

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/10/2025
NAME OF PROVIDER OR SUPPLIER  Retama Manor Nursing Center/San Antonio West		STREET ADDRESS, CITY, STATE, ZIP CODE 636 Cupples Rd San Antonio, TX 78237	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47622</b></p> <p>Based on interviews and record reviews, the facility failed to maintain documentation that an alleged violation was thoroughly investigated for 1 of 8 PIRs reviewed that involved (Resident #1 and Resident #2) for facility compliance to prevent further abuse from resident to resident altercations.</p> <p>The former Administrator A failed to investigate a resident to resident altercation (Resident #1 threw a cup and hit Resident #2 in the back of the head) that occurred on 07/21/2024.</p> <p>This failure could place residents at risk for abuse from altercations and could place the residents at risk of harm.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet dated 1/6/2025 revealed a 56yr old male admitted to the facility on [DATE] with diagnoses that included: epilepsy, encephalopathy, opioid abuse, bipolar disorder, etoh (alcohol) abuse, and blindness of left eye.</p> <p>Record review of Resident #1's Care Plan dated 11/16/2024 revealed he was PASRR+ for developmental disorder, behavioral complex -physically and verbally abusive yelling and cursing.</p> <p>Record review of Resident #1's QMDS dated [DATE] revealed he had a BIMS score of 14.</p> <p>Record review of Resident #2's face sheet dated 1/10/2025 revealed a 64yr old male admitted to the facility on [DATE] with diagnoses that included: DM2 with neuropathy, bipolar disorder, major depressive disorder, HTN. He was discharged to home on 9/5/2024.</p> <p>Record review of Resident #2's QMDS dated [DATE] revealed a BIMS score of 15.</p> <p>Record review of Resident #2's Baseline Care Plan dated 4/22/2024 revealed impaired visual function related to cataracts, falls related psychotropics, inappropriate behaviors with staff and other residents, behaviors defecating in plastic bags from trash can in room, resistive with care (refuse medication).</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation 1/06/2025 at 1:27PM Resident #1 was sitting on the side of his bed, his room was clean and free of clutter, no foul odors. His left eye was blind, but he was able to see out of his right eye. He was alert and oriented x3. Resident #1 said when he had the altercation on 7/23/2024, he had come into the room and his roommate did not like the way he cleaned around his area because he liked for it to be clean, so they started arguing and pushing one another and he threw a coffee cup at his roommate. He said he did not know if he was coming towards him since he was blind in one eye and he thought he needed to defend himself. He said staff were there right away to help them. He said when he was moved to another room, he did not have any other issues, he felt safe, and his care was good.</p> <p>During an interview on 1/8/2025 at 3:23PM CNA I said Resident #1 would hear people talking or think he heard people talk and would believe they would be talking about him, and he would respond with defensive verbal aggression. He said there was a resident that would mumble, and he would think that the resident was talking about him, but the resident would just mumble, not directed at anyone.</p> <p>During an interview on 1/9/2025 at 10:35AM the AIT said she was not able to locate the PIR for intake # 519537. She said she understood the importance of the PIR being done, being sent to TULIP, and being available, but she was not at the facility until December and did not know anything about the incident's existence. The AIT said she made several attempts to contact Administrator A to inquire about the missing PIR, but she did not answer her calls.</p> <p>During an interview on 1/10/2025 at 8:30AM the AIT said she was not able to locate the PIR for the intake# 519537. She said she had been at the facility since December 2024 and she searched the files that were in the office and in medical records. She said she reached out to the Administrator A who did not return her call.</p> <p>Record review of in-service titled Reporting Resident to Resident Altercations dated 12/19/2024 revealed 17 employees received the in-service.</p> <p>Record review of the facility's policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy statement stated: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy Interpretation and Implementation #8 stated: Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869</b></p> <p>Based on observation, interview, and record reviews the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 out of 8 residents (Resident #1 and Resident #2) reviewed for accidents and supervision, in that:</p> <ol style="list-style-type: none"> <li>1. Resident #1 was an elopement risk and provided interventions to include a wander guard and checks to ensure proper placement. On 5/25/24 Resident #1 removed his wander guard and eloped from the facility.</li> <li>2. Resident #2 was an elopement risk with interventions to include structured activity to distract from wandering. On 6/6/24, Resident #2 eloped from the facility.</li> </ol> <p>The noncompliance was identified as a PNC. The PNC IJ began on 5/25/2024 and ended on 6/6/2024. The facility had corrected the non-compliance before the survey began.</p> <p>This failure could place residents at risk for serious harm, disability, or death.</p> <p>The findings included:</p> <p>Observations 1/8/2024 at 9 AM revealed a staff member was placed at the front door to monitor people coming in and out of the facility.</p> <p>Observation on 1/9/2024 at 9 AM revealed a staff member was placed at the front door to monitor people coming in and out of the facility.</p> <p>Observation on 1/10/2024 at 9 AM revealed a staff member was placed at the front door to monitor people coming in and out of the facility.</p> <p>1. Record review of Resident #1's Admission Record dated 1/7/2025 revealed he was admitted on [DATE] with diagnoses of vascular dementia ( type of dementia that occurs when blood vessels in the brain are damaged, reducing blood flow and oxygen supply), epilepsy ( chronic brain disorder that causes seizures, which are brief episodes of involuntary movement.), language deficits, unsteady on feet, anxiety, major depressive disorder, and psychotic disorder with hallucinations (severe mental illnesses that can cause hallucinations and delusions). Record review of Resident #1's Admission Record revealed he was discharged on [DATE].</p> <p>Record review of Resident #1's consolidated physician orders for January 2025 revealed he had an order for wander guard dated 7/2/2024, device alarm change every 90 days, device alarm check via electronic machine every day every shift, device alarm visually check every shift for wandering.</p> <p>Record review of Resident #1's MAR (medications administration record) revealed device alarm change every 90 days, device alarm check via electronic machine every day every shift, device alarm visually check every shift for wandering and monitoring every 15 minutes.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 4 (severely impaired cognition), epilepsy, behaviors of rejecting care and has a walker. After elopement the new interventions for Resident #1 was placed on q 15 minutes, visited by psychological MD and moved to a secure unit.</p> <p>Record review of Resident #1's care plan (initiated 6/12/23 and prior to 5/25/24 incident) revealed he was at risk for elopement with interventions including Assess for distress; Contact family to sit with resident or deescalate situation; Device alarm change every 90 days; Visual check wander guard to left wrist q shift due to elopement risk; Wander guard check via electronic check every day due to elopement risk; Encourage resident to stay in common areas of building for observation if needed; Provide resident with safe place to wander if necessary. Following the elopement on 5/25/24, new intervention for Resident #1 was Monitor resident closely for signs/symptoms of increased wandering and desire to keep walking. New interventions were Resident #1: Resident will be monitored every 15 minutes until evaluated by psych on 5/29/24 (5/28/24); Redirect patient from doors (5/28/24); Involve patient in decision making regarding daily choices (5/28/24); Involve patient in preferred activities (5/28/24); Assess for risk of elopement per living center policy (5/28/24); Use wander guard placed on right ankle (6/11/24); Wander guard place on bottom of wheelchair seat as tolerated (7/12/24).</p> <p>Record review of Resident #1's Wandering assessment dated [DATE] revealed he was forgetful/short attention span, mobility was independent, known wanderer/history of wandering and had a wander guard-scored a 12.0- high risk.</p> <p>Record review of Resident #1's head to toe assessment dated [DATE] revealed no skin issues.</p> <p>Record review of Resident #1's Pain assessment dated [DATE] revealed he was resistant to care/medication aggressiveness/physically or verbally abusive and had no pain.</p> <p>Record review of Resident #1's progress note Interdisciplinary Team dated 5/25/2025 revealed elopement, due to Resident #1's diagnosis of dementia and baseline cognitive status resident #1 is a poor decision maker with poor impulse control resident can ambulate and likes to walk and venture around facility. Resident #1 stated he was trying to take a walk with no distress or agitations noted prior to exiting. intervention were abuse/neglect in service, and elopement in services. The MD and family were notified by DON, ADON, MDS staff.</p> <p>Record review of Resident #1 psychological consult dated 5/2/2024 stated he was oriented to person, time, impaired to place and was to assess Resident #1's safety and comfort with no concerns of any type.</p> <p>Record review of intake 506765, on 5/25/24 at 5:45 PM revealed, Resident #1 left the building. An off-duty staff member informed the facility the resident was seen outside. The resident was found at a bus station (less than a mile away) stating he was going to work. Staff were able to get the resident to come back to the facility. Resident #1's responsible party, ADM, DON, ADON and physician were notified. Record review of intake 506765 had a provider investigation and staff were in-serviced on abuse/neglect, elopement. Record of in-services was completed by all staff on 5/26/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's intake, on 5/26/24 at 7:30 PM revealed, Resident #1 attempted to leave the building, and his wander guard sounded. Staff responded to the alarm and found resident outside of the facility. They were able to redirect him back inside, and there were no injuries.</p> <p>2. Record Resident #2's Admission Record dated 1/8/2025 revealed she was admitted on [DATE] and readmitted on [DATE] with diagnoses of Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills), major depressive disorder (a serious mental illness that causes a persistent low mood, loss of interest, and other symptoms that can affect daily life), cognitive communication deficit, dementia (a general term for a group of diseases that cause severe memory and thinking loss), and asthma (a chronic lung disease that causes inflammation and tightening of the muscles around the airways.).</p> <p>Record review of Resident #2's physician orders dated 6/7/2024 for resident to wear a wander guard at all times due to elopement risk. visual check wander guard to right ankle every shift due to elopement risk. Record review of Mar (medication administration record revealed this was completed.</p> <p>Record review of Resident #2's optional state assessment MDS dated [DATE] revealed she had a BIMS score of 5 out of 15 (severely impaired), she mobilized with walker. Record review of quarterly MDS dated [DATE] revealed she had a wander/elopement alarm.</p> <p>Record review of Resident #2's care plan (initiated 10/10/18 and prior to 6/6/24 incident) revealed she was at risk for elopement with interventions including Distract resident from wandering by offering structured activities; Wander guard alarm: Change every 90 days and as needed. New intervention was Resident #2: Check placement and function of safety monitoring device every shift; Visual check wander guard to right ankle every shift due to elopement risk (6/10/24); Wander guard check via electronic machine every day due to elopement risk (6/10/24).</p> <p>Record review of intake # 509407, Per facility self-report, on 6/6/24 between 4 and 5 PM, Resident #2 had family visiting and was attending an activity. The resident's [family member]informed staff she was missing. Resident #2 was found down the street in front of a church (less than a mile away) and said she was looking for her [family member]. The temperature was 93 that day. Resident #2 was given a head-to-toe assessment upon return to the facility and was sent to the ER for further assessment. Resident #2's ER paperwork revealed heat exhaustion, unspecified, and no other injury. She returned to the facility the same night.</p> <p>Record review of Resident #2's Elopement Risk assessment dated [DATE] revealed she scored an 8-high risk and care plan was initiated/updated to reflect interventions.</p> <p>Record review of Resident #2's 6/6/2024 and 6/12/2024 Head to toe Assessment revealed no injuries.</p> <p>Record review of in-services dated on 6/6/2024 revealed in was on Abuse/Neglect/Exploitation, Elopement, Front door, and Resident Rights with all staff.</p> <p>Observation on 1/9/2025 at 2:25 PM revealed Resident #2 had her wander guard on her ankle.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on 1/7/25at 1:14 PM with LVN F stated they kept a binder of residents that were wander/elopement for staff to check, but most staff know which resident have wandering behaviors. Resident #1 would sundown at night and be more confused. Staff monitored him, but she was not sure how he eloped out of facility. LVN F stated she was not sure how Resident #2 eloped, maybe a family member let her out. LVN F stated no other residents had eloped. Staff try to re-direct residents that wander towards the exits, now they have a staff person near the front door.</p> <p>Interview with previous DON G stated #1 was found at the bus stop and not sure how he left the facility and was not gone more than 15-20 minutes. The previous DON G stated they started the elopement protocol to find Resident #1, he was not injured when they found him. Resident #1 was discharged to another facility that could be more appropriate for his aggressive behaviors and a secure unit. The previous DON G stated Resident #2 had left the building and the family had alerted them, the staff started the elopement protocol, they found Resident #2 less than a mile, at a church. The previous DON G stated they conducted a head to toe and decided to take her to the local clinic, she had heat exhaustion with no other injuries. The previous DON G stated her new interventions was a wander guard bracelet to wear in her ankle. Resident #2 had not had any previous elopements. The previous DON G stated she did conduct in-services with all staff for elopement.</p> <p>Interview 1/8/2025 at 11:19 AM with the previous Maintenance supervisor H stated he found Resident #1 at the church nearby. He was trained on the elopement protocol. Maintenance supervisor H stated Resident #2 had no injuries and offered her water due to a warm day. Maintenance supervisor H stated he tested the wander guard monitors frequently and documented</p> <p>Interview 1/9/2025 at 1:46 PM with the previous Administrator A stated Resident #1 was aggressive, so they worked with family/Ombudsman to get him transferred to a safe facility, since it was not safe for him at this facility. The Administrator stated she had reported the elopements to the STATE and trained staff on elopements. Administrator A stated there were new interventions in place for Resident #1 and #2. The new interventions for Resident #1 was to transfer him to a secure unit q 15 minute checks, and psychological MD visit Intervention for Resident #2 was a wander guard.</p> <p>Interview 1/8/2025 AT 1:32 pm with Resident #2's family stated Resident #2 was found in 30-45 minutes and they took her to the local clinic for evaluation, she was dehydrated. The Family stated the facility acted immediately to Resident #2 missing, she had dementia and felt safer with her wander guard.</p> <p>Interview 1/10/2025 at 4:29 PM with the medical director stated she was aware of the elopements and facility discussed in AD Hoc meeting.</p> <p>Record review of in-services dated 5/26/2024 on Wandering/Elopement, Abuse/Neglect protocol/door alarm/ Resident Rights were completed with all staff.</p> <p>Record review of check operations of door monitoring and resident, and test for doors and locks dated the week of 5/27/2024 and 6/7/2024.</p> <p>Record review of Policy Wandering and Elopement dated 2019 revealed the facility will identify residents who are a t risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Policy Interpretation and Implementation</p> <p>1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>2. If an employee observes a resident leaving the premises, he/she should:</p> <ul style="list-style-type: none"> <li>a. attempt to prevent the resident from leaving in a courteous manner;</li> <li>b. get help from other staff members in the immediate vicinity, if necessary; and</li> <li>c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises.</li> </ul> <p>3. If a resident is missing, initiate the elopement/missing resident emergency procedure:</p> <ul style="list-style-type: none"> <li>a. Determine if the resident is out on an authorized leave or pass;</li> <li>b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; and</li> <li>c. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., emergency management, rescue squads, etc.).</li> </ul> <p>4. When the resident returns to the facility, the director of nursing services or charge nurse shall:</p> <ul style="list-style-type: none"> <li>a. examine the resident for injuries;</li> <li>b. contact the attending physician and report findings and conditions of the resident;</li> <li>c. notify the resident's legal representative (sponsor);</li> <li>d. notify search teams that the resident has been located;</li> <li>e. complete and file an incident report; and</li> <li>f. document relevant information in the resident's medical record.</li> </ul> <p>Record review of the Policy Wander guard (no date) revealed:</p> <p>Identification: Identify residents who are at risk of wandering</p> <p>Consent: Obtain consent from residents, family members.</p> <p>Monitoring: Regularly check on residents to ensure they are safe</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observations on 1/10/2025 at 10am of residents in the elopement binder were checked for wander guard and were randomly checked at the door alarm throughout the day.</p> <p>Observations and interview with the Maintenance Supervisor on 1/9/25 at 745 am-8:05 am stated he began employment in October at the facility; he stated that all of the facility doors were alarmed but the front door and the exit door for C-hall needed more attention for better security and are working properly now; the Maintenance Director stated that he checks all facility exit doors for security purposes twice a day-at the beginning of his shift and the end of his shift; all of the facility exit doors were observed by Surveyor with the Maintenance Director as noted:</p> <p>Facility Front door-alarmed and working</p> <p>D-hall exit door-alarmed and working; the Maintenance Director stated that a new mag lock was installed and he will provide paperwork for Surveyor</p> <p>E-hall-exit door at the end of the hallway was alarmed and worked; door in lounge on hallway was alarmed and opened to outside open smoking area with two locked gates that were checked and secure.</p> <p>A-hall-the door leads to a small courtyard area and was alarmed; the MD stated that the alarm is turned off and back on when he enters for the day and leaves at night and stays on during the w/c; the door stays locked without the alarm being on; the MD stated that the door stays alarmed on the w/e.</p> <p>B-Hall- the exit door was alarmed; the MD stated he plans to purchase another mag lock for this door; he stated that he had been also turning this alarm on/off during his work hours to allow for multiple deliveries thru out the day and the door stays locked; Surveyor suggested that he keep this door alarmed at all times.</p> <p>C-Hall-exit door alarmed and working.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/10/2025
NAME OF PROVIDER OR SUPPLIER  Retama Manor Nursing Center/San Antonio West		STREET ADDRESS, CITY, STATE, ZIP CODE  636 Cupples Rd San Antonio, TX 78237	
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 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>26869</p> <p>Based on observation, interviews and record reviews, the facility's governing body failed to designate a person to exercise the administrator's authority when the facility did not have an administrator and secure a licensed nursing home administrator within 30 days.</p> <p>The facility terminated Licensed Administrator A on 11/08/2024; hired Employee B, who was not a licensed administrator 24 days later and served in the capacity of the administrator for 39 days.</p> <p>This failure could result in a decrease in the quality of care provided to the residents that could result in potential minimal harm to the resident.</p> <p>The findings were:</p> <p>Record review of the All Staff Active Listing, dated 1/4/2025, revealed Employee B was listed as the Administrator with a hire date of 12/02/2024.</p> <p>Record review of an Application for Employment, signed digitally by Employee B on 12/13/24, revealed she applied for the Administrator position, had previously worked at another nursing home as an AIT, did not list the school she attended and did not indicate she was a Licensed Nursing Facility Administrator.</p> <p>Record review of the Administrator Job Description, signed by Employee B on 12/02/2024, revealed under Education and Experience requirement was Active NHA [Nursing Home Administrator] License.</p> <p>Record review of an email dated 12/11/24 from Texas Health &amp; Human Services Long Term Care Regulation, Licensing &amp; Credentialing to Employee B revealed she received authorization to proceed with registration for the Licensed Nursing Home Administrator exam.</p> <p>In an entrance conference on 01/04/2025 at 8:57 a.m., Employee B stated she was an AIT.</p> <p>In a further interview on 01/04/2025 at 9:05 a.m., Employee B stated her title was Operations Manager and the Administrator of the facility was Administrator C who was in the facility daily to monitor and assist Employee B.</p> <p>Interview and observation on 01/04/2025 at 11:42 a.m., Administrator C, who had her name badge on that indicated she worked at Nursing Home D, stated her administrator's license was over Nursing Home D, not this facility; she was in the facility once or twice a week for a few hours to oversee what AIT Employee B did in the facility, and would come to the facility when HHSC surveyors were present.</p> <p>Interview on 01/04/2025 at 12:37 p.m., Employee B stated she would take the licensed administrator's test at the end of January 2025, pulled out her phone to look at and stated the test was on 01/23/2025.</p> <p>(continued on next page)</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 01/05/2025 at 11:56 a.m., the HR Employee stated the previous Administrator A's last day she worked in the facility was 11/08/2024 and provided Administrator A's employee file.</p> <p>Record review of Administrator A's employee file revealed her date of hire was 08/01/2022, was involuntarily terminated on 11/08/2024, and her Texas Nursing Home Administrator License was effective from 03/11/2021 to 03/22/2025.</p> <p>Interview on 01/05/2025 from 3:37 p.m. to 3:59 p.m., the facility's South Texas President [Regional Director] stated he has covered the facility since March 2024. He said Administrator A's last day in the facility was the date the HR Employee provided the surveyor. The South Texas President stated he was aware there was a 30-day grace period to fill the administrator position. He said when Employee B was interviewed, they were aware she was not a licensed administrator, but Employee B was what they were looking for regarding to fitting in with the facility and knew there would be another lull of 30 days before she was licensed. He stated Employee B would take the administrator license test in January 2025; and she was being overseen by Administrator C. The South Texas President stated he could not say that residents would be harmed with an unlicensed administrator to manage the facility.</p>		