

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45E312	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER San Jose Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview 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 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 4 of 12 residents (Resident #1, #19, #21, and #25) reviewed for care plans:1. The facility failed to ensure Resident #1's care plan reflected the resident was at risk for pressure ulcers and used heel protectors.2. The facility failed to ensure Resident #19's care plan reflected the resident was treated with antipsychotic medications.3. The facility failed to ensure Resident #21's care plan reflected the resident was treated with antipsychotic medications.4. The facility failed to ensure Resident #25's care plan reflected the resident was treated with antipsychotic medications. These deficient practices could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. The findings included: 1. Record review of Resident #1's face sheet dated 6/24/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, mental disorders due to known physiological condition (a mental or behavioral disturbance caused by a medical condition affecting the body or brain), seizures (episodes of abnormal, sudden electrical activity in the brain that temporarily disrupt normal brain function), and autistic disorder (a developmental condition that affects how a person communicates, interacts with others, learns and behaves). Record review of Resident #1's most recent comprehensive MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills, was dependent on staff for mobility and ADLs care and was at risk of developing pressure ulcers/injuries. Record review of Resident #1's Physician Orders for June 2026 reflected the following: - Heel protectors at bedtime every evening shift with order date 4/9/26 and no end date Record review of Resident #1's comprehensive care plan dated 4/10/26 and revised on 6/10/26 reflected the resident had a skin problem and had 2 unstageable pressure ulcers (a pressure injury in (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which the extent of tissue damage cannot be determined because the wound bed is unobscured by slough [dead tissue that is soft and stringy] and eschar [dead tissue that is thick or leathery]] on the right and left hips, 2 unstageable boils on the back and 2 Stage 2 pressure ulcers (partial-thickness loss of skin with exposed dermis [the thick layer of skin located beneath the outer layer of skin]) on the shoulders, and 1 Stage 3 pressure ulcer (full-thickness loss of skin) on the foot. Resident #1's care plan reflected the wounds mentioned above were healed on 6/10/26 and the care area had a line marked across it. Resident #1's care plan did not include the resident used heel protectors. During an interview on 6/24/26 at 8:48 a.m., the DON stated she was responsible for developing the residents' care plans and the MDS. The DON stated, Resident #1 admitted with pressure sores, but all the wounds were healed. The DON stated Resident #1 was still considered at risk for pressure injuries related to his immobility and was not sure if the resident continued to use heel protectors. The DON stated that heel protectors were used to relieve pressure on the feet and used as a preventative. During an observation and interview on 6/24/26 at 8:17 a.m., Resident #1 was observed sitting up in bed and was being assisted with feeding by CNA E. Resident #1 was observed with the heel protectors resting on the foot of the bed but not wearing them. Resident #1 had a handwritten note posted on the wall next to the resident's bed that indicted, Bunny boots (heel protectors) on at all times. CNA E stated she believed Resident #1 was supposed to always have heel protectors on but was not sure. CNA E stated she did not know why Resident #1 had to wear the heel protectors but believed he needed them due to bedsores. During an interview on 6/24/26 at 9:54 a.m., the LVN Treatment Nurse stated Resident #1 had several wounds that had recently deemed resolved/healed and interventions to prevent the resident from re-developing wounds included turning and repositioning and heel protectors. The LVN Treatment Nurse stated Resident #1 was supposed to be wearing heel protectors while in bed and should continue to use them otherwise he could develop another sore. During an interview on 6/25/26 at 11:30 a.m., the ADON stated Resident #1 had several wounds on admission and heel protectors were used at the time. The ADON stated Resident #1 no longer had wounds and heel protectors were no longer required. The ADON stated the resident care plans were developed by the IDT (inter disciplinary team) and the DON revised and updated the care plans as needed. The ADON stated, Resident #1's use of heel protectors should be care planned because the care plan was what the staff used to rely on how to take care of the resident and included any orders by the doctor. During a follow up interview and record review on 6/25/26 at 2:41 p.m., the DON stated she had completed a significant change MDS for Resident #1 that indicated the resident no longer had wounds. The DON stated, Resident #1's MDS would continue to trigger risk for pressure ulcers and revised the care plan to include the resident was supposed to wear heel protectors while in the bed and the resident often refused to wear them. The DON presented the revised care plan dated 6/25/26 and the DON stated the significant change MDS was completed on 6/23/26. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #19's admission sheet dated 8/22/2025 documented a [AGE] year-old male resident with diagnoses including type 2 diabetes mellitus, unspecified signs and symptoms involving cognitive function, hyperlipidemia (high cholesterol), and Alzheimer's disease. Record review of Resident #19's MDS dated [DATE] documented a BIMS score of 0 indicating severe cognitive impairment, and recorded the use of antipsychotic and hypoglycemic medications. Record review of Resident #19's order summary included an order for Abilify with an order date of 5/15/2026. Abilify was ordered as Abilify 2 mg, give 2 mg po daily, DX: Unspecified signs and symptoms involving cognitive functions/aware. Record review of Resident #19's care plan with an initiation date of 9/09/2025, did not document the resident was treated with an antipsychotic medication. 3. Record review of Resident #21's admission sheet dated 12/06/2024, documented a [AGE] year-old male resident with diagnoses including hypertension (high blood pressure), seizure disorder, cognitive communication deficit, and traumatic brain injury. Record review of Resident # 21's MDS dated [DATE] documented a BIMS score of 11 indicating moderate cognitive impairment and recorded the use of antipsychotic, antianxiety, anticoagulant, diuretic, and anticonvulsant medications. Record review of Resident #21's order summary included orders for Rexulti with an order date of 11/26/2025, Aristada with a start date of 8/14/2025, and Haldol with an order date of 6/07/2026. Rexulti was ordered as Rexulti 4 mg, give 1 tab po daily DX: schizoaffective bipolar type. Aristada was ordered as Aristada, 882 mg IM monthly. Haldol was ordered as Haldol 5 mg, give 5 mg po Q6H prn DX: Bipolar Disorder. Record review of Resident #21's care plan with an initiation date of 12/05/2024, did not document the resident was treated with an antipsychotic medication. 4. Record review of Resident #25's face sheet undated reflected a [AGE] year-old female admitted into the facility on 6/20/19 with diagnoses that included hypertension (high blood pressure), diabetes (condition where the body has trouble controlling the amount of sugar in the blood), Vitamin D deficiency, and dementia (general term for a decline in memory, thinking, and reasoning abilities that is severe enough to interfere with a person's daily life and independence) with behavioral disturbances. Record review of Resident #25's most recent quarterly MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills and was treated with antipsychotic medications. Record review of Resident #25's comprehensive care plan with revision dated 5/20/26 did not reflect that the resident was treated with an antipsychotic medication. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #25's Physicians Orders for June 2026 reflected the following: - ABH Gel 1MG/25MG/1MG cream, apply 1ML to skin topically as needed every 6 hours for anxiety/agitation with order date 3/18/26 and no end date Record review of Resident #25's Medication Administration Record and Treatment Administration Record for June 2026 reflected the resident was treated with ABH cream on 6/17/26. During an interview on 6/25/26 at 5:03 p.m., the DON stated Resident #25 had an active physician's order for the use of ABH, and since ABH was considered an antipsychotic because it contained Haldol, it should have been care-planned because the medication had side effects and the staff should be aware of that and what interventions should be in place for monitoring side effects. Record review of the facility document titled Comprehensive Care Plans, undated reflected the following, .A facility must develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.The comprehensive care plan must describe the following.the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required.and.any services that would otherwise be required.but are not provided due to the resident's exercise of rights, including the right to refuse treatment.The comprehensive care plan must be.developed within seven days after completion of the comprehensive assessment.periodically reviewed and revised by a team of qualified persons after each assessment.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 3 carts (west ramp medication aide cart) reviewed for pharmacy services. The facility failed to ensure the controlled substance reconciliation log was signed for accuracy of medication quantities during shift change. This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain and anxiety, and a decreased quality of life. The findings included: During an observation of the west ramp medication aide cart on 6/26/2026 at 9:00 AM, the controlled medication reconciliation log revealed 17 signatures were missing from the log between 6/01/2026 and 6/26/2026. During an interview with Med Aide D on 6/26/2026 at 9:06 AM, Med Aide D stated it was important to conduct the audit and sign the reconciliation log at every shift change. Med Aide D stated it was important for the log to be signed to ensure medications are available for the residents. Med Aide D stated if the log is not signed at shift change, the medication audit could be inaccurate. Med Aide D stated if medications were missing, residents could receive a medication they were not prescribed and experience adverse effects or untreated pain if their prescribed medication was unavailable. During an interview with the DON on 6/26/2026 at 9:40 AM, the DON stated, the controlled medication reconciliation log should be signed off at every cart exchange. The DON stated her expectation for staff was to sign the log at every audit to make sure both staff members agreed to the amount of medication left in the cart. The DON stated if the log was not signed each time, and the count was inaccurate, it could indicate a medication might not have been given. The DON stated if a resident's medication was not available it could affect the resident mentally or physiologically. Record review of the facility policy titled Policy for Control Drug-Count Record, undated, noted Nurses must sign the control drugs-count record sheet at the end of every shift with the incoming nurse to acknowledge that they have counted the control drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the controlled drug administration record.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Kitchen reviewed for food safety requirements.1. The facility failed to label and date half a tomato wrapped in clear wrap in the reach in refrigerator; the Dietary Supervisor's hair was not completely covered by a hair restraint, and the facility failed to provide a readily accessible hands-free covered trash receptacle in the kitchen. Kitchen staff were required to touch the trash can lid to dispose of waste.2. The facility failed to label and date two bundles of green leaf lettuce wrapped in plastic, one opened gallon container of milk, and one bin of tomatoes, bell peppers, and celery stored in the refrigerator; and failed to hold the pureed broccoli at the minimum safe food holding temperature. These failures could place residents at risk for spread of infections, food contaminations, food-borne illnesses, and diminished quality of life. The findings included: 1. During an observation and interview on 6/23/26 at 9:06 a.m., during an initial inspection of the facility kitchen, a tomato cut in half and wrapped in clear wrap was observed in the reach in refrigerator. The cut tomato was unlabeled and undated. The Dietary Supervisor stated the tomato in the reach in refrigerator was supposed to be labeled and dated to help determine when it would expire. The Dietary Supervisor stated the cut tomato could not be in the refrigerator for more than 3 days and if it could not be determined how long the item had been in the refrigerator and if a resident ate it, they could get sick. The Dietary Supervisor wore a hair restraint in a manner that the hair on the forehead was not covered by the hair restraint. The Dietary Supervisor stated, the hair restraint should cover all her hair, including the hair on her forehead to prevent hair from falling on the food, or anything that was in the kitchen. A large metal trash can with a detachable lid used to dispose of waste was observed in the kitchen. The Dietary Supervisor stated the trash can was used to dispose of used paper towels after the staff washed their hands in the sink. The Dietary Supervisor stated touching the trash can lid after washing your hands was cross contamination because the trash can lid was dirty because other staff touched the lid. The Dietary Supervisor stated, it's like you really didn't clean your hands. The Dietary Supervisor stated the kitchen staff had used the same metal trash bin for a long time. During an interview on 6/24/26 at 9:13 a.m., the Administrator stated he purchased a new hands-free trash receptacle for the kitchen because if staff touched the metal trash can with a detachable lid, after staff washed their hands, it was considered cross contamination which could result in a resident getting sick due to contamination. 2. During an interview with the Administrator on 6/24/2026 at 4:41 PM, the Administrator stated all food items stored in the kitchen should 2. During an observation of the facility kitchen on 6/24/2026 at 2:44 PM, two bundles of green leaf lettuce wrapped in plastic wrap were stored in the refrigerator with no date, one opened gallon container of milk was stored in the refrigerator with no opened date, and one bin of tomatoes, bell peppers and celery was stored in the refrigerator with no date. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with [NAME] A on 6/24/2026 at 2:56 PM, [NAME] A stated the undated items should have been dated. [NAME] A stated they were supposed to date items after opening or repackaging them so they would know when they were acquired and when they would go bad. [NAME] A stated if residents ate food that had gone bad, they could get sick. During an interview with the Dietary Supervisor on 6/24/2026 at 3:02 PM, the Dietary Supervisor stated items in the refrigerator should be dated when opened or repackaged because the items could go bad and not be safe to eat. The Dietary Supervisor stated residents could get sick if they ate spoiled food. be dated, because after 24 or 48 hours it must be thrown away. The Administrator stated undated items should not be given to the residents, because if they were outdated residents could experience gastrointestinal effects. During an observation of the facility kitchen on 6/25/2026 at 11:34 AM the pureed broccoli for the lunch service was held at 130 degrees. During an interview with [NAME] C on 6/25/2026 at 11:39 AM, [NAME] C stated the minimum holding temper for the pureed broccoli should have been 155 degrees. [NAME] C stated if foods were not held to the proper holding temperature, they could become contaminated with bacteria and be dangerous for the residents to consume. During an interview with the DON on 6/25/2026 at 5:02 PM, the DON stated she expected for all prepared foods to be held at the proper temperature before serving. The DON stated it was important for foods to be held at the appropriate temperature to prevent bacteria growth which could cause digestive problems for the residents. Record review of the facility document titled Temperature Mini-Poster, revised 2002, noted Keep Hot Foods Hot 140 degrees . Record review of the facility document titled Storage of Food and Chemicals, undated reflected in part, .Storage of Food.ALL food items must be COVERED, LABELLED, and DATED. Record review of the facility document titled Food Service Hygiene, undated reflected in part, .Employees.Food service personnel must be in good health and practice good hygienic food-handling techniques.Employees must meet acceptable standards of personal hygiene and appearance.Hair clean and worn in manner that it can be completely covered by hair restraint.Storage.All items are labeled and dated before storing.Handling.Foods are held at temperatures below 40 degrees or above 140 degrees except for intervals when food is being prepared.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 in accordance with accepted professional standards and practices that were complete and accurately documented for 3 of 12 residents (Resident #1, #21, and #37) reviewed for accuracy of records:1. The facility failed to document in Resident #1's treatment records the use of heel protectors at bedtime every evening shift per physician's orders for April 2026 on 4/9/26, and 4/14 - 4/30/2026, and the entire month of May 2026.2. The facility failed to document the diagnoses for use of antipsychotic medications on Resident #21's admission sheet.3. The facility failed to correctly transcribe a portion of the name of one medication to Resident #37's June 2026 MAR.These failures could affect residents whose records were maintained by the facility and could place the residents at risk of errors in care and treatment. The findings included: 1. Record review of Resident #1's face sheet dated 6/24/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, mental disorders due to known physiological condition (a mental or behavioral disturbance caused by a medical condition affecting the body or brain), seizures (episodes of abnormal, sudden electrical activity in the brain that temporarily disrupt normal brain function), and autistic disorder (a developmental condition that affects how a person communicates, interacts with others, learns and behaves). Record review of Resident #1's most recent comprehensive MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills, was dependent on staff for mobility and ADLs care and was at risk of developing pressure ulcers/injuries. Record review of Resident #1's Physician Orders for June 2026 reflected the following: - Heel protectors at bedtime every evening shift with order date 4/9/26 and no end date Record review of Resident #1's Treatment Administration Records reflected there was missing documentation on the April 2026 record on 4/9/26, and 4/14/26 &ndash; 4/30/26, and no documentation for the entire month of May 2026 for Resident #1's use of the heel protectors. Record review of Resident #1's comprehensive care plan dated 4/10/26 and revised on 6/10/26 reflected the resident had a skin problem and had 2 unstageable pressure ulcers (a pressure injury in which the extent of tissue damage cannot be determined because the wound bed is unobscured by slough [dead tissue that is soft and stringy] and eschar [dead tissue that is thick or leathery]) on the right and left hip, 2 unstageable boils on the back and 2 Stage 2 pressure ulcers (partial-thickness loss of skin with exposed dermis [the thick layer of skin located beneath the outer layer of skin]) on the shoulders, and 1 Stage 3 pressure ulcer (full-thickness loss of skin) on the foot. Resident #1's care plan reflected the wounds mentioned above were healed on 6/10/26 and the care area had a line marked across it. Resident #1's care plan did not include the resident used heel protectors. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/24/26 at 9:54 a.m., the LVN Treatment Nurse stated Resident #1 had several wounds that had recently deemed resolved/healed and interventions to prevent the resident from re-developing wounds included turning and repositioning and heel protectors. The LVN Treatment Nurse stated Resident #1 was supposed to be wearing heel protectors while in bed and should continue to use them otherwise he could develop another sore. During an interview on 6/25/26 at 5:03 p.m., the DON stated, missing documentation on the treatment records was a problem and there was no excuse for that. The DON stated she believed the staff were ensuring Resident #1 was provided the heel protectors based on the wounds had been resolved/healed, but staff just weren't documenting it. 2. Record review of Resident #21's admission sheet dated 12/06/2024, documented a [AGE] year-old male resident with diagnoses including hypertension (high blood pressure), seizure disorder, cognitive communication deficit, and traumatic brain injury. Record review of Resident # 21's MDS dated [DATE] documented a BIMS score of 11 indicating moderate cognitive impairment and recorded the use of antipsychotic, antianxiety, anticoagulant, diuretic, and anticonvulsant medications. Record review of Resident #21's order summary included orders for Rexulti with an order date of 11/26/2025, Aristada with a start date of 8/14/2025, and Haldol with an order date of 6/07/2026. Rexulti was ordered as Rexulti 4 mg, give 1 tab po daily DX: schizoaffective bipolar type. Aristada was ordered as Aristada, 882 mg IM monthly DX: bipolar disorder. Haldol was ordered as Haldol 5 mg, give 5 mg po Q6H prn DX: bipolar disorder. Record review of Resident #21's care plan with an initiation date of 12/05/2024, did not document the resident was treated with an antipsychotic medication. 3. Record review of Resident #37's admission sheet dated 1/04/2018 with a re-admission date of 9/10/2022 documented a [AGE] year-old female resident with diagnoses including schizophrenia, Parkinson's disease, dementia, seizure disorder/convulsions, hallucinations, and delusional disorder. Record review of Resident #37's MDS dated [DATE] documented a BIMS should not be conducted due to the resident is rarely/never understood. Further review of the MDS recorded the use of antianxiety and anticonvulsant medications. Record review of Resident #37's care plan with an initiation date of 01/12/2022 documented the resident had Seizures Potential for Injury related to history of seizures ., with a goal of Resident will have no injuries due to seizures. Record review of Resident #37's order summary included an order for the anticonvulsant medication Keppra solution with an order date of 6/18/2026. Keppra was ordered as Keppra 100 mg/mL, give 10ML PGT 2X DAILY. Record review of Resident #37's June 2026 MAR revealed Keppra had been handwritten on the MAR (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as Keppra 100 mg/5 mL give 10 mL = 1000 mg pgt B.I.D. 06/18/26. During an interview with LVN B on 6/25/2026 at 8:30 AM, LVN B stated she had written part of the name of Resident #37's medication order incorrectly on the MAR but would clarify what she had written down with the doctor's order. LVN B stated she always gave the resident 10 mL of medication to equal 1000 mg according to the directions on the pharmacy label on the medication and the directions on the MAR which matched the directions on the doctor's order. LVN B compared what she had written on the MAR with the doctor's order and updated the name of the medication written on the MAR to reflect the doctor's order of Keppra 100 mg/mL, give 10 mL pgt twice daily. LVN B stated it was important for handwritten orders on the MAR to match the label on the medication bottle and the doctor's order, because if they were giving medication incorrectly there could be an adverse effect. During an interview on 6/25/26 at 5:03 p.m., the DON stated missing documentation on the resident and treatment records was a problem and there was no excuse for that. The DON stated orders on the MAR should match the facility order summary, the medication label from the pharmacy, and the original doctor's order to make sure they were giving the right medication and the correct dose. The DON believed Resident #37 received the correct dose of medication based on there being only one strength of Keppra solution on the market and the directions for use matched the directions on the doctor's orders. Record review of the facility document titled, Operational Policy and Procedure Manual, Medical Records, undated reflected in part, .The purpose of charting and documentation is to provide.A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care.Rules for Charting and Documentation.Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc., as well as routine observations. Treatments.Documentation pertaining to treatments should include.Date and time each treatment administered.Name of person administering the treatment.Specific duties performed.Reason(s) for a resident's refusal of the treatment.Signature and title of person recording data.		

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NAME OF PROVIDER OR SUPPLIER San Jose Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 406 Sharmain Pl San Antonio, TX 78221	
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 6 residents reviewed for dignity. The facility failed to ensure CNA E did not feed Resident #1 while standing over him. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth. The findings included: Record review of Resident #1's face sheet dated 6/24/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit, mental disorders due to known physiological condition (a mental or behavioral disturbance caused by a medical condition affecting the body or brain), seizures (episodes of abnormal, sudden electrical activity in the brain that temporarily disrupt normal brain function), and autistic disorder (a developmental condition that affects how a person communicates, interacts with others, learns and behaves). Record review of Resident #1's most recent comprehensive MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills and was dependent on staff for feeding. Record review of Resident #1's comprehensive care plan dated 4/10/26 reflected the resident had a self-care deficit and was fed by staff related to being incapable of holding utensils, comprehending utensil use, leaving food uneaten if not assisted, unable to communicate food preferences, and the potential for weight loss. Resident #1's comprehensive care plan had interventions that included assisting the resident with eating. During an observation and interview on 6/24/26 at 8:17 a.m., Resident #1 was observed sitting up in bed and assisted by CNA E. CNA E was observed standing at the bedside providing Resident #1 with a beverage. CNA E stated she was helping Resident #1 with eating and was supposed to be sitting at eye level with the resident. CNA E pointed to a metal chair folded up on the opposite side of Resident #1's room and stated, she had been feeding the resident while sitting before the State Surveyor entered the resident's room but was done feeding the resident and wanted to offer him a beverage. CNA E stated the reason she should have been sitting when assisting Resident #1 was because it was more dignified than standing over him. CNA E stated, I felt like I was done feeding him (Resident #1) and I just wanted to give him a little more of the fluids. During an interview on 6/24/26 at 3:27 p.m., CNA F stated Resident #1 required staff assistance when feeding. CNA F stated, when feeding Resident #1 while in the bed, we should be standing. I always stand to make sure the resident was swallowing his food or in case something happens such as choking. CNA F stated, if a resident who required assistance with feeding was eating in the dining room she would sometimes sit but she felt more comfortable standing. CNA F stated she had heard of feeding residents at eye level which meant sitting while assisting but did not know why that was important. During an interview on 6/25/26 at 2:41 p.m., the DON stated, Resident #1 required total care, including assistance with feeding. The DON stated her expectation was when a resident was assisted with feeding, the staff should be sitting at eye level with the resident because we want the resident to feel comfortable when they are being fed. Record review of the facility's document titled Resident Rights dated April 2008 reflected in part, .Dignity and Respect. You have the right to be treated with dignity, courtesy, consideration, and respect. Participation in your care. You have the right to receive all care necessary to have the highest possible level of health.		

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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 the resident environment remained as free of accident hazards as was possible for 1 of 6 residents (Resident #17) reviewed for accidents and hazards: The facility failed to ensure Resident #17 did not have disposable razors, a pair of scissors, a can of air freshener, and a one-pound container of disinfectant wipes in her room. These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: Record review of Resident #17's face sheet dated 12/4/25 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included severe cognitive impairment and severe intellectual disabilities. Record review of Resident #17's most current quarterly MDS assessment dated [DATE] reflected the resident was visually impaired and was able to see large print, but not regular print such as in newspapers/books, wore corrective lenses, and was cognitively intact for daily decision-making skills. Record review of Resident #17's comprehensive care plan dated 8/23/23 reflected that the resident had a cognitive deficit and impaired decision-making skills related to severe intellectual disabilities with interventions that included to provide a calm, therapeutic environment and structured routine, and avoid changes in the resident's environment. During an observation on 6/23/26 at 10:20 a.m. Resident 17's bedroom revealed a can of aerosol air freshener placed on top of a personal refrigerator and a disposable razor in a plastic bin with toiletries on the resident's nightstand. During an observation and interview on 6/24/26 at 7:59 a.m. Resident #17 was observed sitting up in bed eating breakfast. Resident #17 stated the disposable razors in the plastic bin with her toiletries and the can of aerosol air freshener were her personal items. Resident #17 stated she was able to shower without assistance, and she used the disposable razor to shave. Resident #17 stated the can of aerosol air freshener was used because sometimes her room smelled. Resident #17 stated there were residents in the facility who would often wander into her room and one resident would come into her room looking for snacks. During an observation on 6/24/26 at 3:03 p.m. Resident 17's bedroom revealed a can of aerosol air freshener placed on top of a personal refrigerator and a disposable razor in a plastic bin with toiletries on the resident's nightstand. During an observation and interview on 6/24/26 at 3:46 p.m. CNA F stated there were residents in the facility who wandered into other residents' rooms looking to see what they can find and one resident in particular who went into resident rooms looking for snacks. CNA F stated the residents in the facility were not supposed to have disposable razors in their room because they were dangerous, and they (residents) could cut themselves. CNA F observed two disposable razors in Resident #17's room and then observed a pair of scissors in a cup next to the disposable razors. CNA F stated she was not sure if Resident #17 was allowed to have the can of aerosol air freshener and stated, I have never seen anybody (residents) with the air freshener. CNA F then observed a one-pound container of disinfectant wipes next to the can of aerosol air freshener. CNA F asked Resident #17 where she got the scissors, and the resident stated she had taken them from a family members house and used them to cut tape. Resident #17 stated she used the disinfectant wipes to clean her hands. CNA F stated, the disinfectant wipes were a product used by the facility and not for use on the skin. CNA F stated the disinfectant wipes were not meant to be used on the skin because they could irritate or worse the ingredients could absorb into the blood. CNA F stated that the disinfectant wipes were used to clean bedside tables and wheelchairs and were never used on a resident. During an interview on 6/25/26 at 4:42 p.m. the Administrator stated there (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were residents in the facility who wandered into other residents' rooms. The Administrator stated items such as disposable razors could not be kept by the residents because the residents using them or other residents could cut themselves. The Administrator stated disinfectant wipes were not for resident use and staff were responsible for routinely monitoring items that residents were not allowed to have. Record review of the facility document titled Policy for Hazardous Items in Resident rooms, undated reflected in part, .Any items that are hazardous or dangerous to the safety of residents, such as razors, wippees (sic), scissors, will be stored in a secure location. Any staff member that finds any of these items will remove them and give them to the charge nurse or to administration.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review the facility failed to post the nurse staffing data daily at the beginning of each shift for 1 of 4 days (6/26/26) reviewed for nursing staffing: The daily posted nurse staffing data had the previous day's nurse staffing data for 6/25/26, instead of the 6/26/26 nurse staffing data. This deficient practice could affect all residents and could result in residents and visitors being unaware of staffing levels in the facility. The findings included: Observation on 6/26/26 at 10:18 a.m. reflected the Daily Nursing Staff Hours posted in front of the nurse's station revealed the daily nursing staff hours from the previous day, 6/25/26 instead of the current day 6/26/26. During an interview on 6/26/26 at 10:20 a.m., RN G stated she started her shift on 6/26/26 at 6:00 a.m. and she was responsible for ensuring the current nursing staff hours were posted on the wall. RN G stated it was important to post the current nursing staff hours because it showed how many nurses were working the floor and the current census. During an interview on 6/26/26 at 10:24 a.m., the DON stated the nursing staff hours were supposed to be updated daily so the residents and family members could see how many nurses were working at any given time. Record review of the facility document titled Policy for Daily Nursing Staffing Sign, undated reflected in part, .The daily staffing sign must be posted on a prominent location by the 6-2 nurse on a daily basis. This sign will include the number of nurses (RN, and LVN), CNAs, Medication Aides and Restorative Aides on duty every shift, as well as the total number of hours they work.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 1 of 1 trash disposal areas that was reviewed for disposal of garbage. The dumpster drainage hole did not have a plug. This failure could place residents at risk for exposure to germs and diseases carried by pests and rodents. The findings included: During an observation of the facility dumpster on 6/24/2026 at 11:20 AM, the dumpster drainage hole did not have a plug. During an interview with the Maintenance Director on 6/24/2026 at 3:07 PM, the Maintenance Director stated the facility did not have a plug for the drainage hole and was not sure of the purpose of the plug. The Maintenance Director stated they had to keep the door of the dumpster closed so mosquitos and flies could not get inside. The Maintenance Director stated mosquitos and flies could not enter the drainage hole in the dumpster. During a second interview with the Maintenance Director on 6/24/2026 at 3:21 PM, the Maintenance Director stated he had found and installed the plug on the drainage hole, and he did not know why it was needed or why it had not been on the dumpster. During an interview with the Administrator on 6/24/2026 at 4:41 PM, the Administrator stated the hole at the bottom of the dumpster is for drainage and should be covered with the plug to prevent flies from getting inside. Record review of the facility policy titled Garbage Dumpster Policy, undated, noted the facility will have a plug in the bottom drain at all times to prevent vermin from entering and liquid waste from escaping.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 1 Laundry Room reviewed for infection control: The facility failed to ensure the Laundry Room did not have personal employee food items on the clean folding table and clean laundered resident linens were stored uncovered on the clean storage shelf. These failures could place residents at risk for cross-contamination and infection and could result in illness due to improper care practices. The findings included: During an observation and interview on 6/26/26 at 10:51 a.m. during the inspection of the facility Laundry Room, the clean folding table was observed with a biscuit wrapped in wax paper and an empty food bowl with a lid. The shelf above the clean folding table was observed with three packages of pastries and a plastic grocery bag with food items. The Laundry Attendant stated the personal food items observed on the clean folding table belonged to her. The Laundry Attendant stated the biscuit wrapped in wax paper was for her lunch and the empty food bowl had eggs and bacon that she had consumed. The Laundry Attendant stated the food items should not be on the clean folding table because the table was used to fold clean clothes. The Laundry Attendant stated if the biscuit had been unwrapped it would be a problem but since it was wrapped it was not a problem. The Laundry Attendant stated, if she had left the biscuit unwrapped, she ran the chance of flies and lint getting on it and then would not be able to eat it. The Laundry Attendant stated, personal food items were kept in the laundry room but were not consumed in the laundry room. The Laundry Room inspection revealed the clean storage shelves had laundered resident linens stored uncovered. Observation revealed there were clean storage shelves on both sides of the laundry room with linens that had a bed sheet covering most of the shelves, but overflow was stacked on top uncovered. The Laundry Attendant stated she believed the linens should be covered because of the dust that could be emitted from the laundry room and the linens were next to the exit that had a screen door that could also expose the linens to dust. The Laundry Attendant stated she had been employed by the facility for over 3 years and it's always been like that. During an interview on 6/26/26 at 12:59 p.m., the Administrator stated, the laundry staff were allowed to have water in the laundry room because it's hot in the laundry room. The Administrator stated, as far as food items, laundry staff were allowed to have them but not consume them in the laundry room. The Administrator stated personal food items were to be kept in the refrigerator and any uncovered food items in the laundry room could soil the clean clothes. The Administrator stated that clean clothing items and linens were supposed to be covered to protect them from dust and to help the items stay clean. Record review of the facility document titled Laundry Room Food and Clean Clothes Storage Policy, undated reflected in part, .Attention: Laundry Staff. No food items of any kind are allowed in the laundry room, especially on top of the clean clothes folding table. Water bottles can be placed only on the hanger shelf. All clean clothes items stored in the clean storage shelves need to be covered or placed inside storage bags. Water bottles and food can only be stored inside the refrigerator.		

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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** Based on interview and record review, the facility failed to ensure bedrooms measured at least 80 square feet per resident in multiple resident bedrooms for 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). 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 inadequate space for activities of daily living in their rooms. The findings included: During an interview with the Administrator on 6/25/2026 at 4:39 PM, the Administrator stated 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, 21, 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. Review of the dimensions of the 16 rooms revealed they measured as followed:- room [ROOM NUMBER] - 79.3 square feet per resident (3 resident occupancy)- room [ROOM NUMBER] - 77.9 square feet per resident (2 resident occupancy)- 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)- 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 document titled Room Size Waiver for Facilities, dated 6/25/2026, documented Rooms 5, 15, 16, 17, 19, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31 met the justification criteria for waiver. Record review of the document titled Resident Master List Report, dated 6/23/2026, documented 21 residents resided in Rooms 5, 15, 16, 17, 19, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31. No residents were residing in room [ROOM NUMBER] during the annual survey.		