

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Juniper Village at Lincoln Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 855 E Basse Rd San Antonio, TX 78209	
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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the 1 of 1 kitchen failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen. 1-The facility failed to have four kitchen staff complete their food handler certificates (Cook-I, DA-J, DA-K, DA-L) These failures could place residents at risk for food borne illness. The findings included: During an interview on 1/8/26 at 1:10pm with the Executive Chef she stated not having the four identified staff (Cook-I, DA-J,DAK,DA-L) completed their Food Handlers Certificates was an oversight. Record review of the Dietary Staff's Food Handler Certificates revealed four kitchen staff had not completed their Food Handler Certificates (Cook-I, DA-J, DA-K, and DA-L) Review of the Texas Food Code revealed the following: The Texas Department of State Health Services (TXDSHS) requires that all food employees must successfully complete an accredited food handler training course within 60 days of employment The training courses teach employees about food safety, including good hygiene practices and how to avoid cross-contamination		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the 1 of 1 kitchen failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in one of one kitchen. 1. The facility failed to clean two wall vents which measured approximately 4x2 ft which were located across from the kitchen's freezer. 2. The facility failed to clean a 3x3 ft ceiling vent in the dry storage room. 3. The facility failed to clean a 3x3 ft ceiling vent located at the entrance to the dish room. 4. The facility failed to maintain proper hair restraints on two kitchen employees (Cook-G and DA-H) 5. The facility failed to maintain the required dish machine rinse temperature, and only reached 110 degrees Fahrenheit. 6.-The facility failed to clean the top surface of the dish machine in the kitchen's pantry room. 7.-The facility failed to repair the brown stained ceiling markings around the sprinkler head in the kitchen's pantry room. These failures could place residents at risk for food borne illness. The findings included: 1-Observation on 1/6/26 from 9:15am-9:55am with the Cook-G revealed the following:a- two wall vents which measured approximately 4x2 ft across from the kitchen's freezer that had dust and dirt on the ventsb- a 3x3 ceiling vent in the dry storage room that had dust and dirt on the vent's outer surface.c- a 3x3 ceiling vent located at the entrance to the dish machine room that had dust and dirt on the vent's outer surface.d- two kitchen staff (Cook-G and Dietary Aide-H) were not wearing hair restraints over the beards.e- the dish machine after running three cycles did not reach the required rinse temperature for a cold rinse machine of 120 degrees Fahrenheit. During each cycle the dish machine only reached 110 degrees Fahrenheit. f- the top surface of the dish machine in the kitchen's pantry had dirt particles on the surface.f- there were numerous brown stain markings on the ceiling around the sprinkler head in the kitchen's pantry. During an interview on 1/6/26 at 10:25am with [NAME] G and Clinical Specialist they stated having clean ceiling vents and wearing beard restraints would prevent dust and hair particles from falling on the kitchen's floor surface or onto prepared food and having the proper dish machine rinse temperature would ensure kitchen plates and silverware were properly cleaned. During an interview on 1/8/26 at 1:10pm the Executive Chef stated that she had not placed a work order for kitchen vents to be cleaned. The Executive Chef stated that the dish machine was a low rinse machine and the required rinse temperature was 120 degrees. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-305.11, 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. Record review of the facility's policy, Sanitation, revised January 2024, revealed, The food service area shall be maintained in a clean and sanitary manner. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. Record review of the facility's policy titled-Cleaning-Keeping the Floors, Walls, and Ceilings Clean dated 7/10/20 revealed Floors, walls, and ceiling must be free of dirt, letter, and moisture.		

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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** Based on observations, interviews and record reviews, 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 disease and infections for 4 of 29 residents (Residents #38, #39, #8 and #3) reviewed for incontinent care. 1. facility failed to ensure LVN C sanitized the blood pressure cuff when she used it between two residents (Residents #38 and #39) during medication pass. 2. The facility failed to ensure CNA D discarded her soiled gloves, sanitized her hands and put clean gloves on when she placed Resident #8's soiled brief in the trash can and continued to place clean items onto the resident. 3. The facility failed to ensure CNA D retracted Resident #3's foreskin on his penis and to clean his buttock and anal area completely. These deficient practices could place residents at risk of cross contamination and infections. The findings included: Observation on 01/08/2026 at 08:40 am revealed LVN C took the blood pressure for Resident #38 who received blood pressure medication and then proceeded to Resident #39 who received blood pressure medication and did not sanitize the blood pressure cuff between residents. During an interview on 01/08/2026 at 08:45 am, LVN C stated she forgot to sanitize the blood pressure cuff between residents. She stated not sanitizing the blood pressure cuff could cause cross contamination and spread infection. She stated she had training on infection control and knew she had to sanitize equipment. 2. Record review of Resident #8's electronic face sheet, dated 01/06/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: hypertensive heart disease with heart failure (long term condition that develops due to unmanaged high blood pressure and can lead to heart failure, thickening of the heart muscle and other serious health issues), anxiety disorders (a group of mental disorders characterized by significant and uncontrollable feelings of nervousness and fear that interferes with daily life), and pain (physical discomfort). Record review of Resident #8's quarterly MDS assessment dated [DATE] reflected she rarely understood and sometimes was able to understand. She was not a candidate for a BIMS which signified her cognitive status was severely impaired. Resident #8 was dependent on staff for her ADLs. She had an indwelling urinary catheter and was always incontinent of bowel. Record review of Resident #8's comprehensive person-centered care plan dated 09/04/2025 reflected Focus, has bowel incontinence, interventions, check resident every two hours and assist with toileting as needed. Further review of Resident #8's comprehensive care plan dated 10/06/2025 reflected she had a urinary tract infection and was placed on antibiotics. Observation on 01/08/2026 at 10:20 am revealed CNA D and CNA E performed incontinent care for Resident #8. CNA E wiped Resident #8's groin area, split labia, wiped the front to back and cleaned the buttocks and anal area. She then changed gloves and sanitized hands to position the resident toward CNA D, who took the dirty brief off the bed, put it in the trashcan near the bed, and continued to place the clean brief onto the resident without changing her soiled gloves or sanitizing her hands. During an interview on 01/08/2026 at 10:30 am, CNA D stated she was trained on infection control and knew she should have discarded the soiled gloves and sanitized her hands prior to working with clean items. She stated cross contamination could result in an infection for the residents. She stated she did not know why she did not sanitize her hands or change gloves. 2. Record review of Resident #3's electronic face sheet, dated 01/07/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: acute respiratory failure with hypoxia (severe impairment of gas exchange in the lungs, leading to low oxygen levels in the blood), muscle weakness (loss of muscle strength), anemia (not having enough health red blood cells to carry oxygen to the body's tissues), atrial fibrillation (irregular and rapid heart rhythm) and heart failure (chronic and progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of Resident #3's admission MDS assessment dated [DATE], reflected he could understand (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and be understood. He scored a 15 of 15 on his BIMS which indicated his cognitive status was intact. He was dependent on staff for the ability to maintain perineal hygiene. He was always incontinent with bowel and bladder. Record review of Resident #3's comprehensive person-centered care plan dated 11/26/2025 reflected Focus, risk for impaired skin integrity, interventions, evaluate for bladder and bowel incontinence, Focus, risk for infection, interventions, educate resident/representative on techniques to prevent infection. Record review of Resident #3's Active Orders as of : 01/07/2026 reflected, apply Zinc (vital mineral essential for wound healing) barrier cream to bilateral buttocks with brief change. Observation on 01/08/2026 at 11:20 am revealed CNA D and CNA E performed incontinent care for Resident #3. CNA D wiped around Resident #3's penis and genital area without pulling back his foreskin to clean his penis. She left dried feces on his buttock area near his thighs after cleaning his anal area. During an interview on 01/08/2026 at 11:30 am, CNA D stated she was trained to pull back the foreskin on uncircumcised males who required incontinent care and to clean the penis. She stated she did not know why she did not do that, and not cleaning under the foreskin could cause infection. She stated Resident #3's stools were sometimes thick, sticky, and difficult to clean off his skin. She stated it was important for the resident to be clean because he could get an infection or have skin irritation. During an interview on 01/08/2026 at 12:00 pm, Resident #3 stated he trusted the staff to provide him with good care, and he thought he was cleaned. He stated he would receive a shower the following day. During an interview on 01/09/2026 at 2:23 pm, the DON stated CNA D should have pulled back Resident #3's foreskin on his penis when he received incontinent care to ensure he was clean and to prevent infection and she needed to completely clean the feces off his skin. She stated Resident #3 could have skin breakdown. She stated she was accountable for the nursing care in the facility and the CNA was trained in infection control and incontinent care. She added LVN C should have sanitized the blood pressure cuff between residents to prevent cross contamination and CNA D needed to change gloves and sanitize hands after throwing the soiled brief away when she performed incontinent care for Resident #8. Record review of Wellness Associate CNA Competency Appraisal for CNA D dated 04/16/2025 reflected Assist residents as needed to include continence management. Follows established safety regulations, including infection control. She was noted to have passed the competencies. Record review of the facility's policy and procedure titled Incontinent Care dated 07/01/2025 reflected, purpose, to remove feces/urine, to maintain skin integrity/comfort and to promote dignity. Procedure, Perineal Care, Male, pull foreskin back of the uncircumcised male to clean the area (be careful to push foreskin back in place after drying well. Record review of the facility's policy and procedure titled Cleaning-Contamination dated 07/10/2020 reflected Clean contaminated surfaces in accordance with CDC recommendations between resident use. Record review of the facility's policy and procedure titled Handwashing dated 07/10/2020 reflected When to wash hands, before and after direct contact with residents, after handling any soiled equipment or linens and after removing gloves. Review of Environmental Cleaning Procedures HAIs CDC dated 03/19/2024 reflected shared equipment, clean and disinfect before and after each use.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 2 of 27 resident rooms on (rooms [ROOM NUMBERS]) and the beauty salon and laundry room reviewed for environmental concerns.1-The facility failed to replace an overhead bathroom sink light cover in room [ROOM NUMBER].2-The facility failed to replace an overhead bathroom sink light cover in room [ROOM NUMBER].3-The facility failed to clean an 18 x 18 ceiling air vent in the beauty salon.4-The facility failed to clean an 18 x 18 ceiling air vent in the laundry room. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.The findings included: Observations during rounds on 1/8/26 from 12:15pm to 12:25pm with the Administrator and Environmental Services Director revealed the following:a-In resident room [ROOM NUMBER] there was a missing light cover on 1 of 4 bathroom sink overhead lights.b-In resident room [ROOM NUMBER] there was a missing light cover on 1 of 4 bathroom sink overhead lightsc-In the Beauty Salon there was an 18 x 18 overhead ceiling vent that was stained and had dirt particles.d-In the Laundry room there was an 18 x 18 overhead ceiling vent that was stained and had dirt particles. During an interview on 1/8/26 at 12:30pm with the Administrator and Environmental Services Director, the Environmental Services Director stated he had not received a work order request for repair of the observed areas. The Environmental Services Director stated building repairs had to be completed for facility upkeep and resident safety. The Administrator stated that building repairs were necessary to be done on a timely basis for facility operations. Record review of facility maintenance work orders from 12/1/25 thru 12/31/25 revealed the observed areas for repair were not noted for completion.Record review of the facility's policy titled Preventative Maintenance Program dated 7/10/20 revealed A preventative maintenance program promotes cost-effectiveness throughout the community, enhances the quality of life for residents, and improves the working conditions for associates.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 16 residents (Resident #8) reviewed for accurate MDS assessments. The Facility failed to ensure Resident #8's fall status was accurately reflected on her quarterly MDS assessment, dated 11/14/2025. This deficient practice could place residents at risk of missed or inaccurate care. The findings include: Record review of Resident #8's electronic face sheet, dated 01/06/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: hypertensive heart disease with heart failure (long term condition that develops due to unmanaged high blood pressure and can lead to heart failure, thickening of the heart muscle and other serious health issues), anxiety disorders (a group of mental disorders characterized by significant and uncontrollable feelings of nervousness and fear that interferes with daily life), and pain (physical discomfort). Record review of Resident #8's quarterly MDS assessment, dated 11/14/2025 reflected she was rarely understood and sometimes was able to understand. She was not a candidate for a BIMS which signified her cognitive status was severely impaired. Resident #8 was dependent on staff for her ADLs. She had an indwelling urinary catheter and was always incontinent of bowel. She was not noted to have any falls since admission/entry or reentry or the prior assessment whichever was more recent. Record review of Resident #8's FRA dated 08/04/2025 reflected she was at risk for falls. Record review of Resident #8's incident report dated 10/06/2025 reflected she was found responsive on the floor with a laceration to her forehead. Record review of the facility incidents and accidents reflected Resident #8 had falls on 10/08/2025 and on 11/08/2025 prior to her quarterly MDS assessment dated [DATE]. Record review of Resident #8's comprehensive person-centered care plan dated 09/04/2025 reflected Focus, has bowel incontinence, interventions, check resident every two hours and assist with toileting as needed. Further review of Resident #8's comprehensive care plan dated 10/06/2025 reflected she had a urinary tract infection and was placed on antibiotics. Focus, has laceration to forehead r/t a fall, resolved 10/27/2025. No history of falls or fall risk was noted on the care plan to include interventions. Observations on 01/06/2026 at 10:30 am, 01/07/2026 at 08:30 am, 01/08/2026 at 1:00 pm and 01/09/2026 at 2:00 pm revealed Resident #8 was laying in bed in her room with the bed in a low position with floor mats positioned on each side of the bed. During an interview on 01/09/2026 at 2:23 pm, the DON stated she had only been at the facility since October 2025 and was accountable for the MDSs, and at present there was an issue with the MDS nurse, and the MDS nurse was not available for interview. She confirmed stated Resident #8 was at risk for falls and had 2 falls recently with interventions in place. She stated Resident #8's quarterly MDS dated [DATE] was inaccurate and needed to reflect the resident history of falls. She stated an inaccurate MDS assessment could lead to an inaccurate plan of care and provision of care. She stated she did not know why the MDS was inaccurate. During an interview on 01/09/2026 at 2:30 pm with the RNC, he stated an inaccurate MDS assessment could result in missed or inaccurate care provided. He stated the facility did not have an RAI policy and procedure and they followed CMS's User Manual. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1, dated October 2025 reflected The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 16 residents (Resident #8) reviewed for comprehensive person-centered care plans. The facility failed to ensure a care plan was developed to address Resident #8 as a fall risk and include interventions to prevent falls. This deficient practice could place residents at risk for falls and could result in injury. The findings include: Record review of Resident #8's electronic face sheet dated 01/06/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: hypertensive heart disease with heart failure (long term condition that develops due to unmanaged high blood pressure and could lead to heart failure, thickening of the heart muscle and other serious health issues), anxiety disorders (a group of mental disorders characterized by significant and uncontrollable feelings of nervousness and fear that interferes with daily life), and pain (physical discomfort). Record review of Resident #8's quarterly MDS assessment dated [DATE] reflected she rarely understood and sometimes was able to understand. She was not a candidate for a BIMS which signified her cognitive status was severely impaired. Resident #8 was dependent on staff for her ADLs. She had an indwelling urinary catheter and was always incontinent of bowel. She was not noted to have had any falls since admission/entry or reentry or the prior assessment whichever was more recent. Record review of Resident #8's FRA dated 08/04/2025 reflected she was at risk for falls. Record review of Resident #8's incident report dated 10/06/2025 reflected she was found responsive on the floor with a laceration to her forehead. Record review of the facility incidents and accidents reflected Resident #8 had falls on 10/08/2025 and on 11/08/2025 prior to her quarterly MDS assessment dated [DATE]. Record review of Resident #8's comprehensive person-centered care plan dated 09/04/2025 reflected Focus, has laceration to forehead r/t a fall, resolved 10/27/2025. No history of falls or fall risk was noted on the care plan to include interventions. Observations on 01/06/2026 at 10:30 am, 01/07/2026 at 08:30 am, 01/08/2026 at 1:00 pm and 01/09/2026 at 2:00 pm revealed Resident #8 was laying in bed in her room with the bed in a low position with floor mats positioned on each side of the bed. During an interview on 01/09/2026 at 2:23 pm, the DON stated she had only been at the facility since October 2025 and was accountable for the care plans, and at present there was an issue with the MDS nurse who was involved in care planning, and the MDS nurse was not available for interview. She stated Resident #8 was at risk for falls and had 2 falls recently with interventions in place. She stated Resident #8's comprehensive person-centered care plan needed to reflect she was at risk for falls and the interventions such as low bed with a floor mat on both sides of the bed needed to be noted. She stated it could cause injury or harm to the residents if the interventions were not communicated through the care plan. She did not know why this information was not placed in the care plan. During an interview on 01/09/2026 at 2:30 pm with the RNC, he stated the comprehensive care plan for Resident #8 needed to reflect her risk of falls and the interventions required to take care of her. Record review of the facility's policy and procedure titled Care Planning Assessment dated 07/01/2025 reflected Residents will receive initial, quarterly, annual, and significant change assessments according to the State and Federal regulations. In addition, residents will have care plans created that address the individualized needs the resident presents. This process will be accomplished through observations, assessments, and interviews. In addition, quarterly reviews and updates are completed by the Care Plan Team to clarify goals and evaluate effectiveness of interventions.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 resident of 2 residents (Resident #3) reviewed for incontinent care. CNA D failed to pull back Resident #3's foreskin to clean his penis during incontinent care. This deficient practice could place residents risk of urinary tract infections (bacteria in the urine) or skin breakdown. The findings include: Record review of Resident #3's electronic face sheet, dated 01/07/2026, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: acute respiratory failure with hypoxia (severe impairment of gas exchange in the lungs, leading to low oxygen levels in the blood), muscle weakness (loss of muscle strength), anemia (not having enough health red blood cells to carry oxygen to the body's tissues), atrial fibrillation (irregular and rapid heart rhythm) and heart failure (chronic and progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of Resident #3's admission MDS assessment dated [DATE] reflected he could understand and be understood. He scored a 15 of 15 on his BIMS which indicated his cognitive status was intact. He was dependent on staff for the ability to maintain perineal hygiene. He was always incontinent with bowel and bladder. Record review of Resident #3's comprehensive person-centered care plan dated 11/26/2025 reflected Focus, risk for impaired skin integrity, interventions, evaluate for bladder and bowel incontinence, Focus, risk for infection, interventions, educate resident/representative on techniques to prevent infection. Record review of Resident #3's Active Orders as of : 01/07/2026 reflected, apply Zinc (vital mineral essential for wound healing) barrier cream to bilateral buttocks with brief change. Observation on 01/08/2026 at 11:20 am CNA D and CNA E performed incontinent care for Resident #3, CNA D wiped around Resident #3's penis and genital area without pulling back his foreskin to clean his penis. During an interview on 01/08/2026 at 11:30 am, CNA D stated she was trained to pull back the foreskin on uncircumcised males who required incontinent care and to clean the penis. She stated she did not know why she did not do that, and not cleaning under the foreskin could cause infection. During an interview on 01/08/2026 at 12:00 pm, Resident #3 stated he trusted the staff to provide him with good care, and he thought he was cleaned. He stated he would receive a shower the following day. During an interview on 01/09/2026 at 2:23 pm, the DON stated CNA D should have pulled back Resident #3's foreskin on his penis when he received incontinent care to ensure he was clean and to prevent infection. She stated she was accountable for the nursing care in the facility. Record review of Wellness Associate CNA Competency Appraisal for CNA D dated 04/16/2025 reflected Assist residents as needed to include continence management. Follows established safety regulations, including infection control. She was noted to have passed the competencies. Record review of the facility policy and procedure titled Incontinent Care dated 07/01/2025 reflected, purpose, to remove feces/urine, to maintain skin integrity/comfort and to promote dignity. Procedure, Perineal Care, Male, pull foreskin back of the uncircumcised male to clean the area (be careful to push foreskin back in place after drying well.		

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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)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 2 of 5 residents (Residents #14 and #15) reviewed for oxygen therapy. The facility failed to replace a dirty and worn oxygen filter in Resident #14's oxygen concentrator, humidifier bottle was not changed and NC tubing was not bagged when not in use. 2. The facility failed to replace a dirty and dusty oxygen filter in Resident #15's oxygen concentrator, nebulizer mask was not bagged when not in use. These deficient practices could places residents at risk of respiratory infection and difficulty breathing. The findings included: Record review of Resident #14's electronic face sheet, dated 01/07/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: fracture of neck of right femur (a break in the strong bone, just below the ball of the hip joint), muscle weakness (a general lack of strength, where muscles don't contract as powerfully as they should), dysphagia (difficulty swallowing) and Parkinsonism (broad term for a group of neurological conditions causing similar movement problems, slowness, muscle stiffness, tremors and balance issues). Record review of Resident #14's admission MDS assessment dated [DATE], reflected she could understand and be understood. She scored 09 of 15 on her BIMS which indicated her cognitive status was moderately impaired. She required moderate amount of assistance with her ADLs. Record review of Resident #14's Active Orders as of: 01/09/2026 reflected she was ordered O2 at 2LPM via NC at nighttime, start date 01/05/2026. Oxygen tubing changes every Wednesday night and PRN, Clean oxygen filters every Wednesday and PRN. Humidifier cannister change every Wednesday and PRN. Start date was 01/05/2026. Record review of Resident #14's baseline care plan dated 12/18/2025 reflected she was not on oxygen therapy at the time of admission. Observation on 01/06/2026 at 10:00 am revealed Resident #14's oxygen concentrator had a dirty worn and crumbling filter; humidifier bottle was labeled 12/31/2026 and nasal canula oxygen tubing was draped over the concentrator and not in a plastic bag when not in use. Observation on 01/07/2026 at 11:00 am, and 01/08/2026 at 1:00 pm of Resident #14's oxygen concentrator revealed the filter was dirty and worn, the oxygen tubing with the nasal canula was unbagged and lying on the floor near the concentrator, The humidifier bottle was dated 12/31/2025. During an interview on 01/08/2026 at 1:00 pm, Resident #14 stated she used oxygen at night, and the nurses took care of the concentrator. Observation on 01/09/2026, at 11:10 am with the RNC revealed Resident #14's oxygen filter was old, worn, torn, and had dirt and dust on it. The humidifier bottle was dated 12/31/2025, and the oxygen tubing with NC was on the floor next to the concentrator. During an interview on 01/09/2026 at 11:13 am, the RNC stated the oxygen filter on Resident #14's concentrator needed to be changed completely, the unit appeared to be old, and he stated the tubing with the NC needed to be bagged when not in use and the humidifier bottle should have been changed on 01/07/2026. He stated dust and dirt could be an obstacle for the oxygen to be clean and to flow freely and it could result in URI or hypoxia (low oxygen blood level). During an interview on 01/09/2026 at 2:23 pm, the DON stated Resident #14's oxygen concentrator filter should have been checked initially prior to hook up and use, and the oxygen filter should have been replaced. She stated she would put the oxygen care issues into the MAR, so the nurses would be reminded to change the tubing, filter and humidifiers as needed. She stated a dirty and worn filter could cause disruption of air flow and result in respiratory distress or a URI. Information provided by the DON revealed, RN B, who was the charge nurse for Resident #14 on the day shift, was not available for interview. During an interview on 09/09/2026 at 2:55 pm, LVN F, who was the charge nurse for Resident #14 on the evening shift stated nurses were supposed to check the oxygen concentrators and change the humidifier bottles and filters if needed. She stated she did not check Resident #14's filter or humidifier bottle and did not (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know why she did not. She stated not changing the tubing, filter and humidifier bottle as ordered could result in a URI or shortness of breath. During an interview on 09/09/2026 at 3:10 pm, LVN C stated she took care of Resident #14, and the Resident was out of her room most of the day and used her oxygen in the evening. She stated the tubing should be bagged when it was not in use and the filter and humidifier bottle needed to be checked and changed as ordered to prevent infection. Record review of Resident #15's electronic face sheet, dated 01/07/2026, reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: acute respiratory failure with hypoxia (condition where there is insufficient oxygen in the blood, causing respiratory distress), metabolic encephalopathy (diffuse brain dysfunction), chronic obstructive pulmonary disease (COPD) (lung and airway disease that restricts breathing) and acute pulmonary edema (accumulation of blood in the pulmonary tissue). Record review of Resident #15's admission MDS assessment dated [DATE], reflected she could understand and be understood. She required moderate assistance with her ADLs. She scored 14 of 15 on her BIMS which indicated her cognitive status was intact. She was noted to receive continuous oxygen therapy while a resident and received respiratory therapy at least 15 minutes per day. Record review of Resident # 15's comprehensive person-centered care plan dated 09/23/2025 reflected Focus, has oxygen therapy r/t acute respiratory failure/COPD, interventions, clean oxygen filter every Wednesday and PRN, O2 via NC at 5-7L/min continuously with humidified cannister. Observation on 01/06/2026 at 10:53 am revealed Resident #15, in her room and oxygen was set at 6L/min via NC, the concentrator filter dirty with dust. The nebulizer mask was not bagged. Observation on 1/07/2026 at 11:00 am revealed Resident #15 received her nebulizer treatment and returned to her room at 1:00 pm the nebulizer mask was not bagged after her treatment. During an interview on 01/07/2026 at 11:05 am, Resident #15 stated she was on oxygen for her breathing and had nebulizer treatments. She stated the nurses were the ones who checked her equipment. During an interview on 01/09/2026 at 2:23 pm, the DON stated Resident #15's oxygen concentrator filter should have been checked initially prior to hook up and use, and the oxygen filter should have been replaced on admission. She stated she would put the oxygen care issues in the MAR, so the nurses would be reminded to change the tubing, filter and humidifiers as needed. She stated a dirty filter could cause disruption of air flow and result in respiratory distress or URI. During an interview on 01/09/2026 at 3:10 pm, LVN C stated she had taken care of Resident #15, and she was the one who administered her nebulizer treatments. She stated the nebulizer mask should be bagged when it was not in use and the filter and humidifier bottle needed to be checked and changed as ordered to prevent infection. She stated she had not noticed the equipment was not bagged or the filter was dirty. Record review of the facility's policy and procedure titled Oxygen Administration dated 07/01/2025 reflected Purpose, to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues, Procedure, at regular intervals, check and clean oxygen equipment, masks, tubing and cannula. Change masks and tubing and cannula's every 7 days and as needed.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interviews and record reviews, the facility failed provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Medication Cart B and C Halls) of 2 medication carts reviewed for expired medications. The facility failed to ensure the Medication Cart for B and C Halls did not contain an expired bottle of Atropine 1% drops. This deficient practice could place residents at risk to receive expired medication with less effective results. Observation on 01/08/2026 at 08:20 am accompanied by LVN F when checking the Medication Cart for B and C Halls, revealed a plastic bottle of Atropine 1%, with an expiration date of 08/29/2025 was found on the cart. During an interview on 01/08/2026 at 3:05 pm, LVN F stated she would usually check the medication cart for expired medications when she worked. She did not know how the expired bottle of Atropine was not removed from the cart sooner. She stated the effectiveness of the medication could decrease after the expiration date and that would harm a resident. During an interview on 01/09/2026 at 2:23 pm, the DON stated the medication carts were checked routinely and the Atropine should have been removed earlier since it had been expired for 6 months. She stated expired medication could have less effect on a resident and might cause harm. During an interview on 01/09/2026 at 3:20 pm, the RNC stated expired medications needed to be removed from carts, and nurses must ensure medication carts and the treatment cart were either within view or locked. He stated medications expired and could have less effectiveness for the residents. Per the DON, no facility policy and procedure addressed expired medications on the medication cart.		

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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. Based on observations, interviews and record reviews, the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable and in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys for and 1 of 1 treatment cart (Treatment Cart) reviewed for medication storage. The facility failed to ensure RN A and the ADON did not leave the treatment cart unlocked when they went to perform a treatment on a resident. These deficient practices could place residents at risk of misappropriation of treatment medications and supplies. The findings were: Observation on 01/07/2026 at 3:20 pm, revealed RN A and the ADON performed wound care for Resident #3 revealed RN A took the wound care treatment and supplies into the residents room without securing the treatment cart and then the ADON closed the door to the room, leaving the treatment cart in the hall unlocked and out of view. During an interview on 01/07/2026 at 3:40 pm, RN A stated she should have secured the treatment cart because there were medicated ointments and solutions used for wound care, and a drug diversion could occur or someone without need to access the cart and it could result in harm. RN A stated she had the keys and it was her responsibility to secure the cart. During an interview on 01/09/2026 at 2:23 pm, the DON stated medications and treatment solutions or ointments must be secured in the medication and treatment cart when out of sight of the nurse. During an interview on 01/09/2026 at 3:20 pm, the RNC stated expired medications needed to be removed from carts, and nurses must ensure medication carts and the treatment cart were either within view or locked. He stated medication carts or the treatment cart left unlocked and attended could result in harm of others or misappropriation of supplies or drugs. Record review of the facility's policy and procedure titled Storage of Medication dated 02/22/2016 reflected purpose of this procedure is to ensure medications are stored in a safe, secure, and orderly manner. Compartments containing medications are locked when not in use.		

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 2 of 2 Dumpsters (Dumpsters #1 and #2) reviewed for garbage and refuse disposal. The facility failed to ensure Dumpster #1 and Dumpster #2 had lids that were completely closed This deficient practice could place residents at risk for exposure to germs and diseases carried by vermin and rodents. The findings included: Observation on 01/6/26 at 10:00 am revealed Dumpster #1 and Dumpster #2 both had lids which measured approximately 3x5 ft that were not secured to the dumpster basin due to overflowing garbage inside the bin. There were also two bags of garbage and a pile of cooked noodles laying on the ground beside Dumpster #2. Interview on 1/6/26 at 10:05am with the Clinical Specialist who stated he was aware of the garbage lids needing to be secure to the garbage bins to prevent rodent infestation. The Clinical Specialist stated that the facility's garbage was to be picked up later in the day but was unsure of the exact time of pick up. Record review of the facility's policy titled Cleaning-Trash Collection Areas dated 7/20/10 revealed Trash containers must have a lid and be closed at all times when not in use.		