STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E312	A. Building B. Wing	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Jose Nursing Center	406 Sharmain Pl San Antonio, TX 78221

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 0639 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintain 15 months of resident assessments in the resident's active clinical record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44978 Based on interviews and record review the facility failed to ensure all resident assessments completed within the previous 15 months in the resident's active record were maintained in the resident's active medical records for 6 of 6 residents reviewed for MDS assessments. (Resident #1, Resident #10, Resident #13, Resident #18, Resident # 21, and Resident #35) in that -MDS assessments for Resident #1, Resident #10, Resident #13, Resident #18, Resident # 21, and Resident #35 were not accessible to staff and ready to review, when the DON/Owner was not on site and able to unlock the cabinet in which all resident MDS assessments were stored. These failures affected 6 residents and placed them at risk of not having their assessments available for review. Findings included: Record review of Resident #1's face sheet revealed an admitted [DATE] and included the following diagnoses: Schizophrenia (mental disorder characterized by reoccurring episodes of psychosis that are corrected with a general misperception of reality) , paranoid state (thought process that is believed to possibly lead to delusion and irrationality), depressive disorder, anemia(deficiency of healthy red blood cells may cause fatigue and unexplained weakness) and in situ of the breast (breast cancer). Record review of Resident #10's face sheet revealed an admitted [DATE] and included the following diagnoses: cerebral infarction , hypertension, anxiety, seizure disorder/convulsions, depressive disorder, and dysphagia. Record review of Resident #13's face sheet revealed an admitted [DATE] and included the following diagnoses: hypertension, acute renal failure, and dementia. Record review of Resident #18's face sheet revealed an admitted [DATE] and included the following diagnoses: Schizophrenia, Parkinson's disease, anemia, chronic pain syndrome, dementia, seizure disorder/convulsions, hallucinations, and delusional disorder. (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 0639 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #21's face sheet revealed an admitted [DATE] and included the following diagnoses: cerebral infarction (stroke)., diabetes mellitus (high blood sugar), CKF(chronic kidney failure), dementia (cognitive decline in thoughts and abilities), and dysphagia (difficulty in swallowing). Record review of Resident #35's face sheet revealed an admitted [DATE] and included the following diagnoses: Dementia, with behavioral disturbance, hypertension, diabetes with chronic kidney disease, and hyperlipidemia (high cholesterol) In an interview with the DON/ Owner on 03/05/2024 at approximately 4:00 p.m. requested medical records for Resident #1 and Resident #35. The DON/Owner said they were behind the nurses' station. On 03/06/2024 at approximately 10:00 am this state surveyor went to the nurses' station to get the medical records for Resident #1 and Resident #35, began reviewing them and noticed there were no MDS assessments in either chart. On 03/06/2024 at approximately 10:45 am this state surveyor asked the DON/Owner where the MDS information was for Resident #1 and Resident #35. The DON/Owner explained all MDS assessments were kept on paper in her office in a locked filing cabinet. If staff want to view them, they have to ask her to get them out of the locked filing cabinet in her office. She said she did not see that as a problem and said, all they have to do is ask to see them. The DON/Owner stated she usually gets to the facility around 9:00 a.m. and leaves a little after 6:00 p.m. On 03/07/2024 at approximately 3:25 p.m. this state surveyor went to the nurses' station to get charts for Resident #10, Resident #13, Resident #18, and Resident #21. After reviewing each of the Resident's charts, there were not MDS assessments in any of those 4 charts either, making the total charts initially reviewed which contained no MDS Assessment for 6 of 6 residents. On 03/07/2024 at 5:45 p.m. with the DON/Owner and the Administrator/Owner, they said they were aware there were no MDS assessments in the resident's medical records and directed the state surveyor to let the DON/Owner know which MDS assessments need to be viewed and she would provide them. The Administrator/Owner explained they recently hired a nurse, but no longer worked for the company and was only employed by the facility for a short time. Then he said they think the medical records staff person, (that no longer works for the company), took a lot of records out of the resident charts which should not have been removed. The Administrator then explained the facility did not keep the MDS assessments in the charts and did not know that information should be maintained as a part of the master record. During the same interview, the DON/Owner stated she was responsible for completing all MDS Assessments and ensuring they are maintained as required for all residents in the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44978 Based on interviews and record review, the facility failed to ensure that the assessments accurately reflected the resident's status for 1 of 3 residents (Resident #35) reviewed for assessments: The facility reported diagnoses included depression, psychotic disorder(serious illness that affects the mind and make it hard for someone to think clearly make good judgements), schizophrenia (mental disorder characterized by reoccurring episodes of psychosis that are corrected with a general misperception of reality), and post-traumatic stress disorder(a mental health condition that is triggered by a traumatic event) on Resident #35's most recent MDS assessment, (dated 01/04/2024). No medical record available in the resident's chart or that the DON/Owner could provide supported the resident having been given those diagnoses at that time or historically. This failure could affect residents who had been at the facility more than 14 days by contributing to inadequate care based on inaccurate assessments. The findings were: Record review of Resident #35's face sheet, (with at report date of 09/01/2023), revealed an admitted [DATE] and included the following diagnoses: Dementia with behavioral disturbance, hypertension, diabetes with chronic kidney disease, and hyperlipidemia (high cholesterol). Record review of Resident #35's most recent Quarterly MDS assessment, (01/04/2024), indicated the resident had the following diagnoses under Section I, (Psychiatric/Mood Disorder): Depression (other than Bipolar), Psychotic Disorder (other than Schizophrenia), Schizophrenia, and Post Traumatic Stress Disorder, PTSD. Interview with the DON/Owner on 03/06/2024 at 2:38 p.m., she stated she checked the box indicating Resident #35 had depression, psychotic disorder, schizophrenia, and post-traumatic stress disorder in error and should not have because the resident did not have any of those diagnoses. She further explained she had been completing a lot of MDS's at the time and must have made a mistake and that mistake did not have any effect on the resident or the resident's care. Stated she is responsible for completing all MDS assessments at the facility and did not believe the residents' MDS not being accurately completed effected resident care or the resident in any way. A facility policy related to completion of MDS in facility, was requested prior to exit, however no policy was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47611 Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Resident #4 and resident # 141) of 8 residents reviewed for care plans. Resident #4 had no care plan in his chart. Resident #141's care plan was incomplete and only had two pages in the care plan. The findings included: Record review of Resident #4's electronic face sheet dated 05/10/2018 reflected he was initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: nontraumatic intracerebral hemorrhage (bleeding in the brain), vitamin D deficiency, hyperlipidemia (too much fat in the blood), and age-related nuclear cataract (clouding and thickening of the eye lens). Record review of Resident #4's MDS assessment dated [DATE] reflected he scored a 2/15 on his BIMS which signified he was severely cognitively impaired. Record review of Resident #4's medical chart showed there was no care plan filed in his chart. Record review of Resident #141's electronic face sheet dated 02/29/2024 reflected he was admitted on [DATE]. His diagnoses included: epilepsy (disorder of the brain characterized by repeated seizures), muscle weakness, anxiety, and age-related physical debility. Record review of Resident #141's medical chart showed an incomplete care plan. In an interview on 3/8/2024 at 10:30 am with the DON, she stated there have been situations which have led to documents missing in the chart. She stated the facility had hired someone to thin the charts. She stated the OIG , had also requested documents out of the chart which caused the chart to be missing documents. She stated that the facility does not have a Care Plan policy, but that the facility follows federal and state regulations.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44978 Based on interviews and record review, the facility failed to provide a minimum of 80 square feet per resident in 16 of 32 double occupancy resident rooms (Rooms 5, 15, 16, 17, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31), in that: Rooms 5, 15, 16, 17, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31 did not have the required 80 square feet per resident. This deficient practice could place residents at risk of problems in their activities of daily living. The findings were: Interview on 03/08/2023 at 12:00 p.m., the Administrator confirmed the facility had 16 resident rooms with square footage less than the 80 feet per resident required and identified the resident rooms as Rooms 5, 15, 16, 17, 19, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. The Administrator stated there was a room waiver in effect for these rooms and stated the measurements of the rooms had not changed. The 16 rooms measured as followed: - room [ROOM NUMBER] - 79.3 square feet per resident (3) - room [ROOM NUMBER] - 77.9 square feet per resident (2) - room [ROOM NUMBER] - 61.9 square feet per resident (2) - room [ROOM NUMBER] - 72.0 square feet per resident (2) - room [ROOM NUMBER] - 69.6 square feet per resident (2) - room [ROOM NUMBER] - 74.9 square feet per resident (3) - room [ROOM NUMBER] - 72.0 square feet per resident (2) - room [ROOM NUMBER] - 72.0 square feet per resident (3) - room [ROOM NUMBER] - 76.0 square feet per resident (2) - room [ROOM NUMBER] - 69.6 square feet per resident (2) - room [ROOM NUMBER] - 69.6 square feet per resident (2) - room [ROOM NUMBER] - 70.8 square feet per resident (2) (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	- room [ROOM NUMBER] - 72.0 square feet per resident (2) - room [ROOM NUMBER] - 72.0 square feet per resident (2) - room [ROOM NUMBER] - 72.0 square feet per resident (2) - room [ROOM NUMBER] - 72.0 square feet per resident (2) Record review of the Resident Room and Bed Report, dated 03/05/2024 provided by the facility, revealed 19 residents resided in Rooms 5, 15, 16, 17, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. No residents were residing in rooms [ROOM NUMBERS] during the annual survey.

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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. 44978 Based on observations and interviews the facility failed to provide a safe functional, sanitary, and comfortable environment for residents, staff, and the public. The facility failed to ensure good general safety precautions were in place in one outside building, 39.11 feet away from the nursing facility; where food was stored, staff complete laundry services for residents, and facility maintenance items were stored. Findings Included: During an observation on 03/06/2024 at approximately 5:45 p.m., the following observations were made: A building adjacent to the main nursing facility building was used to house the laundry room, food pantry, and the maintenance room. The maintenance room and laundry room were separated by a cinder brick wall, the pantry and the maintenance room were separated by a gypsum wall. The building measured at approximately 39.11 feet away from the main building. The following discrepancies were noted: 1. Dryer electrical cord was wrapped around the flexible gas connection. 2. Flexible gas tubing connected to the dryer was being held in place by a wire tie around a galvanized pipe. 3. Maintenance room had flammable liquids and gasses stored inside to include two e-size, gas powered lawn equipment, 1 can (110 fluid ounces) of engineered premixed fuel, and 1-quart container of paint thinner, along with various flammable aerosol spray cans. 4. The Maintenance room had numerous electrical wires hanging down from the ceiling, exposed. The electrical wires were live/energized, and covered with black tape, some had wired connection. Further observation revealed where the sheath around the wired had fallen apart exposing the electrical wire. During an interview with the Administrator, after the observation on 03/06/2024 at approximately 6:15 p.m., the Administrator said, We use that building for storage and laundry, it has a completely different address than the building we are in now, (referring to the building the residents live in). We get a different water and electric bill for that building as well. The Administrator then said, We will correct the identified concerns brought to our attention immediately, we want everything to be the way it is supposed to be.