

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 45F410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER St. Francis Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 630 W Woodlawn Ave San Antonio, TX 78212	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on Observation, Interview, and Record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 2 of 5 (Residents #3 and #49) reviewed for resident rights, in that:</p> <p>The facility failed to ensure Resident #3's and Resident #49's call light was within reach.</p> <p>This failure could place residents at risk of not achieving independent functioning, dignity, and well-being.</p> <p>Findings include:</p> <p>1. Record review of Resident #3's face sheet dated 10/16/24 reflected an 86 - year old female who was admitted to the facility on [DATE] with diagnoses which included: Chronic Obstructive Pulmonary Disease (lung disease that damages the airways or other parts of the lungs, making it difficult to breathe), Depressive Disorder (a mood disorder that can affect a person's thoughts, feelings, and ability to perform daily activities), and Dementia (condition characterized by loss of brain functions such as memory loss).</p> <p>Record review of Resident #3's Quarterly MDS assessment, dated 8/05/24, reflected a BIMS score of 3 which indicated severe cognition impairment.</p> <p>Record review of Resident 3's care plan, dated 2/14/24, reflected Impaired mobility related to Dementia interventions keep call light within reach.</p> <p>Observation and interview on 10/16/24 in Resident #3's room at 10:20 AM revealed the call light was found on the night stand out of arms reach. Resident # 3 stated, They will come check on me if call light is out of reach.</p> <p>2. Record review of Resident #49's face sheet, dated 10/16/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included: Heart Failure (a condition in which heart doesn't pump as well as it should), Osteoarthritis (a degenerative joint disease that occurs when the cartilage that cushions the end of bones breaks down over time), and Hyperlipidemia (a condition where there are high levels of lipids in the blood) .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #49's Quarterly MDS assessment, dated 7/30/24, reflected a BIMS score of 12 which indicated moderate cognition impairment.</p> <p>Record review of Resident #49's care plan, dated 11/8/23, reflected Impaired physical mobility related to decreased strength with interventions keep essential items call light within reach.</p> <p>Observation and interview on 10/16/24 in Resident #49's room at 10:45 AM, revealed the call light was on the night stand out of arm's length. Resident #49 stated they work so hard they forgot to move that thing (call light) close to me, I will have to send smoke signals if I need help.</p> <p>During an interview on 10/16/24 at 11:00 AM, CNA A stated she was the assigned nursing assistant for Resident #3, and Resident #49 she mentioned she did not know how Resident #3's and Resident # 49's call light ended up on the nightstand, but she always clipped call light to the residents' clothes when they were up out of bed. CNA A also noted if Resident #3 and Resident #49 lacked access to the call light, it could potentially lead to a possible fall if they requested assistance.</p> <p>During an interview with the DON on 10/17/24, at 8:35 AM, the DON emphasized the importance of ensuring the call light was accessible to all residents, and stated that the lack of accessibility to a call light for any resident could lead to a potential negative outcome if assistance is needed. The DON also mentioned charge nurses currently monitored this task during their morning rounds daily, and she and her ADON were responsible for overseeing this process.</p> <p>Record review of the facility's policy titled, Answering Call Light, undated, revealed, when a resident is in bed or confined to a wheel chair be sure call light is with in reach.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for 1 of 5 residents (Resident #3) reviewed for privacy, in that:</p> <p>The facility failed to ensure MA D locked the computer, which exposed Resident #3's morning medication list after she walked away and left the computer unattended.</p> <p>This failure could place residents at risk of having medical information exposed to others and cause residents to feel uncomfortable and disrespected.</p> <p>The findings include:</p> <p>Record review of Resident #3's face sheet dated 10/16/24 reflected an 86 - year old female who was admitted to the facility on [DATE] with diagnoses which included: Chronic Obstructive Pulmonary Disease (lung disease that damages the airways or other parts of the lungs, making it difficult to breathe), Depressive Disorder (a mood disorder that can affect a person's thoughts, feelings, and ability to perform daily activities), and Dementia (condition characterized by loss of brain functions such as memory loss).</p> <p>Record review of Resident #3's Quarterly MDS assessment, dated 8/05/24, reflected a BIMS score of 3 which indicated severe cognition impairment.</p> <p>Observation on 10/17/24 at 9:12 AM, revealed MA D prepared Resident's #3's morning medication and , walked away from the computer, MA D did not lock the computer screen.</p> <p>During an interview on 10/17/24 at 9:20 AM, MA D stated she was not aware of the option to lock the computer screen and believed minimizing the screen was sufficient. MA D stated when she stepped away from the computer, Resident #3's private medical information may have been exposed.</p> <p>During an interview on 10/17/24 at 11:41 AM, the DON stated she was not aware Resident #3's records were left open and unattended. The DON stated it was her expectation for the facility nursing staff to uphold HIPAA regulations and lock computer screens when they were away from them. The DON emphasized that all staff members were responsible for ensuring the protection of residents' information. The DON expressed concern that leaving residents' charts open and unattended could lead to unauthorized access. The DON also stated the ADON would be responsible for overseeing compliance with this task, and she would monitor it by conducting random computer screen checks.</p> <p>Record review of the facility's policy titled, Privacy of Computers during medication pass, dated March 2014, reflected: all patient information accessed during the medication pass shall be positioned to minimize visibility.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care, including tracheostomy care and tracheal suctioning was provided such care, consistent with professional standards of practice, for 2 of 3 residents (Residents #6 and #23) reviewed for respiratory care in that:</p> <p>The facility failed to ensure Residents #6 and #23's, oxygen tubing was dated.</p> <p>This deficient practice could place residents at risk for an increase in respiratory complications.</p> <p>The findings were:</p> <p>1. Record review of Resident #6's face sheet, dated 10/17/24, reflected a [AGE] year old female who was admitted to the facility on [DATE] with diagnoses which included: Hypertension (a condition where the pressure in your blood vessels is persistently high), Heart Failure (long term condition that occurs when the heart can not pump enough blood to meet the body's need's), and Hearing loss (Inability to hear sound in one or both ears).</p> <p>Record review of Resident #6's Quarterly MDS, dated [DATE], reflected a BIMS score of 12 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #6's care plan, dated 8/13/24, reflected the resident received oxygen therapy with interventions of administer oxygen as ordered.</p> <p>Record review of Resident #6 monthly physician orders for The month of October 2024, reflected an order to change oxygen tubing weekly on Sunday.</p> <p>Observation and interview on 10/17/24 at 9:45 a.m. revealed Resident #6 in her room reading with the oxygen tubing which was undated. Resident #6 stated she did not recall if the tubing was ever dated.</p> <p>2. Record review of Resident #23's face sheet dated 10/17/24, reflected a [AGE] year old female who was admitted to the facility on [DATE] with diagnoses which included: General Anxiety (feeling of fear, dread and uneasiness that can be a normal reaction to stress), Congestive Heart Failure (serious condition that occurs when the heart cant pump enough blood to meet the needs of body), and Dependent on Oxygen (requirement of supplemental oxygen constantly).</p> <p>Record review of Resident #23's Quarterly MDS, dated [DATE], reflected a BIMS score of 13 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #23's care plan, dated 4/10/24, reflected the resident was on continuous oxygen related to shortness of breath.</p> <p>Record review of Resident #23's monthly physician orders for the month of October 2024, reflected an order to change oxygen tubing weekly on Sunday.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with Resident #23 on 10/17/24 at 11:25 a.m., in the dining room revealed Resident #23 waiting to be served lunch wearing a portable oxygen tank with oxygen tubing which was undated. Resident #23 stated, I don't recall if oxygen tubing gets changed.</p> <p>During an interview with LVN C on 10/17/24 at 12:28 p.m., LVN C stated she was the assigned LVN for Residents #6 and #23 and stated there was no date on the oxygen tubing for both residents. LVN C stated she did not know why the residents' oxygen tubing was undated and revealed night shift nurses usually dated and changed oxygen tubing weekly. LVN C stated, if the oxygen tubing was undated, we would not know when it was last changed which could cause a possible respiratory infection.</p> <p>During an interview with the DON on 10/18/24 at 2:27 p.m., the DON confirmed Residents #6 and #23 should have had their oxygen tubing changed and dated by the night shift. The DON stated Residents #6 and #23 risked a possible respiratory infection due to the oxygen tubing being undated as no one would know when it was last changed. The DON stated she was responsible for over seeing this task was completed and would have the ADON start monitoring this weekly moving forward.</p> <p>Record review of the facility's policy titled, Oxygen Equipment, undated, revealed, label all equipment such as oxygen tubing with date / time / initials.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>27923</p> <p>Based on observation, interviews, and record reviews, the facility failed to post information on a daily basis regarding the total number of the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift for registered nurses, licensed practical nurses or licensed vocational nurses, certified nurses aides and resident census for 1 of 1 facility reviewed for posting.</p> <p>The facility failed to include the actual hours worked for the nursing staff on the nursing daily staff posting</p> <p>This deficient practice could place residents at risk or missed or inadequate care.</p> <p>The findings were:</p> <p>Observation on 10/16/24 at 9:30 a.m., revealed the facility had a daily nursing staffing posting for 10/16/24 in a visible area on the wall adjoining the main entrance to the facility. The daily nursing staffing posting included the following: 1- the hours of each of the nursing shifts for the 24 hour period, 2- the staff working on the shift which included registered nurses, licensed vocational nurses, certified nurses aides, restorative aides, and medications aides, 3-the number of the staff by discipline who worked on the shift, 4- the total hours worked for each group of staff during the shift, and 5- the summary of the total hours worked for that nursing discipline during the shift, and 6-the resident census for the day.</p> <p>During an interview with the HR Director on 10/18/24 at 12:15 p.m. the HR Director stated the hours worked by licensed and unlicensed nursing staff usually exceeded the number of hours for these disciplines that were posted. The HR Director provided sample documentation for the dates of 10/11/24, 10/12/24, 10/13/24, 10/14/24, 10/15/24, and 10/16/24 which reflected licensed and unlicensed staff, on those days, had actual hours worked that exceeded the number of hours that were posted for that day. The HR Director stated the licensed and unlicensed staff generally stayed at the facility longer than required in order to ensure a more thorough change of shift.</p> <p>During an interview with the Administrator on 10/18/24 at 12:30 p.m., the Administrator stated the facility always posted the daily nurse staffing form in a visible location and the nursing hours posted was usually less than the actual hours worked. The Administrator stated she felt the nursing staff hours that were posted demonstrated staffing levels that met the needs of the residents.</p> <p>Record review of the facility's posted daily nursing staffing forms for the time period 9/1/24 through 10/16/24 reflected the daily staffing postings did not include the actual hours worked for the licensed and unlicensed nursing staff</p> <p>Record review of the facility's undated policy on Staffing reflected, Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Our facility furnishes information from payroll records setting forth the actual recorded time, and types of personnel on each day of each quarter to appropriate state agencies.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on interview and record review, the facility failed to ensure PRN orders for psychotropic drugs were limited to 14 days , except if the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record, and indicate the duration for the PRN order for 1 of 3 residents (Resident #41) reviewed for pharmacy services, in that:</p> <p>The facility failed to ensure Resident #41 had a stop date for PRN Xanax 0.25 mg (a medicine used to treat the symptoms of anxiety).</p> <p>This failure could place residents at risk of receiving unnecessary psychotropic medications.</p> <p>The findings include:</p> <p>Record review of Resident #41's face sheet, dated 10/16/24, reflected an 84- year old female who was admitted to the facility on [DATE] with diagnoses which included: Anxiety (a feeling of fear, dread, and uneasiness), Dementia (the loss of cognitive functioning to such an extent that it interferes with a person's daily life and activities), and Hypertension (when the pressure in your blood vessels is too high).</p> <p>Record review of Resident #41's most recent comprehensive MDS assessment, dated 10/08/24, revealed the resident was severely cognitively impaired for daily decision-making skills and was treated with anti-anxiety medications.</p> <p>Record review of Resident #41's comprehensive care plan dated 10/16/24 reflected the resident had a diagnosis of anxiety and used antianxiety medication as ordered by the physician.</p> <p>Record review of Resident #41's Order Summary Report, dated 10/16/24, reflected the following:</p> <p>- Xanax Oral Tablet 0.25 MG, give 1 tablet by mouth twice a day as needed for anxiety disorder, with start date 10/11/24 and no stop date.</p> <p>Record review of Resident #41's Medication Administration Record for October 2024 revealed Xanax 0.25 mg was not administered PRN all month in October 2024.</p> <p>During an observation and interview on 10/16/24 at 12:17 p.m. Resident #41 was observed in wheelchair awake and alert. Resident #41 stated she did not recall if she had been administered any medications.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/16/24 at 12:25 p.m., LVN C disclosed she did not recall if she had administered Xanax to Resident #41 to help with anxiety. LVN C stated psychotropic medications like Xanax should be used for a limited time, usually up to 14 days. After 14 days, the nurse was required to contact the physician to reassess the resident's need for the medication. LVN C stated she was unsure why the order for Xanax for Resident #41 was written for an indefinite period, and she expressed concern the resident was at risk of falls by taking the medication for more than 14 days.</p> <p>During an interview and record review on 10/17/24 at 2:10 p.m., the DON revealed Resident #41 required the use of Xanax as recommended by the physician due to the resident's diagnosis. The DON stated if the medication was taken all the time, it could result in Resident #41 being overmedicated. After reviewing Resident #41's order summary, the DON confirmed there was no stop date on the order for prn Xanax . The DON revealed she was unaware Xanax should only be ordered for 14 days and then reassessed by a physician for continued use. The DON stated moving forward she would be responsible for overseeing that psychotropic drugs were limited to 14 days, and her Assistant Director of Nursing was to start monitoring this daily moving forward to prevent this from occurring again.</p> <p>Record review of the facility's policy and procedure titled, Antipsychotic Medication, undated, revealed, PRN antipsychotics: 14 day limitation on all PRN orders, order may not be extended beyond the 14 day limit.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36232</p> <p>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, in that:</p> <ol style="list-style-type: none"> The facility failed to store, label and date food items properly in the walk-in cooler, freezer, and dry storage room. The facility failed to store a dented can in a separate location in the dry storage room. <p>These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Observation on 10/15/2024 at 8:40 AM in the walk-in cooler revealed a half-gallon container of Lactose-Free whole milk. The container had been opened with approximately 1/2 of the milk remaining in the container. There was no label or marking indicating the date the container had been opened or a use-by date. Observation on 10/15/2024 in the walk-in freezer 8:46 AM revealed a plastic bag containing six biscuits. The bag was sealed with a knot and there was no label or marking indicating the date stored or use-by date. Observation on 10/15/2024 at 8:52 AM in the dry storage room revealed a plastic storage bin containing brown sugar. The transparent plastic lid of the bin was ajar, exposing the sugar to the ambient air in the dry storage room. <ol style="list-style-type: none"> Observation on 10/15/2024 at 8:50 AM in the dry storage room revealed a dented 6 lb. can of Mandarin oranges. The can of oranges was stored on a shelf with other cans that were not dented in the middle of the room. <p>During an interview on 10/18/2024 at 11:05 AM, the KS and assistant KS stated the milk, biscuits and sugar were all used for the breakfast meal that morning and were placed in the cooler and freezer immediately after use. They were not labeled immediately due to the time constraint of preparing and serving the meal. The dented can was received with the other cans that morning and staff had not had an opportunity to separate it from the others. They stated the risk of serving residents food that was not labeled and dated was potential food borne illness from bacteria due to not knowing how long the food had been opened. The risk of having a dented can on the same shelf with other cans before it was segregated with the other dented cans in a separate place was potentially causing foodborne illness. The risk of an opened bin of sugar in the dry storage room was the potential for contamination by rodents. Rodents could carry diseases and contaminate food. Staff was trained on food service topics every month by the KS, assistant KS, or consultant RD.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility policy, Dietary Department Infection Control General Procedures, undated, revealed: The following activities of dietary personnel may involve or have an effect on the risk of infection for residents and personnel of the nursing home. Storing Food. All food items should be checked for expiration dates on a periodic basis. Opened containers of food (e.g., flour, sugar) should be stored in clean bins with tightly sealed lids. Planning of Menus: 3. The walk-in refrigerator is checked daily for over-ripe or decaying fruits and vegetables. All foods that are left over must be labeled, dated, and covered with a tightly fitted lid and placed in the dietary refrigerator for use within 24 hours.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.1, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-101.11, Safe, Unadulterated, and Honestly Presented. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard.</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232</p> <p>Based on observation, interview, and record review, the facility failed to have a policy regarding the use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption of residents' food items for 4 of 5 resident refrigerators (refrigerators in resident Rooms 115, 208, 213, and 215) reviewed for personal food policy, in that:</p> <ol style="list-style-type: none"> The personal refrigerators in three residents' Rooms (115, 208, and 215) contained food items which were unlabeled and undated. The internal temperature of the refrigerator on resident room [ROOM NUMBER] exceeded 41 degrees Fahrenheit. <p>These deficient practices could place residents at risk of foodborne illness due to consuming foods which were spoiled.</p> <p>The findings were:</p> <ol style="list-style-type: none"> Observation on 10/15/24 at 10:28 a.m. revealed the personal refrigerator in resident room [ROOM NUMBER] contained melted ice cream shake in refrigerator which was unlabeled and undated. <p>Observation on 10/15/24 at 11:10 a.m., revealed undated and unlabeled melted ice cream shake in resident room [ROOM NUMBER] personal refrigerator was still present.</p> <p>During an Interview with CNA A on 10/15/24 at 11:20 a.m., revealed personal refrigerator in resident's room [ROOM NUMBER] contained undated and unlabeled melted ice cream shake.</p> <ol style="list-style-type: none"> Observation on 10/15/24 at 11:20 a.m. revealed the personal refrigerator in residents' room [ROOM NUMBER] contained sliced apples that were undated and unlabeled <p>Observation on 10/15/24 at 11:30 a.m., revealed unlabeled and undated sliced apples in resident's room [ROOM NUMBER] personal refrigerator was still present.</p> <ol style="list-style-type: none"> Observation on 10/15/24 at 11:35 a.m. revealed the personal refrigerator in resident's room [ROOM NUMBER] contained hard boiled eggs that were undated and unlabeled. <p>Observation on 10/15/24 at 10:37 a.m. revealed the unlabeled and undated hard-boiled eggs in residents room [ROOM NUMBER] personal refrigerator was still present.</p> <p>During an Interview with CNA B on 10/15/24 at 11:45 a.m. revealed the personal refrigerator in rooms [ROOM NUMBERS] contained food that was undated and unlabeled.</p> <p>During an interview with the DON and ADON on 10/15/24 at 12:25 p.m., the DON and ADON stated perishable food and drinks in residents' personal refrigerators should be labeled and dated to prevent residents from consuming spoiled foods. The DON stated housekeeping were responsible for overseeing this and currently this was not being monitored.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Observation on 10/15/2024 at 11:06 a.m. of the thermometer inside the refrigerator revealed it read 53 degrees Fahrenheit.</p> <p>During an interview on 10/15/2024 at 11:15 a.m., LVN E stated the thermometer inside the refrigerator read 55 degrees and was too high. LVN E also stated according to the temperature log, the temperature of the refrigerator had exceeded the acceptable range for several days and nothing had been done about it. The night shift took and recorded the temperatures; however, it was also his responsibility to monitor the temperatures to ensure they were in the proper range and sometimes these things got overlooked.</p> <p>Record review of the Refrigerator Temperature Log for October 2024 placed inside a document protector taped to the right side of the refrigerator inside room [ROOM NUMBER] revealed the temperature recorded every day from 10/01/2024 - 10/14/2024 was 50 degrees Fahrenheit.</p> <p>Record review of the facility's undated policy, Foods Brought by Family/Visitors, reflected, .Food brought to the facility by visitors and family is permitted. The nursing staff will discard perishable foods on or before the use by date</p> <p>Record review of the facility's undated In-Room Refrigerator Policy, reflected, The housekeeping supervisor, or her designee, will also inspect in-room refrigerators monthly and keep a written log of all in-room refrigerators and the dates they are inspected .In room refrigerators must be kept clean and in good working condition .</p> <p>46131</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on observation, interview, and record review, the facility failed to establish and 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 infection for 1 of 1 resident (Resident #6) reviewed for infection control, in that:</p> <p>The facility failed to ensure LVN C changed her gloves when moving from a dirty to clean task and failed to use appropriate hand hygiene between glove changes when she provided wound care to Resident #6.</p> <p>This deficient practice could place residents at risk for infection .</p> <p>The findings include:</p> <p>Record review of Resident #6's face sheet, dated 10/17/24, reflected a [AGE] year old female who was admitted to the facility on [DATE] with diagnoses which included: Hypertension (a condition where the pressure in your blood vessels is persistently high), Heart Failure (long term condition that occurs when the heart cannot pump enough blood to meet the body's need's), and Hearing loss (Inability to hear sound in one or both ears).</p> <p>Record review of Resident #6's Quarterly MDS, dated [DATE], reflected a BIMS score of 12 which indicated moderate cognitive impairment.</p> <p>Record review of Resident #6's Physician Monthly Orders for the month of October 2024 reflected an order dated 10/4/24, sacral / Coccyx wound : clean with normal saline pat dry with 4x4 gauze, apply silver collagen to wound bed daily.</p> <p>Observation on 10/16/24 at 10:35 a.m., during wound care revealed LVN A removed Resident #6's old dressing, and did not remove her gloves, did not wash hands, or sanitize her hands and put on a new pair of gloves. LVN C then obtained a clean dressing and placed it on the resident's wound. LVN C then removed her gloves, washed her hands, and left the bedside to document.</p> <p>During an interview on 10/16/24 at 10:51 a.m., LVN C stated she did not realize she had not changed her gloves after removing Resident #6's soiled dressing and before touching and applying the clean dressing. LVN C stated she did not sanitize her hands and change gloves after removing the old dressing because she was nervous as she was being observed by the State Surveyor. LVN C added it was an infection control issue not washing her hands after touching the dirty dressing LVN C stated she was in-serviced and had competency training on infection control recently.</p> <p>During an interview on 10/17/24 at 12:58 p.m., the DON stated there was hand washing between glove changes, after touching a dirty dressing and then a clean dressing were potential causes for the spread of infection due to improper infection control practices. The DON stated she and the ADON currently monitored infection control practices at random, which included monthly in-services, and she was responsible for overseeing that this was completed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of LVN C's clinical competency validation document for Hand Hygiene, dated 10/1/24, reflected LVN C had satisfied the requirement for proper hand hygiene.</p> <p>Record review of the facility's policy titled, Infection Prevention practices policy, undated, revealed, wearing clean gloves to avoid direct contact with contaminated infectious materials.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>36232</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 1 of 1 facility reviewed for effective pest control, in that:</p> <p>The facility failed to ensure the facility was free from live rodents.</p> <p>This deficient practice could place residents at risk of remaining in an environment that was not free of pests and rodents.</p> <p>The findings include:</p> <p>Observation on 10/15/2024 at 8:54 AM in the dry storage room of the kitchen revealed a rat running out of the dry storage room into the kitchen.</p> <p>During an interview on 10/17/2024 at 11:30 AM, the assistant KS stated she observed the rat as it exited the dry storage room.</p> <p>During an interview on 10/18/2024 at 11:05 AM, the KS and assistant KS stated neither of them had ever seen a rat in the kitchen prior to that day. There was no evidence of any food packages that were chewed open by a rat anywhere in the kitchen. Rodents could carry diseases and contaminate food.</p> <p>During an interview on 10/18/2024 at 11:20 AM, the Maintenance Director stated Pest Control came to the facility twice per month to treat for rodents and pests. A small opening in the drywall was found in the mechanical room that housed the compressors for the cooler and freezer, but the opening did not lead to the outside and he did not believe the rat entered from this opening. The Maintenance Director did not know how the rat could have possibly entered the facility. There had never been a rat sighting in the facility prior to this one.</p> <p>Record review of the contracts provided by the facility revealed the facility had a contract with a pest control company and the facility was serviced for roaches and pests twice per month. The most recent visit was 4 days prior to the sighting of the rodent, on 10/11/2024. The contractor serviced every area of the facility, including exterior areas and the kitchen.</p> <p>Record review of the facility policy, Pest Control Policy, undated, revealed: 3. Definitions: Pests: Includes rodents, insects, and other unwanted organisms that may affect the health of the residents. 4. Responsibilities: Management: Oversee pest control measures and ensure compliance with health regulations. Staff: Report pest sightings. Pest Control Contractor: Conduct regular inspections and treatments, adhering to safety measures.</p>		