

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Golden Estates Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure residents had a safe, clean, comfortable and homelike environment, for 30 of 75 residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29 and #30) and 11 additional residents with rooms on the 200/100 hallways (all residents of 300 affected), 3 of 3 halls (halls 300, 200 and 100) and affected residents who utilized the facilities hallways, and main living area reviewed in that:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, #28, #29) had a warm and comfortable environment on 2/18/2025-2/27/2025 when the local weather temperatures were as low as 21 and the inside facility temperatures were as low as 51 degrees Fahrenheit (F). The facility temperatures affected all three hallways of the facility, the common living room area, and all rooms on the 300-hallway. This resulted from a known issue where the heater motor had been out since 1/22/2025 on the 300-hallway and the 200-hallways heaters did not function at a capacity to heat all of the resident rooms. In addition, the motor on the 100-hallway heater had not been operational affecting the hallways for an unknown period of time. This failure resulted in the identification of an Immediate Jeopardy (IJ) on 2/21/2025 at 8:52 p.m. The IJ template was provided to the facility on [DATE] at 8:52 p.m. While the IJ was removed on 2/28/2025 the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility needed to monitor the implementation of the plan of removal. 2. The facility failed to ensure a hole in the ceiling of Resident #3 and #26's room was repaired in a timely manner. 3. The facility failed to ensure the cord to Resident #30's room over bed light cord was repaired timely. 4. The facility failed to ensure the toilet in Resident #20's room was repaired timely. 5. The facility failed to ensure the hot water temperatures were within 100-110 F for comfort on all three wings of the facility. <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 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #4's Progress notes dated 2/22/2025 revealed: family notified of room change due to in climate weather documented by the BOM.</p> <p>During an observation and interview on 2/21/2025 at 3:21 p.m., Resident #4 was in bed covered by multiple blankets. He stated he was cold even with extra blankets. He stated he was unsure how long it had been going on just that he was cold.</p> <p>During an interview on 2/21/2025 at 6:41 p.m. Resident #4 stated Of course it's cold in here. That's a silly question. Can't you see? when asked how the cold was affecting him. He stated when his whole body was under the covers, he felt warm. He stated when even the edge of his arms came out of the covers, he was cold. He stated he had not refused therapy or showers. He stated he was still going to therapy, but he did have to wear a hoodie or a jacket and hat to go to therapy because it was cold. He stated yes, he had told the staff he was cold (unknown name) and they provided blankets.</p> <p>Resident #5</p> <p>Record review of Resident #5's face sheet dated 2/23/2025 revealed a 91-yo-female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: hypothyroidism, hypertensive heart disease without heart failure and chest pain. The face sheet indicated Resident #5 was discharged to another nursing facility on 2/21/2025 (at family request).</p> <p>Record review of Resident #5's BIMs evaluation dated 2/21/2025 revealed a score of 12 which indicated a moderate cognitive impairment. (MDS not completed due to new admission status).</p> <p>Record review of Resident #5's Care Plan revealed she was dependent on staff for ADL care.</p> <p>During an observation and interview on 2/21/2025 at 3:23 p.m. Resident #5 was observed in bed with multiple blankets including a large thick comforter. A portable mini heater was observed on in the room and the room felt warmer than some of the other rooms. Resident #5 stated she had been very cold. She stated it was very bad during the past night. She stated many of the residents could be heard during the night crying and screaming that it was cold. She stated last night she heard a man saying over and over that he was cold. She stated he was screaming he was cold. Resident #5 stated she also heard another person, right next to her room crying and saying it was cold. Resident #5 stated she was very worried about the other residents. She stated she had her family to help her, and they brought her extra blankets from home. Resident #5 appeared concerned and stated, Will you please help them?</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 2/21/2025 at 6:48 p.m. a family member #1 of Resident #21 was in the room for a visit. He stated there used to be a portable space heater in the room but for some reason the staff had pulled it. He stated the whole week had been cold at the facility. He stated he was cold just visiting. He stated he has talked to staff and facility management but did not remember the date. He stated he has heard residents tell staff and management they are cold, and everyone was just ignoring them. The family member stated, What are my options? He stated his other family member had talked to the Administrator about the conditions. He offered the phone number for the other family member and stated, she had a lot to say.</p> <p>During a telephone interview on 2/21/2025 at 8:28 p.m., a family member #2 of Resident #21 stated the local weather had been extreme and most of the residents at the facility were elderly. She stated the resident rooms were so cold. She stated she was informed by staff if she kept the resident room closed (on 300-hallway) with a space heater it would keep the room warm. She stated she visited at night and heard a man near her family members room crying and screaming that he was cold. She stated she gave the man her hat and saw him shaking but she did not know his name. She stated her family member had been complaining every day of the cold. She stated he had been tossing and turning because it was too cold for him to sleep. She stated her family member was so fragile and did not deserve to be treated like this. She stated she brought her family member extra blankets from home to cover him, but because he was so thick, he complained that the blankets felt heavy on him. She stated she complained to the nurses, and they offered blankets and the portable space heater.</p> <p>Resident #22</p> <p>Record review of Resident #22's face sheet dated 2/27/2025 revealed an [AGE] year-old male admitted on [DATE] with diagnoses which included: type 2 diabetes mellitus without complications, emphysema, and major depressive disorder.</p> <p>Record review of Resident #22's 5-day admission MDS dated [DATE] revealed a BIMs score of 15 which indicated he was cognitively intact. The assessment indicated he required supervision or touch assistance for ADL care.</p> <p>During an interview on 2/21/2025 at 3:39 p.m. Resident #22 and a family member in the room, both dressed in layers stated they were not warm. They declined further interview at this time.</p> <p>Resident #23</p> <p>Record review of Resident #23's face sheet dated 2/23/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted [DATE] with diagnoses which included: fracture of unspecified part of neck of right femur, encounter for closed fracture, metabolic encephalopathy and type 2 diabetes mellitus.</p> <p>Record R review of Resident #23's progress notes revealed she had a history of removing clothing and behaviors.</p> <p>Record Review of Resident #23's MDS revealed one was not completed due to new admission status.</p> <p>Record Review of Resident #23's care plan revealed she was reliant on staff for ADL care.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an observation and interview on 2/21/2025 at 3:40 p.m. Resident #23 was wearing long sleeved layered clothes and a knit hat and wearing a blanket on her lap. She stated she was cold and did not know how to turn the heater. She was unable to answer further interview questions due to cognitive status.</p> <p>Resident #25</p> <p>Record review of Resident #25's face sheet dated 2/23/2025 revealed a [AGE] year-old female with admitted [DATE] with diagnoses which included: cerebral infarction, vascular dementia moderate and hypertensive heart disease without heart failure.</p> <p>Record Review of Resident #25's 5-day admission MDS dated [DATE] revealed a BIMs score of 6 which indicated a severe cognitive impairment.</p> <p>Record review of Resident #25's shower sheet dated 2/19/2025 revealed the resident refused the shower at 9:00 a.m. and an unknown staff member wrote refused building to (sic) cold.</p> <p>During an observation and interview on 2/21/2025 at 6:55 p.m. Resident #25 was observed lying in bed in a fetal position with a hat and two blankets covering her. She stated she was trying to stay warm under the covers. She stated she still felt cold and was very uncomfortable. She stated she had not told anyone she was cold or uncomfortable because she did not know who to tell.</p> <p>During an observation and interview on 2/21/2025 at 7:05 p.m., Resident #25 was brought in her wheelchair to the nurse's station on 300-hallway. She stated she did not want to sit there because it was too cold. Resident #25 was observed wearing a winter knit hat, layered clothing, and had one fleece blanket draped across her legs. She stated she was not comfortable and hollered NO, it's fucking cold that's a stupid question. The interview was ended because the resident was agitated.</p> <p>200-hallway Residents</p> <p>Resident #1</p> <p>Record review of Resident #1's face sheet dated 2/24/2025 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: hydrocephalus, seizures, and generalized muscle weakness.</p> <p>Record Review of Resident #1's modification of quarterly MDS dated [DATE] revealed a BIMS of 4 which indicated a severe cognitive impairment and total dependence on staff for ADL care.</p> <p>Record review of Resident #1's shower sheet dated 2/21/2025 revealed an unknown staff member documented the resident refused the shower and documented refused to (sic) cold.</p> <p>Resident #6</p> <p>Record review of Resident #6's face sheet dated 2/27/2025 revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: cerebral infarction due to thrombosis of basilar artery (stroke), severe protein-calorie malnutrition, and hypertensive heart disease without heart failure.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #7's annual MDS dated [DATE] revealed a BIMs score could not be obtained because the resident was rarely/never understood and had both short term and long-term memory problems. The assessment indicated the resident was able to recall with accuracy the location of his own room and had some difficulty with decisions in new situations only. The assessment indicated the resident needed supervision or touch assistance with mobility and transfers and moderate assistance for ADL care.</p> <p>Record review of Resident #7's care plan last revised on 2/17/2025 revealed he had diabetes mellitus with interventions which included avoid exposure to extreme heat or cold.</p> <p>During an observation and interview on 2/21/2025 at 1:33 p.m. Resident #7 was observed in a room on the 200 hallway seated in a recliner wearing layered clothing including a sweatshirt and hat with arms cross over his chest. Resident #7 did not respond verbally to questions due to cognitive status.</p> <p>Resident #8</p> <p>Record review of Resident #8's face sheet dated 2/27/2025 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: iron deficiency anemia, cerebral infarction (stroke), and major depressive disorder.</p> <p>Record review of Resident #8's quarterly MDS dated [DATE] revealed a BIMs score of 11 which indicated a moderate cognitive impairment. The assessment indicated the resident required substantial maximal assistance for bed mobility and transfers and ADL care and was non-ambulatory.</p> <p>Record review of Resident #8's care plan last revised on 2/20/2025 revealed her resident rights would be respected and maintained with interventions which included the right to complain about care or treatment and receive prompt response to resolve the complaint without fear of reprisal or discrimination.</p> <p>Resident #9</p> <p>Record review of Resident #9's face sheet dated 2/27/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: type 2 diabetes mellitus, bilateral osteoarthritis of knee and anorexia.</p> <p>Record review of Resident #9's quarterly MDS dated [DATE] revealed a BIMs score of 4 which indicated a severe cognitive impairment. The assessment revealed she was required moderate assistance with ADL care and transfers.</p> <p>Record review of Resident #9's care plan last revised on 1/09/2025 revealed she had a potential to be underweight due to anorexia and she was a fall risk in which staff should anticipate her needs.</p> <p>During an observation and interview on 2/21/2025 at 1:38 p.m. in a room on the 200 hallway, Resident #8 was observed wearing layered clothes, socks a sweater and had on two blankets. She stated she was cold. Further information was unable to be obtained due to cognitive status. Resident #9, who was not interviewable due to cognitive status was laying on her left side facing the door curled in a fetal position with multiple blankets covering her.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #10</p> <p>Record review of Resident #10's face sheet dated 2/27/2025 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: type 2 diabetes mellitus, generalized anxiety disorder and protein-calorie malnutrition.</p> <p>Record review of Resident #10's quarterly MDS dated [DATE] revealed a BIMs score of 15 which indicated he was cognitively intact. The assessment indicated the resident needed supervision or touch assistance with ADL care and transfers.</p> <p>Record review of Resident #10's care plan last revised on 12/19/2024 revealed her resident rights would be respected and maintained with interventions which included the right to complain about care or treatment and receive prompt response to resolve the complaint without fear of reprisal or discrimination.</p> <p>Resident #11</p> <p>Record review of Resident #11's face sheet dated 2/27/2025 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral palsy, type 2 diabetes mellitus, and Duchenne or [NAME] muscular dystrophy (progressive muscular and neurological disease that results in wasting and muscle atrophy and eventual death).</p> <p>Record review of Resident #11's quarterly MDS dated [DATE] revealed a BIMs score of 15 which indicated the resident was cognitively intact. The assessment revealed the resident required supervision for ADL care and mobility.</p> <p>Record review of Resident #11's care plan revealed he was PASRR positive for developmental disability. Resident #8's care plan last revised on 11/27/2024 revealed her resident rights would be respected and maintained with interventions which included the right to complain about care or treatment and receive prompt response to resolve the complaint without fear of reprisal or discrimination.</p> <p>During an observation and interview on 2/21/2025 at 1:41 p.m. of a room on the 200 hallway, Resident #10 and Resident #11 were both wearing a sweatshirt over clothing. Resident #10 stated they were warm in the room as long as they stayed under the blankets, but at night it was too cold. He stated even in the daytime if he got out of the blankets, he was cold. He stated this had been going on for a few days. Resident #11 was unable to answer interview questions due to cognitive status.</p> <p>Resident #12</p> <p>Record review of Resident #12's face sheet dated 2/27/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: moderate protein-calorie malnutrition, Alzheimer's disease with late onset, and generalized anxiety disorder.</p> <p>Record review of Resident #12's quarterly MDS dated [DATE] revealed a BIMs score could not be obtained because the resident was rarely/never understood and had both long term and short-term memory problems. The assessment revealed the resident required partial assistance with ADL care.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #12's Care Plan last revised 2/20/2025 revealed she had a history of weight loss with interventions to monitor weight loss.</p> <p>Resident #13</p> <p>Record review of Resident #13's face sheet dated 2/27/2025 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: malignant neoplasm of pancreas (cancer), generalized anxiety disorder and vitamin deficiency unspecified.</p> <p>Record review of Resident #13's 5-day admission MDS dated [DATE] revealed a BIMs of 6 which indicated a severe cognitive impairment. The assessment revealed she needed moderate assistance with ADL's.</p> <p>Record review of Resident #13's shower sheet dated 2/20/2025 revealed CNA A documented a shower refusal and wrote resident states that it is too cold.</p> <p>During an observation of a room on the 200 hallway and interview on 2/21/2025 at 1:43 p.m., Resident #13 was wearing long pajamas, a sweater and a thick robe over her clothes while lying under a fleece blanket. She had socks on her feet. She stated she was okay, but the room was cold, and her feet were staying cold despite the blankets and layers. Resident #12 was lying in a fetal position under multiple blankets and was not interviewable due to cognitive status.</p> <p>Resident #14</p> <p>Record review of Resident #14's face sheet dated 2/27/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: cerebral infarction (stroke), mild protein-calorie malnutrition, and nutritional deficiency.</p> <p>Record review of Resident #14's quarterly MDS dated [DATE] revealed a BIMs score could not be obtained because the resident was rarely or never understood and had both long-term and short-term memory problems. The assessment revealed she was totally dependent on staff for all care.</p> <p>Resident #15</p> <p>Record review of Resident #15's face sheet dated 2/23/2025 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: multiple sclerosis, Parkinson's disease, and protein-calorie malnutrition.</p> <p>Record review of Resident #15's 5-day admission MDS revealed a BIMs of 13 which indicated the resident was cognitively intact.</p> <p>Record review of Resident #15's Care Plan revealed she was dependent on staff for care.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview and observation of a room on the 200 hallway, on 2/21/2025 at 1:46 p.m. Resident #14 was observed lying in bed covered with multiple fleece blankets. She was not interviewable due to cognitive status. Resident #15 was lying in her bed which was underneath a large window. She was visibly shaking from head to toe. She was wearing layered clothing, socks with slippers and was covered with a fleece blanket. She stated she was very cold and stated she always shakes when she was cold. Resident #15 was unable to state how long this had been occurring or answer any detailed interview questions.</p> <p>Resident #16</p> <p>Record review of Resident #16's face sheet dated 2/27/2025 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: type 2 diabetes mellitus with diabetic neuropathy, protein-calorie malnutrition and dependence on renal dialysis.</p> <p>Record review of Resident #16's quarterly MDS dated [DATE] revealed a BIMs score of 8 which indicated a moderate cognitive impairment. The assessment revealed he required moderate assistance with ADLs.</p> <p>Record review of Resident #16's Care Plan last revised on 2/20/2025 revealed the resident rights wou</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511</p> <p>Based on observation, interview, and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 24 hours after the allegation was made to the State Survey Agency for neglect for 1 of 1 facility, in that;</p> <p>The facility did not report to the State Survey Agency (HHSC) an incident in which the facilities heater system was not operation on the 300-hallway and was in need of repair since 1/22/2025 and when Resident #24 complained of lack of heat on the 200-hallway and a repair could not be immediately completed leaving the facility without heat when the local temperatures dropped to 21 degrees.</p> <p>This failure could place residents at risk for neglect and could lead to a diminished quality of life and harm.</p> <p>The findings included:</p> <p>Record review of Resident #24's face sheet dated 2/27/2025 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: type 2 diabetes mellitus with diabetic neuropathy, primary osteoarthritis, and fibromyalgia.</p> <p>Record review of Resident #24's quarterly MDS assessment dated [DATE] revealed a BIMs score of 10 which indicated a moderate cognitive impairment. The assessment revealed the resident required partial to moderate assistance with ADL's.</p> <p>Record review of Resident #24's care plan last revised on 8/29/2024 revealed her resident rights would be respected and maintained with interventions which included the right to complain about care or treatment and receive prompt response to resolve the complaint without fear of reprisal or discrimination.</p> <p>Record review of Resident #24's shower sheet dated 2/20/2025 revealed CNA A documented the resident refused a shower and wrote Resident states that it is too cold.</p> <p>During an interview on 2/21/2025 at 1:40 p.m., the Maintenance Director stated acknowledgement that building was cold. He sated the heater repairman had just arrived approximately 20 minutes prior. He stated the heater repairman had also been to the building on 2/20/2025 because the heater was not warming up hot. He stated the resident room temperatures varied.</p> <p>During observations on 2/21/2025 at 1:48 p.m. of the Maintenance Director obtained room temperatures with his laser thermometer at bed level revealed for Hallway 200:</p> <p>*outside room [ROOM NUMBER]: 63 F</p> <p>*room [ROOM NUMBER]-69 F</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*room [ROOM NUMBER]-61 F</p> <p>*room [ROOM NUMBER]-70 F</p> <p>*room [ROOM NUMBER]-59 F</p> <p>*room [ROOM NUMBER]-62 F</p> <p>*room [ROOM NUMBER]-63 F</p> <p>*room [ROOM NUMBER]-66 F</p> <p>During observations on 2/21/2025 at 2:32 p.m. of the Maintenance Director obtained room temperatures with his laser thermometer at bed level revealed the following:</p> <p>*room [ROOM NUMBER]- 65 F</p> <p>*room [ROOM NUMBER]- 62 F</p> <p>*room [ROOM NUMBER]- 61 F</p> <p>*room [ROOM NUMBER]- 61 F</p> <p>*room [ROOM NUMBER]- 62 F</p> <p>*room [ROOM NUMBER]- 63 F</p> <p>*room [ROOM NUMBER]- 59 F</p> <p>*room [ROOM NUMBER]- 62 F</p> <p>*room [ROOM NUMBER]- 66 F</p> <p>*room [ROOM NUMBER]- 63 F</p> <p>*room [ROOM NUMBER]- 67 F</p> <p>*room [ROOM NUMBER]- 67 F</p> <p>*room [ROOM NUMBER]- 63 F</p> <p>*room [ROOM NUMBER]- 64 F</p> <p>*room [ROOM NUMBER]- 65 F with mini-split with heater on, set at 85 degrees</p> <p>*room [ROOM NUMBER]- 60 F with mini-split with heater on, set at 80 degrees</p> <p>*room [ROOM NUMBER]- 64 F with mini-split with heater on, set at 88 degrees</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*room [ROOM NUMBER]- 63 F with mini-split with heater on, set at 88 degrees</p> <p>*room [ROOM NUMBER]- 65 F with mini-split with heater on, set at 78 degrees</p> <p>During an observation of room temperatures on 2/21/2025 at 3:30 p.m. on the 300 hallway (not connect to the 100/200 hallway) with the Maintenance Director revealed:</p> <p>* room [ROOM NUMBER]- 65 F</p> <p>* room [ROOM NUMBER]- 57 F</p> <p>* room [ROOM NUMBER]- 58 F</p> <p>* room [ROOM NUMBER]- 70 F (with portable heater brought by family)</p> <p>* room [ROOM NUMBER]- 63 F</p> <p>* room [ROOM NUMBER]- 60 F</p> <p>* room [ROOM NUMBER]- 60 F</p> <p>* room [ROOM NUMBER]- 57 F</p> <p>* room [ROOM NUMBER]- 55 F</p> <p>*Hall temperature on 300 hallway- 51 F</p> <p>*Physical therapy gym on 300 hallway- 52 F</p> <p>*Main living room/dining room area 58 F</p> <p>During an observation and interview on 2/23/2025 at 7:41 a.m., Resident #24 was observed wearing multiple layers of clothes on the top and bottom and she had her head wrapped in a scarf. Multiple layers of blankets were on her bed. She stated today was warmer than the previous days. She stated she was still cold. She stated a not last night but before (date unknown) she was not able to sleep or get comfortable because it was so cold. She stated she told her nurse (name unknown), the Staffing Coordinator and other members of management because the nurse encouraged her to tell them. She stated they all responded that they were working on it.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 2/21/2025 at 2:02 p.m., the Maintenance Director stated he had not received any complaints about room temperatures. He stated the heater system ran on boiling water. He stated he had been checking the room temperature randomly but was not documenting the temperatures. He stated to his knowledge there was not a regulation that required him to monitor room temperatures or record them. He stated the water lines that ran on the 100/200 hallways heater were clogged. He stated it was a known issue at the facility, but declined to indicate a timeframe that this was a known issue. He stated the lines were clogged due to a buildup in the lines, so he had the water softeners upgraded on all hallways. He stated it would take an unknown amount of time for the buildup to resolve. He stated his plan was just to give the new system time to unclog the lines. He stated on 2/20/2025 he had called a repair company to get a quote to place mini-split units in all rooms and to get a motor repaired on the 300-hallway heater. He stated he did not remember when he first knew the motor for the 300 hallways heater was not working. He stated the rooms and offices on the 100 hallways already had mini-splits that were heating the rooms but not the hallways.</p> <p>During an interview on 2/21/2025 at 2:50 p.m., the heater repairman stated he had a small company with a few employees. He stated he had been working for the building for [AGE] years. He stated the facility had changed management several times and he does not always work with the same people. He stated approximately 5 months ago, he was called for various problems and resulted in him working on the heaters on the 200-hallway. He stated at that time the boiler was not working, then the igniter was not working and then he was called and worked on the pressure switches. He stated one of the problems with the heaters in the facility was the heaters originally had 3 speed motors. When they went out, the facility replaced them with 1 speed motors. He stated that meant that the heater which was meant to work on low-medium and high would only operate on low. He stated the facility would turn the switches to high and then complain that the heater was not working. He stated the facility needed to keep the thermostats on low for them to work. The repairman stated what needed to happen was for each thermostat in each room to be replaced or they need to block and mark the thermostat so it could not be adjusted or moved. He stated each room also had two valves that adjusted the water in the pipes that heated the rooms. He stated the valves were broken and stuck. He stated all valves needed to be manually opened. He stated this would have to be done anytime the ac/heater was switched from ac to heat or heat to ac because they were broken. He stated they were designed to automatically open and close. The repairman stated two weeks ago the facility asked him to work on the 300 hallways. He stated they had two options. They could replace the chiller/heater which was over [AGE] years old, or they could place a mini-split in each room. He stated there was a motor broken on the 300 hallway and he had not yet ordered the part. The repairman stated the chiller system was complicated and sometimes people do not know how to properly operate them. He stated the chiller motor went down at least two weeks ago. When asked for a date that he responded to the facility for the 300 motors being down, he stated he was in the facility between 1/16/2025-1/22/2025 and the facility was notified that it the motor was out and needed to be replaced at that time. He stated he asked them at that time what they wanted to do. He stated he had not been given any direction on how they wanted to proceed. He stated he was not called to look at the 200-hallway heater until 2/21/2025 (date of surveyor arrival).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 2/21/2025 at 3:44 p.m., the Maintenance Director stated he was new to the facility as of late September 2024. He stated when he came to the facility, he had heard there were issues with citations related to the heater from the previous year. He stated he came to the facility with the idea of fixing things. He stated he talked to the owner about mini-splits for the whole facility. He stated they talked about installing them in section. He stated when he first came the 100-hallway was the worst, so mini-splits were put in that section of the building. He stated the owner wanted to wait a while to see how well the mini-splits worked and how they held up. The Maintenance Director stated he did not have an answer to when he first became aware of heating issues. He stated the facility had issues on both the 300 and 200 hallways. He stated he went down to the 200-hallway to some rooms where there were complaints. He stated he then called the repairman, and they cleaned out some of the lines and he called about the water softeners. He stated no one told him the 300-hallway was cold. He stated none of the staff told him. He stated a resident approached him and told him they were cold. He stated he did not know who the resident was.</p> <p>During an interview on 2/21/2025 at 4:24 p.m. LVN D stated the building had issues with the cold since it started getting cold in the city in November. She stated most of the time it had been manageable with extra clothes until the end of January when a cold spell blew through and again now in February. She stated she stated the staff were not just wearing jackets in the building, but they were wearing layered clothing and full coats. She stated all of the residents were complaining of the cold. She stated some of the residents were still complaining of the cold even when they were all bundled up in bed. LVN D stated they were trying to keep blankets stocked. She stated the management staff all knew how cold it was. She stated she had personally told the Maintenance Director. She stated again that everyone in management knew of the issue. LVN D stated they had not received any instructions or direction from management other than just use blankets. She stated most of the residents were refusing showers. She stated she did not blame them because they were too cold to come out from the blankets.</p> <p>During an interview on 2/21/2025 at 4:43 p.m., the Marketer stated when she made rounds today (2/21/2025) some of the residents told her they were cold. She stated during morning meeting today (2/21/2025) the cold inside the building was discussed. She stated in the meeting they said the heaters were working but the air was not circulating or heating enough. She stated nothing else was discussed in the meeting.</p> <p>During an interview on 2/21/2025 at 5:11 p.m., the ADON stated he became of aware that the heaters were not working approximately one and a half weeks ago. He stated the heating system was an old system and the temps had been fluctuating. He stated the inside temps fluctuated with the weather. The ADON stated the 100-hallway had an issue at another time, but mini-splits were put in on the 100-hallway. He stated the mini-splits only heated some of the resident rooms and the hallways even on the 100-hallway remained cold. The ADON stated Resident #24 had complained of the cold. He stated that was the only resident that had complained. The ADON stated they had discussed the cold in morning meetings.</p> <p>During an interview on 2/21/2025 at 5:35 p.m., the Administrator stated the room temperatures were cold right now, mostly in the front of the building. She stated she had not noticed it was cold in the facility. She stated only Resident #24 had complained (date unknown).</p> <p>During an interview on 2/25/2025 at 5:19 p.m. the Administrator stated</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>she did not report the loss of heat to the facility because the heater was not running as intended 2/17/2025. Part of it was running and part of it was not. She stated she would report to HHSC if there was a total outage and we were not able to get it back up and or if we were not able to get the repair to hold up. She said I do not believe we reached the point where it needed to be reported. The front side of the building was working when the back side was not working.</p> <p>During an interview on 2/28/2025 at 12:14 p.m., the Administrator stated the facility abuse policy indicated she should report any allegations of abuse, neglect or exploitation and any building concerns that something was faulty, and they could not get it repaired, then she would report. She stated the time frame for reporting to HHSC was dependent of when depend on if there was no option to get something up and running and it would cause an issue the community (residents). She stated her expectation from staff were to report any concerns about the building to the Maintenance Director and then to her. She stated they discuss maintenance concerns in the morning meeting.</p> <p>Record review of TULIP did not reflect a facility reported incident that corresponded to the allegations in the complaint described above.</p> <p>Record review of a facility policy titled Risk Management: Abuse, neglect, Exploitation, Mistreatment of Resident, or Misappropriation of Resident Property last reviewed August 2017 revealed: An immediate report will be filed with DADS for alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property .not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency .) in accordance with State law through established procedures.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Golden Estates Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511</p> <p>Based on the observations, interviews, and record review the facility failed to ensure that the resident's environment remained free of accidents and hazards as was possible and each resident received adequate supervision to prevent accidents for 1 (Resident #17) of 2 residents reviewed for accidents.</p> <p>The facility failed to ensure Resident #17 had two staff in attendance during a mechanical lift transfer when the resident was left hoisted in the sling and connected to the lift on her bed without any staff in the room.</p> <p>This failure could place the resident at risk of falls and place them at risk for injury.</p> <p>The findings included:</p> <p>Record review of Resident #17's face sheet dated 2/27/2025 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: heart failure, type 2 diabetes mellitus with hyperglycemia, vitamin B12 and folate deficiency anemia and hypothyroidism.</p> <p>Record review of Resident #17's significant change in status MDS dated [DATE] revealed a BIMs score of 15 which indicated the resident was cognitively intact. The assessment indicated she was dependent of staff for transfers and required the assistance of 2 or more helpers.</p> <p>Record review of Resident #17's care plan last revised on 2/25/2025 revealed the resident required 2 staff participation with transfers with mechanical lift.</p> <p>During an observation and interview on 2/21/2025 at 2:08 p.m., Resident #17's door was closed, surveyor knocked on the door and entered the room. Resident #17 was observed in a sling which was attached to a mechanical lift that was positioned over the resident's bed. Resident #17's buttocks was resting on the bed and she was not suspended in the air, but her body was engulfed in the sling. The resident was not able to move out of the sling which was attached to the hoist. Resident #17 was awake, calm and was not moving. There were no staff members in the room. Resident #17 stated the staff left her in the sling often. She stated they need two staff members for the transfer. She stated they would put her in the sling and then they would leave to go get help. She stated she had been in the sling for approximately 10 minutes. She stated she knew it was about 10 minutes because she had been watching the clock. She pointed out the clock on the wall near the door. She stated she was anxious to get transferred to her wheelchair because she did not want to miss her smoke break. She stated it made her feel helpless when they left her hanging in the sling. The interview was conducted while the resident was in the sling attached to the hoist. As the surveyor was exiting the room to go find staff to assist, CNA A entered the room and asked the resident if she was ready to be transferred. Resident #17 answered yes. Shortly after another male staff member entered the room to assist.</p> <p>(continued on next page)</p>		

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 2/21/2025 at 2:18 p.m., CNA A stated she left Resident #17 alone in her room in the sling on the mechanical lift for approximately 3 minutes. She stated she was waiting for someone to help her. She stated she asked another staff member to help with the transfer and they said they were helping someone else. She stated she put Resident #17 on the sling and attached it to the hoist lift and then left the room to assist another resident in the room next door. She stated she was trained to put the sling under the resident and then wait for another staff member before proceeding. She stated she saw another staff member walk by so she proceeded with the sling. CNA A stated Resident #17 had been up in her wheelchair and was laid down to change and then the resident wanted back up to her wheelchair. CNA A stated Resident #17 liked to stay up all day. CNA A stated she did not know why she did not wait with the resident. CNA A stated she had not received training in mechanical lifts from the facility. She stated she had received training from the previous place she worked. She stated she had completed competencies and knew it was important not to leave the resident suspended in the sling because they could hurt themselves.</p> <p>During an interview on 2/25/2025 at 5:42 p.m., the DON stated there should always be two people in the room during mechanical lift transfers. She stated if a staff member left a resident attached to the lift unattended it would be a write up for the staff member. The DON stated the CNA should not leave a resident in a Hoyer lift unattended. The DON stated it was a safety hazard.</p> <p>During an interview on 2/28/2025 at approximately 10:00 a.m., the Staffing Coordinator stated he was a Certified Medication Aide and had observed and signed off on CNA A proper use of the mechanical lift which included use of two staff for transfers.</p> <p>Record review of CNA A's Nurse Aide Competency dated 10/28/2024 revealed the Staffing Coordinator who was a CMA had signed the competencies as completed which included: Basic Restorative Skills: use of lifts.</p> <p>Record review of an email from the Administrator to surveyor dated 2/27/2025 at 4:21 p.m. with the last facility in-service training for mechanical lifts. A review of the training titled Transferring Resident's and position. Hoyer transfers require 2 persons dated 7/17/2024. The training included 13 nursing staff but did not include CNA A (training date prior to hire).</p> <p>Record review of a facility policy, titled Safe Lifting and Movement of Resident last reviewed December 2023 revealed: In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. 4. Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices.</p>		