STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675690	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Estates Rehabilitation Center	130 Spencer LN San Antonio, TX 78201

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46677 Based on interview, observations, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 6 resident (Resident #1, Resident #2, Resident #3) reviewed for care plans. The facility failed to ensure Resident #1, Resident #2 and Resident #3's comprehensive care plans were person centered and included fall preventions interventions that had been implemented prior to investigation beginning, such as appropriate footwear, non-slip socks, and bed in low position. This deficient practice could place residents at risk for not receiving appropriate treatment and services. The findings included: Record review of Resident #1's Face sheet dated 03/28/2024 revealed resident to be a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident #1's diagnoses included Muscle wasting, Difficulty walking, and Muscle weakness. Record review of Resident #1's MDS assessment, dated 03/08/2024, revealed Resident #1 had a BIMS of 08. Resident #1's bed mobility and transfer functional status was identified as needed extensive assistance and requiring two+ person physical assist. Record review of Resident #1's comprehensive care plan, revised on 01/31/2024, identified Resident #1 to be at risk for falls. Interventions/task identified included: -Be Sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all request for assistance. -Follow facility fall protocol (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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NAME OF PROVIDER OR SUPPLIER Golden Estates Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 130 Spencer LN San Antonio, TX 78201	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review information on past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. Record review of Resident #2's Face sheet dated 03/28/2024, revealed resident to be a [AGE] year-old female at the time of her expiring. Resident was originally admitted to the facility on [DATE] and then readmitted on [DATE]. Resident #2 had diagnoses of dementia, primary osteoarthritis, muscle weakness, and difficulty in walking. Record review of Resident #2's MDS assessment, dated 03/08/2024, revealed Resident #2 had a BIMS of 04. Resident #2's functional abilities for indoor mobility was not identified. Resident #2's mobility was identified dependent on others for assistance. Record review of Resident #2's comprehensive care plan, revised on 01/31/2024, identified Resident #2 to be at risk for falls. Interventions/task identified included: -If Resident is a fall risk, initiate fall risk precautions Record review of Resident #3's Face sheet dated 03/28/2024 revealed resident #3 to be a [AGE] year old female. Resident #3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses of unspecified dementia, difficulty in walking, and muscle weakness. Record review of Resident #3's MDS assessment, dated 03/08/2024, revealed Resident #3 had a BIMS of 04. Resident #3's bed mobility and transfer functional status was identified as needed extensive assistance and requiring two+ person physical assist. Record review of Resident #3's comprehensive care plan, revised on 01/31/2024, identified Resident #3 to be at risk for falls. Interventions/task identified included: -Anticipate and meet my needs - Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. -Educate me/family/caregivers about safety reminders and what to do if a fall occurs -Encourage me to participate in activities that promote exercise, physical activity for strengthening and improved mobility -Follow facility fall protocol (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #1 on 03/27/2024 at 1:35 PM revealed the resident to be asleep on her bed. Resident #1's bed was low to the ground and call light was within reach of resident. There were no floor mats next to Resident #1's bed. Resident #1's room was free of clutter. Observation of resident #3 on 03/27/2024 at 1:45 PM revealed resident siting in a wheelchair in her room. Resident's room appeared clean and free of clutter. Resident's bed was in low position to the floor with call light on the mattress. Resident was wearing slip-on shoes. Interview with Resident #3 was attempted on 03/27/2024 at 1:47 PM. Resident refused interview. Interview with DON, on 03/28/2024 at 2:44 PM revealed once a resident was identified as a fall risk the care plan was updated to reflect appropriate interventions. DON stated that interventions could include, but not limited to, floormats next to bed, bed in low position, call light within reach and increased checks. DON stated that resident care plans will reflect them to be a fall risk and interventions added as task for CNAs. Interview with MDS Nurse on 03/29/2024 at 10:27 AM revealed when a resident was identified as a fall risk the care plan gets updated to reflect fall prevention interventions that were identified. MDS nurse was responsible to update the care plans and ensure that the tasks are listed for CNAs to do each shift. MDS nurse stated Resident #1, Resident #2 and Resident #3's care plans identified them as fall risks but did not list the individual interventions for each, only that staff were to follow the facility fall prevention policy. MDS nurse also stated Resident #1, Resident #2 and Resident #3's individual interventions were listed as task for staff to complete. Interview with CNA A, on 3/29/24 at 8:37 AM, revealed if residents are identified as fall risks when they are admitted then interventions put into place to prevent them from falling. CNA A stated the nurses informed the CNAs what interventions each resident had in place. CNA A also stated that the interventions are listed as tasks to be completed in the resident's medical chart. CNA was unaware any other location where interventions should be listed. CNA A stated that residents identified as fall risk had their beds in low position and their call lights within reach when they were in bed. CNA A stated that a resident who was independently ambulatory were to have nonslip footwear on when not in bed. CNA A went on to say residents that were not able to ambulate independently get mats placed next to their bed when they were in bed as well as their call light within reach. CNA A stated Resident #1 and Resident #3 were identified as a fall risks and ambulated independently. CNA A stated that both Resident #1 and #3 were to have nonslip footwear when not in bed, call lights within reach while in bed and their beds in low position. CNA A stated Resident #2 was not able to independently ambulate, so she received fall mats next to bed when she was in it and her call light within reach. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN B, on 03/29/24 at 8:44 AM, revealed if a resident was identified as a fall risk the facility would implement precautions to help prevent residents from falling. LVN B identified common precautions included beds in low position, call lights, frequent rounds to check on the residents, appropriate nonslip footwear, and floormats next to beds when residents are in bed as applicable. LVN B stated that the fall preventions are listed resident's medical chart. LVN B identified Resident #1, Resident #2 and Resident #3 as fall risk. LVN B stated Resident #1 and Resident #3 both walked around the facility independently and had interventions including nonslip footwear and frequent checks. LVN B stated she did not work with Resident #2. LVN B stated nurses on duty inform the CNAs which of the resident are fall risk and what interventions they receive. LVN B also stated that the interventions are located in resident's chart under interventions. LVN B is unaware of any other location of interventions. Record review of the facility's policy named Falls-Clinical Protocol dated December 2023 revealed the policy stated, As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling and Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. Policy also included a list of fall prevention potential interventions.