mask for breathing treatment weekly.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy, titled Nebulizer, undated, reflected . 5. Nebulizer tubing to be changed and dated weekly and kept bagged when not in use.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure residents were free of any significant medication errors for 1 of 5 residents (Resident #1) reviewed for medication administration.</p> <p>During medication administration observation on 07/30/2024, MA hold Resident #1's Metoprolol Tartrate 25 mg because of low blood pressure (118/50), but the MA did not notify holding the medication to the charge nurse, LVN D.</p> <p>This failure could place residents at risk for not receiving the therapeutic effects of their prescribed medications.</p> <p>The findings included:</p> <p>Record review of Resident #1's electronic face sheet, dated 07/31/2024, reflected the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: urinary tract infection (bladder infection), type 2 diabetes mellitus (trouble controlling blood sugar), hypertensive (high blood pressure), chronic atrial fibrillation (abnormal heart rhythm), chronic kidney disease stage 3 (damage to or disease of a kidney), and hyperlipidemia (high levels of fat).</p> <p>Record review of Resident #1's significant change MDS assessment with an ARD of 06/24/2024 reflected the resident scored an 8/15 on his BIMS which signified the resident had moderately cognitive impairment, and the resident needed to have setup or clean-up assistance (helper sets up or cleans up) for eating and dependent (helper does all of the effort) for hygiene, shower/bathe, and transfer.</p> <p>Record review of Resident #1's physician order, dated 06/21/2024, reflected Metoprolol Tartrate tablet 25 mg - give 1 tablet by mouth two times a day related to hypertensive (high blood pressure). Hold for SBP [systolic blood pressure] less than 110 or pulse less than 60.</p> <p>Record review of Resident #1's MAR, dated from 07/01/2024 to 07/31/2024, reflected Metoprolol Tartrate tablet 25 mg - give 1 tablet by mouth two times a day related to hypertensive (high blood pressure). Hold for SBP [systolic blood pressure] less than 110 or pulse less than 60 - Scheduled AM 07 [from 7 am to 11 am] and PM 15 [from 3 pm to 7 pm].</p> <p>Observation on 07/30/2024 at 9:12 a.m. revealed MA C took Resident #1's blood pressure before giving the resident's medications, and the blood pressure was 118 (systolic blood pressure) / 50 (diastolic blood pressure) and pulse 62 per minute. MA C held Resident #1's Metoprolol Tartrate tablet 25 mg by saying holding this medication because the resident's diastolic blood pressure was low as 50. Further observation on 07/30/2024 at 9:29 a.m. revealed the MA C did not notify holding Resident #1's Metoprolol Tartrate tablet 25 to the charge nurse.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 07/30/2024 at 2:21 p.m. with MA C stated Resident #1 did not receive his Metoprolol Tartrate tablet 25 mg one tablet because of his low diastolic blood pressure as 50, and MA C did not notify holding this medication due to low diastolic blood pressure to the charge nurse. MA C stated she knew she could hold Resident #1's Metoprolol Tartrate tablet 25 mg when his SBP [systolic blood pressure] less than 110 or pulse less than 60 per the physician order. However, MA C thought that she should hold it because Resident #1's diastolic blood pressure was low as 50. Further interview with the MA C stated she should have notified to the charge nurse immediately and followed the charge nurse's directions. MA C stated she was aware of notifying the charge nurse immediately but totally forgot because she was very nervous.</p> <p>Interview on 07/30/2024 at 2:30 p.m. the DON stated Resident #1 should have received his Metoprolol Tartrate tablet 25 mg because his systolic blood pressure was 118 (more than 110), and his pulse was 62 (more than 60). If MA C thought she should hold the medication because Resident #1's diastolic blood pressure was low as 50, she should have notified it to the charge nurse immediately and followed the charge nurse's directions. Medication aide could not hold medications without nurse's directions and physician orders. It was medication error.</p> <p>Record review of the facility policy, titled Medication Administration, undated, revealed It is the policy of this facility that medications shall be administered as prescribed by the attending physician. 2. Medications must be administered in accordance with the written orders of the attending physician.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observations, interviews, and record reviews, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys, for 1 of 4 medication carts (treatment cart) reviewed for drug security and 2 of 13 residents (Resident #16 and Resident #41) reviewed for medications at the bedside.</p> <ol style="list-style-type: none"> <li>1. Facility treatment cart was left unattended and unlocked at the North-hall on [DATE] at 9:52 a.m.</li> <li>2. Resident #16's Triad Hydrophilic wound dressing cream was left unattended and unsecured on the nightstand at the resident's bedside.</li> <li>3. South-hall nursing cart had Resident #41's insulin pen with open date [DATE], but DON said Novolog insulin pen should have been discarded after 28 days once it was opened.</li> </ol> <p>This failure could place residents at risk for misappropriation of property and could place residents at risk for accidents, hazards, and not receiving therapeutic effects.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Observation on [DATE] at 9:52 a.m. revealed treatment cart was located at the North-hall, and the cart was left unattended and unlocked. Nobody was around the cart, and there were many wound dressings, gauzes, ointments, and cream for wound care inside the cart.</li> </ol> <p>Interview on [DATE] at 9:53 a.m. RN B stated facility treatment cart was left unattended and unlocked. The cart was opened, and RN B stated the cart should have been locked all the time. RN B did not know what reason the treatment cart was left unattended and unlocked. Usually treatment nurse used the cart, but [DATE] was Sunday, so the floor charge nurses might unlock the cart after using it. It was nurses' responsibility to lock the cart all the time, and the potential harm was residents could have taken some creams or ointments from the cart, and it could cause harm to residents.</p> <p>Interview on [DATE] at 5:42 p.m. DON stated all facility medication carts and treatment cart should be locked all the time when the carts were left unattended.</p> <ol style="list-style-type: none"> <li>2. Record review of Resident #16's electronic face sheet, dated [DATE], reflected the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: parkinsonism (clinical syndrome characterized by tremor), hypertension (high blood pressure), muscle wasting and atrophy (the decrease in size and wasting of muscle tissue), and difficulty in walking.</li> </ol> <p>Record review of Resident #16's quarterly MDS assessment with an ARD of [DATE] reflected the resident scored an ,d+[DATE] on her BIMS which signified the resident had moderately cognitive impairment, and the resident needed to have setup or clean-up assistance (helper sets up or cleans up) for eating and dependent (helper does all of the effort) for hygiene, shower/bathe, and transfer.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #16's physician order, dated [DATE], reflected Triad Hydrophilic wound dress external paste (Wound dressings) - Apply to bilateral buttock topically every shift for prevention cleanse skin completely with peri wipes, pat dry. Mix Triad and antifungal ointment together then apply.</p> <p>Record review of Resident #16's MAR, dated from [DATE] to [DATE], reflected Resident #16 received her Triad Hydrophilic wound dress external paste (Wound dressings) cream to her buttock area every morning, evening, and night shift as ordered.</p> <p>Observation on [DATE] at 10:36 a.m. revealed in Resident #16's room, Triad Hydrophilic wound dress external paste (Wound dressings) cream was on the nightstand at the resident's bedside unattended. Resident #16 was not in her room and attending in the activity.</p> <p>Interview on [DATE] at 10:41 a.m. with ADON and RN B stated Resident #16's Hydrophilic wound dress external paste (Wound dressings) cream was on the nightstand at the resident's bedside unattended. Further interview with ADON and RN B stated it was medication. All medications should not be in resident's room. They did not know what reason the medication was on the nightstand unattended in Resident #16's room. Nurses might forget putting the medication in the cart after using it. The potential harm was that Resident #16 or other residents might use the medication incorrectly even though the resident was alert and oriented and had no roommate.</p> <p>Interview on [DATE] at 5:42 p.m. DON stated all medications should not be in resident's room unattended per the facility policy.</p> <p>3. Record review of Resident #41's electronic face sheet, dated [DATE], reflected the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: malignant neoplasm of prostate (Prostate cancer), dementia (a group of symptoms affecting memory, thinking and social abilities), type 2 diabetes mellitus (trouble controlling blood sugar), and hypertension (high blood pressure).</p> <p>Record review of Resident #41's admission MDS assessment with an ARD of [DATE] reflected the resident scored an ,d+[DATE] on his BIMS which signified the resident had severe cognitive impairment, and the resident needed to have supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating and dependent (helper does all of the effort) for hygiene, shower/bathe, and substantial/maximal assistance (helper does more than half the effort) for transfer.</p> <p>Record review of Resident #41's physician order, dated [DATE], reflected NovoLoG FlexPen Subcutaneous Solution Pen injector 100 unit/ml. Inject as per sliding scale: if ,d+[DATE] = 0 unit; ,d+[DATE] = 2 unites. If greater than 400 administer 2 units and notify physician for type 2 diabetes mellitus.</p> <p>Record review of Resident #41's MAR, dated from [DATE] to [DATE], reflected Resident #41 received his NovoLoG FlexPen Subcutaneous Solution Pen injector 100 unit/ml as per sliding scale by scheduled 6:30 am, 11:30 am, and 4:30 pm as ordered.</p> <p>Observation on [DATE] at 3:27 p.m. revealed there was Resident #41's Novolog Flex pen with open date [DATE] inside South-hall nursing cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 3:40 p.m. ADON stated Resident #41's Novolog Flex pen with open date [DATE] was inside South-hall nursing cart. Further interview with the ADON stated Novolog insulin pen should have been discarded after 28 days once it was opened. The ADON did not know what reason this insulin pen was inside the cart. The potential harm was Resident #41 might have ineffective therapeutic drug result.</p> <p>Interview on [DATE] at 5:42 p.m. DON stated Resident #41's Novolog insulin pen should have been discarded after 28 days once it was opened.</p> <p>Record review of the facility policy, titled Medication Access and Storage, undated, reflected . 2. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 6. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area.</p> <p>Record review of health direct pharmacy services' standard of care for insulin pen, dated [DATE], reflected For Novolog Flex pen was expired after 28 days upon opening.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Resident #1) of 13 residents reviewed, in that:</p> <p>Resident #1's personal refrigerator located in his room was observed on 07/28/2024, and there was a small plastic container inside the refrigerator with olives, but no date on the plastic container.</p> <p>The findings included:</p> <p>Record review of Resident #1's electronic face sheet, dated 07/31/2024, reflected the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: urinary tract infection (bladder infection), type 2 diabetes mellitus (trouble controlling blood sugar), hypertensive (high blood pressure), chronic atrial fibrillation (abnormal heart rhythm), chronic kidney disease stage 3 (damage to or disease of a kidney), and hyperlipidemia (high levels of fat).</p> <p>Record review of Resident #1's significant change MDS assessment with an ARD of 06/24/2024 reflected the resident scored an 8/15 on his BIMS which signified the resident had moderately cognitive impairment, and the resident needed to have setup or clean-up assistance (helper sets up or cleans up) for eating and dependent (helper does all of the effort) for hygiene, shower/bathe, and transfer.</p> <p>Observation on 07/28/2024 at 11:38 a.m., revealed Resident # 1 was watching on television on the bed, and there was a personal refrigerator in room with undated olives inside a small plastic container on bottom shelf.</p> <p>Interview with Resident # 1 on 07/28/2024 at 11:39 a.m., stated that the olives were brought in by his son and could not recall how long ago that was.</p> <p>Interview on 07/28/2024 at 11:50 a.m. with RN B stated there were seven olives inside a small plastic container in Resident # 1's personal refrigerator, and they should have been thrown out by nursing staff because it was undated.</p> <p>Interview on 07/31/2024 at 5:42 p.m. DON stated night nurses were responsible for overseeing Resident's personal refrigerators and also responsible for monitoring it daily, and the potential harm was Resident # 1 risked possible food - illness by consuming undated food in personal refrigerator.</p> <p>Record review of the facility policy, titled Resident personal food storage, revised 01/2022, revealed 4. Resident and individuals bringing food in from outside sources will be educated on safe food handling and storage techniques by designated facility staff as needed.</p>		

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NAME OF PROVIDER OR SUPPLIER  Patriot Heights Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39049</p> <p>Based on interviews and record review, the facility failed to maintain clinical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) of 13 residents reviewed for accuracy and completeness of clinical records.</p> <p>LVN D did not document Resident #1's refusal of wound care on 07/04/2024 to the resident's treatment administration record.</p> <p>This failure placed facility residents at risk for lack of wound care or incorrect wound care due to misinformation by incomplete and inaccurate medical record.</p> <p>Findings included:</p> <p>Record review of Resident #1's electronic face sheet, dated 07/31/2024, reflected the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included: urinary tract infection (bladder infection), type 2 diabetes mellitus (trouble controlling blood sugar), hypertensive (high blood pressure), chronic atrial fibrillation (abnormal heart rhythm), chronic kidney disease state 3 (damage to or disease of a kidney), hyperlipidemia (high levels of fat), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Record review of Resident #1's significant change MDS assessment with an ARD of 06/24/2024 reflected the resident scored an 8/15 on his BIMS which signified the resident had moderately cognitive impairment, and the resident needed to have setup or clean-up assistance (helper sets up or cleans up) for eating and dependent (helper does all of the effort) for hygiene, shower/bathe, and transfer. Further record review of the MDS Section M (Skin Conditions) revealed to the question (M0210 - Does this resident have one or more unhealed pressure ulcers/injuries? the answer was Yes, and Resident #1 had one state 3 pressure ulcer (full thickness tissue loss) to left ischium (left buttock area).</p> <p>Record review of Resident #1's physician order, dated 06/26/2024, reflected Left ischium - state 3 - clean with wound cleanser, gently pat dry, apply skin prep to peri wound. Apply Anasept mixed with collagen sprinkles to wound bed, cover with calcium alginate, and secure with bordered foam dressing - every day.</p> <p>Record review of Resident #1's treatment administration record, dated from 07/01/2024 to 07/31/2024, revealed Left ischium - state 3 - clean with wound cleanser, gently pat dry, apply skin prep to peri wound. Apply Anasept mixed with collagen sprinkles to wound bed, cover with calcium alginate, and secure with bordered foam dressing - every day was scheduled to Day, and Resident #1 received the wound care as ordered every day, except 07/04/2024. There was a hole (empty space) on 07/04/2024 to Resident #1's treatment administration record for July 2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455969	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Patriot Heights Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5000 Fawn Meadow San Antonio, TX 78240	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility 24-hour nursing report, dated 07/04/2024, revealed 6 am to 2 pm shift nurse documented [Resident #1] refused wound care. Patient stated to tired, and 2 pm to 10 pm nurse documented [Resident #1] refused wound care and patient stated tomorrow.</p> <p>Interview on 07/31/2024 at 4:17 p.m. LVN D stated she worked for Resident #1 on 07/04/2024 from 6 am to 10 pm, and when the LVN D tried to provide the wound care to Resident #1 in the daytime, the resident refused and tried one more time the evening time, but the resident refused again. The LVN D also confirmed LVN D did not document regarding the resident refused wound care on 07/04/2024 in the resident's treatment administration record because wound care nurse usually provided the care to Resident #1, but on 07/04/2024 was holiday, so the wound care nurse did not work. For this reason, LVN D was very busy and totally forgot documenting on the treatment administration record. However, LVN D documented it to the 24-hour nursing report. Further interview with the LVN D stated LVN D should have documented Resident #1's refusal for wound care on the treatment administration record because it was official medical record. Potential harm was Resident #1 could have incorrect wound care or received same wound cares twice because of no charting.</p> <p>Interview on 07/31/2024 at 5:42 p.m. DON stated LVN D should have documented Resident #1's refusal for wound care on 07/04/2024 to the resident's treatment administration record, and the treatment administration record should have been accurate because it was a medical record.</p> <p>Record review of the facility policy, titled Medication Administration, undated, reflected . 13. The nurse must enter an explanatory note on the medication/treatment administration record when drugs are withheld, refused, or given other than at scheduled times.</p>		