STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41937 Based on observation and interviews, the facility failed to ensure the resident received care and services safely and that the physical layout of the facility maximized resident independence and did not pose a safety risk, with housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior and adequate and comfortable lighting levels in all areas; for 2 of 2 shower rooms (A hall shower and B hall shower) reviewed for trip hazards and lighting. 1. The facility failed to have adequate safe lighting for the showers as evidenced by the B Hall shower having a shower stall with no light fixture within the shower stall and the A hall shower stall having no functioning light bulb in the fixture within the shower stall. 2. The facility failed to ensure there was no trip hazard in the A hall shower room as evidenced by the A hall shower stall had an inclined ramp up to the shower stall with a tile bump atop of the ramp. These failures could place residents at risk for injuries by not having adequate lighting and trip hazards. The findings included: Daily observations beginning on 1/7/2025 at 10:45 AM through 1/10/2025 at 3:00 PM revealed the facility had a census of 34 with 2 shower rooms within the facility, located in A hall and B hall. An observation of the B hall shower room revealed a shower stall with an inclined ramp up into the shower stall, the stall appeared dark and was dimly illuminated by the nearby fluorescent ceiling lamp. Further observation revealed no light fixture within the shower stall. Observation of the A hall shower room revealed a shower stall with an inclined ramp which led up into the shower stall. The ramp presented with a tiled and curved bump atop of the ramp. An observation and interview on 1/10/2025 at 11:34 AM revealed the Maintenance Director reviewed the B hall shower room. The Maintenance Director stated the shower stall did not have a light fixture. The Maintenance Director stated the shower stall had an inclined ramp up into the shower stall, the stall appeared dark and was dimly illuminated by the nearby fluorescent ceiling lamp. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 1/10/2025 at 11:41 AM revealed the Maintenance Director reviewed the A hall shower room. The Maintenance Director stated the shower stall did have a light fixture with a burned-out bulb and was not aware when the bulb may have burned-out. The Maintenance Director stated the shower stall had an inclined ramp which led up into the shower stall. The ramp presented with a tiled curved bump atop of the ramp. The Maintenance Director stated the curved bump tile may have been added to the top of the ramp to prevent water from draining down on to the floor when the drain may clog. The Maintenance Director stated he was not aware if this tiled bump would be a safety risk to anyone. An observation and interview on 1/10/2025 at 1:34 PM revealed hospice CNA K prepared linens and clothing for a Resident's shower in the A hall shower room and stated a light within the shower stall would allow her to better serve her residents with their skin assessments and ensure hygiene. CNA K stated the bump atop of the ramp made it difficult to push or pull residents over the bump, into the shower stall, and would often startle residents when the bump was overtaken. An observation and interview on 1/10/2025 at 2:20 PM revealed CNAs A and J reviewed the A hall shower room and stated the bump atop of the ramp had caused near trip hazards for them as they pushed or pulled residents over the bump. CNAs A and J stated there were several residents who used the shower by themselves, and the poor light and the bump could place them at risk for falling. During an interview on 01/10/2024 at 4:00 PM, the DON stated the poor lighting in the shower rooms should be corrected, and the tile curved bump atop of the A hall shower room ramp would be reviewed for safety and necessity. During an interview on 1/10/2025 at 5:00 PM, the Administrator stated he agreed with the DON assessment of the shower rooms. A policy was requested on 1/10/2025 and was not provided to the survey team before exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 - 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** 50531 Based on interview, record review and observation, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 12 residents [Resident #6] reviewed for care plans. The facility failed to develop the appropriate care plan intervention of implementing an abdominal binder to prevent Resident #6 from pulling out her feeding-tube per physician's order. This deficient practice could place resident at risk of trauma or injury. The findings include: Record review of Resident #6 face sheet dated 9/20/24 revealed an [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE]. Relevant diagnosis included Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with behavioral disturbance, bilateral below the knee amputee. Record review of Resident #6 Quarterly MDS dated [DATE] revealed resident unable to complete BIMS assessment due to severe cognitive impairment. Resident #5 had functional limittion in rang of motion with impairment on both sides of upper extremity to include shoulder, elvow, wrist, hand. The MDS reealed resident was dependent. The BIMS assessment was unable to be completed due to Resident#6 severe cognitive impairment. Resident #6 was dependent and helper did all the effort in ADL needs. Resident did none of the effort to complete any of the ADL activities. Record review of Resident #6 Care Plan (last updated 9/24/24) revealed absence of behavioral disturbance reflecting behavior of pulling out feeding tube or potential for injury related to pulling out feeding tube. Record review of Resident #6 physician's orders reflected an order dated 1/20/16 apply abdominal binder to prevent pulling of G-tube all shifts. During observation on 01/07/2025 at 10:55 AM Resident #6 was resting in bed, eyes closed with tube feeding connected and an abdominal binder was not in place. During observation on 01/08/2025 at 11:05 AM Resident #6 was resting in bed, eyes closed with tube feeding connected and abdominal binder was not in place. During an observation on 01/09//2025 at 2:20 PM Resident #6 was resting in bed, eyes were closed, and tube feeding was not running. An abdominal binder was not in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 - Few	An interview on 01/09/25 AM with CNA A revealed Resident #6 has a tendency to pull out tube feeding which is why abdominal binder is placed on resident. CNA A stated she worked with resident on 01/08/25 and applied binder. CNA stated abdominal binders were located in the linen closets. An interview on 01/09/25 at 10:25 AM with CNA B revealed staff used a binder to prevent Resident #6 from pulling out tube feeding. CNA B stated she has not worked with Resident #6 this week. An interview on 01/10/25 at 8:00 AM with LVN E confirmed that resident had an order for an abdominal binder. LVN E stated CNA's apply binder daily and reapply after peri-care as needed. LVN confirmed Charge Nurse is responsible to ensure abdominal binder is in place. LVN stated the staff know about the binder and that she will put it on the nursing MAR so it will not be missed. An interview on 01/10/25 at 8:22 AM with the DON confirmed that Resident #6 did have an order for an abdominal binder on at all shifts. DON confirmed that adverse effects to include trauma / injury to stoma site could occur if resident pulled feeding tube out. A request for a policy on Care Plan development and implementation was made on 01/09/2025 at 9:00 AM and was not provided by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41937 Resident #33 FTag Initiation 01/10/25 10:39 AM Thorazine consent not signed, wrong resident and theo [NAME] res was not on thorazine vns check was not on mar, 50531 Resident #6 FTag Initiation 01/10/25 03:31 PM Initiate F700 & F656 initiated d/t order for abdominal binder and fact that abdominal binder is not identified in the care plan and use of 1/2 side rail for positioning (not appropriate need for this resident).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 50531 Resident #6 FTag Initiation 01/10/25 03:31 PM Initiate F700 & F656 initiated d/t order for abdominal binder and fact that abdominal binder is not identified in the care plan and use of 1/2 side rail for positioning (not appropriate need for this resident).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5%, for 27 medication administration opportunities with 15 errors resulting in a 55.56% medication error rate, for 4 of 4 residents (Residents #6, #7, #22, and #30) reviewed for medication administration. 1. LVN D administered Resident #6's medications by her gastronomy tube (often called a G tube, is a surgically placed device used to give direct access to a person's stomach for supplemental feeding, hydration, or medicine), contrary to professional standards by administering all the medications together rather than one by one, and late by 11 minutes. 2. LVN D administered Resident #30's medications by her gastronomy tube contrary to professional standards by administering all the medications together rather than one by one, and late by 50 minutes. 3. Medication Aide I did not administer Amlodipine 5mg to Resident #7 as prescribed by her physician. 4. Medication Aide I did not administer hydrochlorothiazide 25mg to Resident #22 as prescribed by his physician. These deficient practices placed residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: A record review of Resident #6's admission record dated 1/9/2025, revealed an admitted [DATE] with diagnoses which included hypertension (high blood pressure), diabetes (a person's difficulty using blood sugar in their cells) and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). A record review of Resident #6's quarterly MDS assessment dated [DATE] revealed Resident #6 was an [AGE] year-old female admitted for long term care and was unable to participate in a BIMS assessment which indicated severe cognitive impairment. Resident #6 was assessed with the need for a feeding tube (also known as a g-tube). A record review of Resident #6's care plan dated 01/09/2025 revealed, potential for weight loss and dehydration r/t CVA, dementia, tube feeding . flush PEG tube (Feeding tubes, or PEG tubes, allow you to receive nutrition through your stomach) with water and post medication administration as ordered per physician for hydration. tube feeding . flush tube as ordered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #6's physicians orders dated 1/9/2025 revealed the physician prescribed Resident #6 to receive medications which included metformin 500mg 1-tab PGT daily diagnoses diabetes mellitus type 2 at 8:00 AM and acetaminophen 500mg 1-tab PGT every 8 hours diagnosis generalized pain at 8:00 AM, 4:00 PM, and at midnight. Further review revealed the physician prescribed for Resident #6 to receive a water flush before and after each medication all shifts. During an observation on 01/09/2025 at 9:11 AM revealed LVN D prepared and administered medications for Resident #6 per Resident #6's g-tube. LVN D crushed and mixed the prescribed acetaminophen, metformin, miralax, and her liquid multivitamin by flushing the medications with an unmeasured amount of water poured from a 9-ounce plastic cup. LVN D began by pouring water into the resident's G-tube, adding water to the medications, and pouring the medications together in to Resident #6's g-tube, and completed the administration by pouring the remainder of the water from the plastic cup without administering the medications individually and with a water flush in between all individual medications. 2. A record review of Resident #30's admission record dated 07/22/2024 revealed an admitted [DATE] with diagnoses which included gastronomy status (presence of a g-tube), dementia, and seizures (electrical storms of the brain). A record review of Resident #30's quarterly MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old female admitted for long term care and assessed with severely impaired cognition, could not communicate her needs. Resident #30 was assessed with the need for a feeding tube. A record review of Resident #30's care plan dated 12/13/2024 revealed Resident #30 was quadriplegic (a symptom of paralysis that affects all a person's limbs and body from the neck down), NPO (Latin for nothing by mouth) and required enteral feeding (enteral administration is food or drug administration via the human gastrointestinal tract), Tube feeding . Resident has gastronomy tube . assess feeding tube placement, patency, and residual every shift and before and after administration of any fluids or medications. A record review of Resident #30's physician order summary dated January 2025, revealed the physician prescribed Resident #30 would have her g-tube flushed with 15 ml of water before and after administration of medications. Further review revealed the physician prescribed Resident #30 to have 11 medications administered by her g-tube, at 8:00 AM, as follows: Apixaban 5mg 1-tab PGT 2x daily crush tab and suspend in 60ml water 8:00 AM, 8:00 PM. Escitalopram 5mg 1-tab PGT daily 8:00 AM. Memantine 5mg 1-tab PGT daily 8:00 AM. Tramadol 50mg 1-tab PGT 2x daily 8:00 AM / 8:00 PM. Reglan 5mg/5ml 10mg PGT 3x daily 8:00 AM, 4:00 PM, midnight. Aspirin 81 mg 1-tab PGT daily 8:00 AM. Docusate sodium 100mg 1-tab PGT 2x daily 8 AM and 8 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sodium chloride 1 gram 1-tab PGT 3x daily 8:00 AM, 2:00 PM, 8:00 PM. Simethicone 80mg 1-tab PGT 2x daily (may crush med) 8:00 AM, 8:00 PM. Oxcarbazepine 300mg 1-tab PGT 2x daily 8:00 AM, 8:00 PM. Miralax 17 grams powder 1 capful 2x daily 8 ounces of water. During an observation on 1/9/2025 at 9:50 AM revealed LVN D prepared and administered medications for Resident #30 per Resident #30's g-tube. LVN D crushed, mixed, with water, and administered the following prescribed medications together and not separately - individually: Apixaban 5mg 1-tab PGT 2x daily crush tab and suspend in 60ml water 8:00 AM, 8:00 PM. Escitalopram 5mg 1-tab PGT daily 8:00 AM. Memantine 5mg 1-tab PGT daily 8:00 AM. Tramadol 50mg 1-tab PGT 2x daily 8:00 AM / 8:00 PM. Reglan 5mg/5ml 10mg PGT 3x daily 8:00 AM, 4:00 PM, midnight. Aspirin 81 mg 1-tab PGT daily 8:00 AM. Docusate sodium 100mg 1-tab PGT 2x daily 8 AM and 8 PM. Sodium chloride 1 gram 1-tab PGT 3x daily 8:00 AM, 2:00 PM, 8:00 PM. Simethicone 80mg 1-tab PGT 2x daily (may crush med) 8:00 AM, 8:00 PM. Oxcarbazepine 300mg 1-tab PGT 2x daily 8:00 AM, 8:00 PM. Miralax 17 grams powder 1 capful 2x daily 8 ounces of water. During an interview on 01/09/2025 at 9:40 AM, LVN D stated the physician's order for Resident #30 was for 15 ml of water to be flushed by the g-tube before and after medication administration. LVN D stated the 9-ounce plastic water cup was unmarked for measurement. During an interview on 01/10/2024 at 11:20 AM, LVN D stated she had administered all medications mixed without a water flush in between each individual medication for Residents #6 and #30, on 1/9/2025, and did not have a response for why nor what effect the action could have had for residents. 3. A record review of Resident #7's admission record dated 7/22/2024 revealed an admitted [DATE] with diagnoses which included hypertension (high blood pressure). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #7's quarterly MDS assessment dated [DATE] revealed Resident #7 was an [AGE] year-old female admitted for long term care with the diagnosis of hypertension and assessed with a BIMS score of 8 out of a possible 15 which indicated mild cognitive impairment. Further review revealed Resident #7 was assessed with the ability to usually understand others and could usually make her needs known. A record review of Resident #7's care plan dated 10/18/2024 revealed Resident #7 was a fall risk with the intervention to assess medications for contributing factors. A record review of Resident #7's physician's orders, dated January 2025, revealed the physician prescribed for Resident #7 to receive amlodipine 5 g daily at 8:00 AM with the stipulation hold for systolic blood pressure less than 100 or diastolic blood pressure less than 60. During an observation and interview on 1/9/2025 at 8:54 AM revealed MA I prepared Resident #7's medications and checked Resident #7's blood pressure with a digital electronic blood pressure cuff. MA revealed the result was 102 systolic blood pressure (the pressure in your arteries when your heart beats) over 63 diastolic blood pressure (the pressure of blood in the arteries when the heart is resting between beats). MA I stated I will not give the (name brand for amlodipine) due to (Resident #7's name) low blood pressure. 4. A record review of Resident #22's admission record dated 7/22/2024 reveled an admitted [DATE] with diagnoses which included hypertension (high blood pressure). A record review of Resident #22's quarterly MDS assessment dated [DATE] revealed Resident #22 was a [AGE] year-old male admitted for long term care, diagnosed with high blood pressure, and assessed with a BIMS score of 06 which indicated severe cognitive impairment. A record review of Resident #22's care plan dated 10/11/2024 revealed, evaluate medications and diet for adverse interactions. A record review of Resident #22's physician orders dated January 2025 revealed the physician prescribed for Resident #22 to receive hydrochlorothiazide 25mg daily at 10:00 AM. Further review of the order revealed no stipulations. During an observation and interview on 1/10/2025 at 9:46 AM revealed MA I prepared medications for Resident #22 and prior to medication administration MA I checked Resident #22's blood pressure and stated the result was 99 SBP over 60 DBP with a pulse of 69 beats per minute. MA I stated she would not administer the amlodipine due to a low blood pressure. During an interview on 1/10/2024 at 1:20 PM, LVN E stated she was the charge nurse and had not received a report from MA-I regarding Resident #22's low blood pressure and the resulting MA-I holding the hydrochlorothiazide. LVN E stated Resident #22 did not have stipulations on the hydrochlorothiazide administration and would assess Resident #22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/10/2025 at 11:23 AM, LVN E stated she did not have any standing physician orders for g-tube medication administration to reference for enteral flushes. LVN E stated Residents #6 and #30 did have orders for each medication to be administered separately with a water flush in between each medication administration. LVN E stated all nurses should know the professional standard for medication administration per g-tube was for each medication to be administered one at a time with a water flush in between each medication. During an interview on 1/10/2025 at 1:30 PM the DON stated Residents #7 and #30 had physician orders for water flushes in between medication administration and the expectation was for all nurses to administer g-tube medications individually, flush the g-tube with 5-10 ml of water in between each medication, and to flush the g-tube with water before and after the whole medication administration. The DON stated medication aides should administer medications as prescribed by the physician and follow the parameters set by the physician. The DON stated if the medication had no stipulations / parameters then the medication should be administered per physicians' orders. The DON stated she had not received a report that Resident #22 had not received his hydrochlorothiazide this morning and stated if Resident #22's hydrochlorothiazide order did not have parameters it should have been administered with a blood pressure of 99 sbp / 63 dbp. The DON stated the risk for residents could be for residents not to receive the therapeutic effects of their medications. During an interview on 01/10/2025 at 4:40 PM, the Administrator stated he agreed with the DON on her expectations for g-tube medication administration and other medication administration practices. A policy for g-tube medication and medication errors was requested on 1/10/2025 and as of 1/16/2025 was not provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the United States of America's National Library of Medicine website, titled Preventing Errors When Drugs Are Given Via Enteral Feeding Tubes, https://pmc.ncbi.nlm.nih.gov/articles/PMC3875244/#:~:text=Appropriate%20administration%20techniques%20must%20be,drugs%20through%20enteral%20feeding%20tubes accessed 01/10/2025, revealed, Preventing Errors When Drugs Are Given Via Enteral Feeding Tubes Problem: Giving medications through a feeding tube can be fraught with errors that occur more often than they are reported or recognized. These mistakes are often the result of administering drugs that are incompatible with administration via a tube, of not preparing the medications properly, and of using faulty techniques. These inaccuracies can result in an occluded feeding tube, a reduced drug effect, or drug toxicity. These potential adverse outcomes can lead to patient harm or even death. FAULTY PREPARATION - Oral medications that are intended to be taken by mouth must be prepared for enteral administration. Tablets must be crushed and diluted, capsules must be opened so the contents can be diluted, and even many commercially available liquid forms of drugs should be further diluted before being administered enterally-a practice not well known to all practitioners. WRONG ADMINISTRATION TECHNIQUE - Most nurses rely primarily on their own experience and on that of their coworkers for information about preparing and administering enteral medications. Because few nurses rely on pharmacists, nutritionists, or printed guidelines, a variety of improper techniques and an overall lack of consistency have often been the result. The most common improper administration techniques include mixing multiple drugs together to give at the same time and failing to flush the tube before giving the first drug and between giving subsequent drugs. Safe Practice Recommendation: Within each organization, an interdisciplinary team of nurses, pharmacists, nutritionists, and physicians should work together to develop protocols for administering drugs through enteral feeding tubes. Protocols should address using appropriate dosage forms; preparing the drugs for enteral administration; administering each drug separately; diluting the drugs as appropriate; and flushing the feeding tube before, between, and after drug administration. A record review of the United States of America's National Library of Medicine website, titled, Hydrochlorothiazide https://medlineplus.gov/druginfo/meds/a682571.html Accessed 1/10/2025, revealed Why is this medication prescribed? Hydrochlorothiazide is used alone or in combination with other medications to treat high blood pressure. Hydrochlorothiazide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease and to treat edema caused by using certain medications including estrogen and corticosteroids. Hydrochlorothiazide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine. High blood pressure is a common condition and when not treated, can cause damage to the brain, heart, blood vessels, kidneys, and other parts of the body. Damage to these organs may cause heart disease, a heart attack, heart failure, stroke, kidney failure, loss of vision, and other problems. How should this medicine be used? Hydrochlorothiazide comes as a tablet, capsule, and solution (liquid) to take by mouth. It usually is taken once or twice a day. When used to treat edema, hydrochlorothiazide may be taken daily or only on certain days of the week. Follow the directions on your prescription label carefully and ask your doctor or pharmacist to explain any part you do not understand. Take hydrochlorothiazide exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. Hydrochlorothiazide controls high blood pressure but does not cure it. Continue to take hydrochlorothiazide even if you feel well. Do not stop taking hydrochlorothiazide without talking to your doctor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41937 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 3 medication carts (the medication aide cart) reviewed for supervision and security. The Medication cart was left unsupervised and unsecured for 25 minutes by an unknown staff member. This failure could place residents at risk for harm by not receiving the therapeutic effects of their medications. The findings included: During an observation on 1/9/2025 at 10:30 AM revealed the medication cart was left unsupervised and unsecured and positioned in the A hall by Resident #4's room. Continued observation from 10:30 AM until 10:55 AM revealed Resident #4 and Resident #20, housekeepers, and CNAs walked freely in the hallway back and forth past the unattended and unsecured medication cart. During an observation and interview on 1/9/2025 at 10:56, LVN D was alerted to the unsecured and unattended medication cart. LVN D was observed to lock the cart and stated the medication cart was not her assigned cart for the day and MA I was assigned to the medication cart. LVN D stated MA I was, on a break most likely. During an interview on 1/9/2025 at 3:00 PM, the DON stated all medication carts should be secured when not in use. The DON stated the risk for residents could be uncontrolled medications, unsecured During an interview on 1/10/2025 at 5:00 PM, the Administrator stated he agreed with the DON's expectations for secured medication carts. A policy was requested on 1/10/2025 and had not been received by exit on 1/10/2025. A record review of the CMS Review of Current Standards of Practice for Long-Term Care Pharmacy Services website: https://www.cms. gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/LewinGroup.pdf accessed 1/19/2025 revealed, . Medication carts must be supervised at all times by the nurse administering medications. When medication carts are not in use, they must be stored in a designated locked area with all drawers locked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews, 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 diseases and infections, which must include, at a minimum, the following elements: A. Standard and transmission-based precautions to be followed to prevent spread of infections, and B. The hand hygiene procedures to be followed by staff involved in direct resident contact; for 2 of 2 residents reviewed for incontinent care and medication administration (Residents #6 and #30) reviewed for standard and transmission-based precautions for infection control and prevention. 1. On 1/9/2025, CNA A and CNA J assisted Resident #6 with incontinent care and failed to change gloves with hand hygiene in between glove changes after touching handling Resident #6's soiled linens and supplies prior to touching handling Resident #6's clean linens and supplies. 2. On 1/9/2025, LVN D failed to change gloves with hand hygiene after touching handling Resident #6's clothing and furniture prior to administering Resident #6's medications. 3. LVN D failed to doff a potentially contaminated PPE gown prior to exiting Resident #6's room and wore the potentially soiled PPE gown in the hallway. 4. On 1/9/2025, LVN D failed to change gloves with hand hygiene after touching handling Resident #30's clothing and furniture prior to administering Resident #30's medications. 5. LVN D failed to doff a potentially contaminated PPE gown prior to exiting Resident #30's room and wore the potentially soiled PPE gown in the hallway. 6. The facility failed to store oxygen concentrator equipment in a clean room and stored the oxygen concentrator equipment in a bathroom. These failures could place residents at risk for harm by cross-contamination. The findings included: A record review of Resident #6's admission record dated 1/9/2025, revealed an admitted [DATE] with diagnoses which included hypertension (high blood pressure), diabetes (a person's difficulty using blood sugar in their cells) and dementia (A group of symptoms that affects memory, thinking and interferes with daily life). A record review of Resident #6's quarterly MDS assessment dated [DATE] revealed Resident #6 was an [AGE] year-old female admitted for long term care and was unable to participate in a BIMS assessment which indicated severe cognitive impairment. Resident #6 was assessed with the need for a feeding tube (AKA a g-tube). A record review of Resident #6's care plan dated 01/09/2025 revealed, at risk for covid-19 virus . follow strict CDC guidelines (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #6's physicians orders dated 1/9/2025 revealed the physicians' prognosis for Resident #6 was guarded. During an observation on 1/9/2025 at 10:57 AM revealed CNA A and CNA J assisted Resident #6 with incontinent care by donning PPE to include gowns and gloves. CNA A was observed to position and disrobe Resident #6 and continued to dispense cleansing wipes from the clean wipes package, clean Resident #6's genitalia and buttocks with multiple wipes kept atop of Resident #6's soiled under-pad, changed gloves without hand hygiene in between glove changes, and proceeded to remove the soiled linen and under pads, and then provided clean linen and adult briefs with the same soiled contaminated gloves. CNA A then doffed the gloves without performing hand hygiene and exited Resident #6 room. During an observation on 1/9/2025 at 11:17 AM, CNA A stated she changed gloves after every 3 to 4 wipes. CNA A stated she should have sanitized her hands after changing gloves, and improper hand hygiene was a risk for causing infections and cross contaminations or getting stool into Resident #6's vagina. 2. An observation and interview on 1/9/2025 at 9:11 AM revealed LVN D administered medications to Resident #6 via her g-tube. LVN D donned gloves without providing hand hygiene prior to donning, handled medication cart and keys, and entered Resident #6's room and assessed Resident #6's blood pressure, exited Resident #6 room without doffing the gloves and or performing hand hygiene, nor disinfecting the blood pressure cuff, and proceeded to prepared Resident #6's medications with the same gloves. LVN D donned PPE to include a gown and continued with the same gloves. LVN D was observed to handle Resident #6's person, clothing, furniture, and enteral piston syringe and then proceeded to administer Resident #6's medications via her g-tube while not changing gloves with hand hygiene prior to the medication administration. After the medication administration LVN D was observed to exit Resident #6's room without doffing the gown, doffed the gloves without providing hand hygiene, and continued into the hallway and entered a bathroom to wash Resident #6's enteral piston syringe and performed hand hygiene. LVN D continued in the hallway and reentered Resident #6's room to replace the piston syringe in the package, exited Resident #6's room and doffed the gown without performing hand hygiene. LVN D stated she should have changed gloves with hand hygiene before administering Resident #6's g-tube medications and stated the potential harm for residents was infections. 3. A record review of Resident #30's admission record dated 07/22/2024 revealed an admitted [DATE] with diagnoses which included gastronomy status (presence of a g-tube), dementia, and seizures (electrical storms of the brain). A record review of Resident #30's quarterly MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old female admitted for long term care and assessed with a severely impaired cognition, could not communicate her needs. Resident #30 was assessed with the need for a feeding tube. A record review of Resident #30's care plan dated 12/13/2024 revealed Resident #30 was quadriplegic (a symptom of paralysis that affects all a person's limbs and body from the neck down), NPO (Latin for nothing by mouth) and required enteral feeding (enteral administration is food or drug administration via the human gastrointestinal tract), Tube feeding . Resident has gastronomy tube . assess feeding tube placement, patency, and residual every shift and before and after administration of any fluids or medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #30's physicians orders dated 1/9/2025 revealed the physicians' prognosis for Resident #30 was guarded. During an observation on 1/9/2025 at 9:48 AM revealed LVN D donned gloves without performing hand hygiene, prepared Resident #30's medications, doffed the gloves without hand hygiene, donned new gloves, entered Resident #30's room, recognized she was missing a piston syringe and a PPE gown, exited the room while continuing with the same gloves, walked to the supply cabinet closet in the hallway, donned a gown and returned to Resident #30's bedside with the same gloves. LVN D was observed to administer Resident #30's medications with the same gloves. After LVN D administered Resident #30's medications she was observed to exited Resident #30's room, without doffing the gown and gloves, continued in the hallway to the bathroom where she doffed the gloves provided hand hygiene and washed the piston syringe. LVN D continued with the same gown in the hallway and returned to Resident #30's room to replace the piston syringe and doffed the gown. 4. During daily observations from 1/7/2025 through 1/10/2025 revealed the A Hallway public bathroom for staff and visitors. Further daily observations revealed the bathroom housed 2 clean oxygen concentrators covered with plastic translucent bags. The bags were labeled cleaned 1/6/2025 and 12/2/24. During an interview on 1/8/2025 at 1:20 PM, LVN E stated the clean oxygen concentrators were available for resident-use and were stored in the staff and visitors public restroom due to lack of space with in the facility. During an interview on 01/10/2025 at 2:00, the DON stated the expectation for infection control and prevention was for staff to follow standard precautions for all residents and enhanced barrier precautions for residents with g-tubes. The DON stated standard precautions were for staff to perform glove changes when going from a dirty to clean scenario and to perform hand hygiene in between all glove changes and when gloves are doffed. The DON continued to state all PPE must not be worn in the hallways and should be doffed in the enhanced barrier precautions room. The DON stated the nursing staff were trained per CDC guidelines for standard and enhanced barrier precautions. During an interview on 1/10/2025 at 5:00 PM, the Administrator stated he agreed with the DON's expectations for infection control and prevention. A policy for infection control was requested on 1/10/2025 and was not provided upon exit on 1/10/2025. A record review of the United States of America's Centers for Disease Control and Preventions website titled, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings. https://www.cdc.gov/infection-control/hcp/core-practices/index.html Accessed 1/10/2025, revealed, Use Standard Precautions to care for all patients in all settings. Standard Precautions include: 5a. Hand hygiene 5b. Environmental cleaning and disinfection . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5f. Reprocessing of reusable medical equipment between each patient or when soiled Standard Precautions are the basic practices that apply to all patient care, regardless of the patient's suspected or confirmed infectious state, and apply to all settings where care is delivered. These practices protect healthcare personnel and prevent healthcare personnel or the environment from transmitting infections to other patients. 5a. Hand Hygiene . Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or the patient's immediate environment. After contact with blood, body fluids or contaminated surfaces. Immediately after glove removal. Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled. Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. 5d. Risk Assessment with Appropriate Use of Personal Protective Equipment . Ensure proper selection and use of personal protective equipment (PPE) based on the nature of the patient interaction and potential for exposure to blood, body fluids and/or infectious material: Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Wear a gown that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions, or excretions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	. Remove and discard PPE . upon completing a task before leaving the patient's room or care area. Do not use the same gown or pair of gloves for care of more than one patient. Remove and discard disposable gloves upon completion of a task or when soiled during the process of care. Ensure that healthcare personnel have immediate access to and are trained and able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45E341	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Nursing Center	5819 Pecan Valley Dr San Antonio, TX 78223

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 FACILITY Environment 01/09/25 02:35 PM poor lighting in shower rooms. a and b, resident little stated she used shower and she could use a better light, and could be warmer, the heater in a and b were not working. 01/09/25 05:36 PM pm [NAME] stated laundry door gap ok, ok for concern and no tag for door gap, shower curtain in between dirty and clean, and toilet on pedestal, Resident #19 FTag Initiation 01/10/25 01:31 PM no light in shwr and bump on ramp.