

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER The Army Residence Community Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7400 Crestway Dr San Antonio, TX 78239	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 27520</p> <p>Based on interview and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 of 8 Residents (Resident #25) whose records were reviewed for abuse.</p> <p>CNA D failed to immediately report a witnessed act of verbal abuse to the ADM, the abuse coordinator on 2/28/24. Instead CNA D told RN E the following day and then left a message for the facility HR. As a result, the ADM did not learn about the witnessed abuse until 3/8/24, 8 days after the incident.</p> <p>These deficient practices could affect any resident and contribute to continued and avoidable resident abuse.</p> <p>The findings were:</p> <p>Review of facility policy, Review of Facility Policy on Abuse and Neglect undated read: The philosophy and policy of [name of nursing facility] is to protect residents from any and all forms of abuse, neglect and misappropriation of property. Standard: The system will include but is not limited to: 4. Identification. Note: All concerns are to be brought to the Administrator immediately.</p> <p>Review of facility policy Abuse Investigations, undated, read: Purpose It is the purpose of the Abuse Investigations Policy to ensure that there is a systematic means in place for investigating all reports of resident abuse and related incidents. Responsibility Administrator Policy It is the policy of the Army Residence Community Health Care Center that all reports of resident abuse, neglect, mistreatment, and misappropriation of resident property will be promptly and thoroughly investigated by facility management.</p> <p>Review of Resident #25's face sheet, undated, revealed his original admitted to the facility was 10/4/23 with diagnoses including secondary Parkinsonism and Cognitive Communication Deficit.</p> <p>Review of Resident #25's quarterly MDS, dated [DATE], revealed his BIMS was severely impaired never/rarely made decisions.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #25's Care Plan, dated 4/18/24, revealed Resident #25 required maximum assistance with all ADL's and that he used a Foley catheter for toileting.</p> <p>Review of Provider Investigation Report, dated 3/12/24 revealed CNA D left a Google text with the facility HR that RN F told Resident #25 to quit crying like a baby. CNA D stated she also reported the incident to RN E. RN E did not report the allegation of abuse to the ADM. HR reported the allegation of abuse to the ADM on 3/8/24.</p> <p>Review of a statement, dated 3/8/24, provided by CNA D revealed during care Resident #25 was holding his catheter and slowly started to pull it and yelled out very loudly. RN F stuck his head in the room, looked around but did not ask if CNA D needed any help. He closed the door and CNA D yelled out at RN F telling him Resident #25 would need a patch for his breakdown. CNA D stated RN F never replied and returned a few minutes later. RN F told Resident #25 why was he yelling like a baby three or four times. CNA D stated Resident #25 stayed quiet and so did. She because she was in shock. CNA D stated she told RN E about it the following evening on the 11 PM to 7 AM shift. RN E did not respond. CNA D stated she did not know who else to tell at the moment and was concerned that someone would retaliate against her.</p> <p>Interview on 04/24/24 at 12:56 PM with the facility HR revealed CNA D left a Google text for her and she did not answer the text right away. She commented, It must have been a missed call. HR stated her response to CNA D was delayed and did not call CNA D on the same date she left the text.</p> <p>Attempted to call RN F on 04/25/24 at 5:30 PM. Left a voicemail asking he return the call but he did not return the call.</p> <p>Interview on 04/25/24 at 2:20 PM with the ADM, DON and ADON revealed RN E never reported the incident. The DON and ADON stated they met with RN F and he basically denied the incident and stated he did not know what incident they were talking about.</p> <p>Interview on 04/25/24 at 2:42 PM with CNA D revealed she reiterated what she reported in her statement dated, 3/8/24. In addition, she stated her perception of the incident was that RN F was getting onto Resident #25 for yelling out and insulted Resident #25 by telling him to quit crying like a baby. CNA D stated she believed RN F was disrespectful and was putting Resident #25 down. She stated she understood that she should report the incident to the ADM and her number was available at the nurse's desk. However, she was reluctant because RN F was her immediate supervisor and RN E was related to RN F.</p> <p>Telephone interview on 04/26/24 at 9:21 AM with RN E revealed she denied that any staff approached her about an allegation of verbal abuse involving RN F and Resident #25. She denied knowing about it and stated had she had not been told about it or it would have required she report the allegation to the ADM right away.</p> <p>Attempted to call RN F on 04/26/24 at 9:30 AM. Left a voicemail asking he return the call but he did not return the call.</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>Interview on 04/26/24 at 9:35 AM with the ADM revealed there were multiple failures in reporting the allegation of abuse: CNA D, RN E and HR did not report an allegation of abuse to her right away. She stated CNA D had worked at the facility for about [AGE] years and stated she was a reliable and a trustworthy staff member.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520</p> <p>Based on observation, interview and record review the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 1 of 8 Residents (Resident #25) who whose records were reviewed for hygiene.</p> <p>Nursing staff failed to ensure Resident #25 received a bed bath for five days, from 4/19/24 to 4/24/24.</p> <p>This deficient practice could affect any resident who required assistance with showers/bed baths and could result in poor hygiene.</p> <p>The findings were:</p> <p>Review of Resident #25's face sheet, undated, revealed his original admitted to the facility was 10/4/23 with diagnoses including secondary Parkinsonism (nervous system disorder due to reduced levels of dopamin) and Cognitive Communication Deficit.</p> <p>Review of Resident #25's quarterly MDS, dated [DATE], revealed his BIMS was severely impaired never/rarely made decisions and he was dependent for all activities of daily living including baths.</p> <p>Review of Resident #25's Care Plan, dated 4/18/24, revealed Resident #25 required maximum assistance with bathing by 1 staff.</p> <p>Review of Resident #25's monthly shower sheet for April 2024 revealed his last bed bath was provided on 4/19/24. A CNA initialed Resident #25 was provided a bed bath and LVN C did not sign to confirm Resident #25 had received a bed bath.</p> <p>Review of Resident #25's nurse's notes did not reveal documentation stating he refused a bed bath on 4/22/24 or on 4/24/24.</p> <p>Observation and interview on 04/24/24 02:55 PM revealed Resident #25 was lying in bed with the head of bed elevated to about 30 degrees. Attempted interview with Resident #25 revealed he was not understandable. Further observation revealed Resident #25's hair was tangled and matted on the top of his head.</p> <p>Interview on 04/24/24 at 2:58 PM with Resident #25's caregiver revealed staff provided Resident #25 with a bed bath on Monday, Wednesday and Friday's, during the morning. Caregiver A stated staff washed his hair. Caregiver A stated he worked Monday through Friday from 8:00 AM to 8:00 PM and Resident #25 did not get bathed this morning, 04/24/24.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/24/24 at 03:00 PM with CNA B revealed he did not shower Resident on Monday, 4/22/24 or on this date, 04/24/24. He stated he had worked all week from 7:00 AM to 3:00 PM. CNA B stated today was hectic and he had 2 Residents who had very large bowel movements and he spent a lot of time with them. He stated he did not have time to shower Resident #25. CNA B stated he should let the charge nurse know he did not get to shower Resident #25 on his scheduled shower days. CNA B stated they had started giving Resident #25 bed baths instead of showers. Upon review of Resident #25's shower schedule and log for April 2024, CNA B confirmed Resident #25 was scheduled for a bed bath on Monday, Wednesday and Fridays. CNA B stated Resident #25's last bed bath was provided on 4/19/24. CNA B stated he did not tell charge nurse, LVN C, about not bathing Resident #25 on 4/22/24 and on 4/24/24</p> <p>Interview on 04/24/24 at 03:05 PM with LVN C revealed she did not know Resident #25 had not received a bed bath on Monday, 4/22/24 or on this date, 4/24/24 according to his shower schedule. Upon review it was noted LVN C signed on most days Resident #25 received a bed bath. She did not sign off on 4/22/24 or on date 4/24/24. LVN C stated she would get second shift to bathe Resident #25.</p> <p>Interview on 04/25/24 at 09:45 AM with LVN C revealed CNAs were expected to try to talk the residents into a shower or bed bath at least a couple of times before they told her the resident had refused. She stated the CNA would initial when a resident was provided a shower/bed bath or write in refused on their scheduled day for a shower/bed bath. She stated Resident #25 would refuse bed baths at times, but the aides should document when he refused a bed bath and let her know. She stated last Friday, 4/19/24, Resident #25 received 1/2 bed bath because he became agitated. On Monday, 4/22/24, he refused a bed bath for her; after she found out Resident #25 refused a bed bath. LVN C stated yesterday was kind of a crazy morning but she had the 2nd shift CNA bathe Resident #25. She stated she was not good about documenting and didn't think she documented Resident #25 refused his bed bath on Monday, 4/22/24.</p> <p>Interview on 04/25/24 at 2:30 PM with the ADON revealed he provided multiple policies about activities of daily living. However, upon review the policies did not address staff providing care for residents who required assistance.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>27520</p> <p>Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 2 of 2 kitchens (Satellite Kitchen and Main Kitchen) reviewed for sanitation.</p> <ol style="list-style-type: none"> 1. The freezer in the satellite kitchen did not have a thermometer inside of it. 2. Multiple sheet pans were stacked on a shelf underneath the microwave while wet. 3. The DM and DA put their hands on the surface of the sheet pans to check if wet. DA dried the wet sheet pans with a cloth towel and stacked the sheet pans back on the shelf under the microwave. 4. Three Dietary Staff in the main kitchen and one DW in the satellite kitchen did not have a beard restraint on while in the kitchen. The Dietary Service Director (DSD) had a mask on and it did not cover his facial hair along the jaw line. 5. A pot of rue was left on the stove for about 15 minutes and it was not covered. 6. There were 3 round trash barrels and 2 rectangular trash cans in the main kitchen. They did not have a lid. <p>These deficient practices could affect all residents who received food from the kitchen and could contribute to foodborne illnesses and the spread of diseases.</p> <p>The findings were:</p> <p>Observation and interview on 04/23/24 at 9:21 AM during a brief tour of the satellite kitchen revealed there was not a thermostat inside the freezer. Interview with the DM revealed there was not a thermostat in the freezer but there should be one.</p> <p>Observation on 04/23/24 at 9:40 AM revealed the DM pulling out multiple sheet pans from the shelf underneath the microwave. There were multiple sheet pans that were wet; there was water dripping down the sheet pans as the DM turned them over. Further observation revealed the DM and DA touching the inside surface for multiple sheet pans with their bare hands; checking if they were wet. DA proceeded to get a cloth towel and dried the wet sheet pans with the cloth towel. The DM and DA did not wash their hands before or after handling the dish pans with their bare hands.</p> <p>Interview on 04/23/24 at 9:42 AM with the DM and DA G revealed the DM washed her hands before the Surveyor walked into the kitchen but did not wash her hands at any other point. DA G stated she washed her hands after handling the sheet pans and then put on a clean pair of gloves before drying the sheet pans. DA G further stated she would regularly towel dry the sheet pans when wet.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation and interview on 04/23/24 at 9:50 AM in the main kitchen revealed 4 round trash barrels and 2 rectangular trash cans without a lid. Interview with Chef H revealed all trash barrels should have a lid on them to avoid attracting insects and rodents.</p> <p>Observation and interview 04/23/24 at 9:55 AM revealed the DSD wearing a surgical mask. He had a full facial beard. The hair on the sides of his face around the jaw line were not covered. He stated he was wearing the beard restraint underneath the face mask earlier but took it off and then walked back into the kitchen.</p> <p>Observation and interview on 04/23/24 at 9:50 AM at 9:10 AM revealed a pot on the stove. It was not covered. Chef I stated it was rue which they used for thickening soups and it had been sitting out about 15 minutes. Chef I stated they would be using it for the lunch.</p> <p>Interview on 04/23/24 at 10 AM with the Dietician revealed all kitchen equipment in the main kitchen was shared with the satellite kitchen affecting all residents in the facility.</p> <p>Observation and interview on 04/23/24 at 10:15 AM revealed Cook J walked into the kitchen. He had a mustache and did not have a beard restraint on. Interview with Cook J revealed he didn't have a beard restraint on but stated he would put one on.</p> <p>Interview on 04/23/24 at 10:20 AM with the DSD stated Cook J should have a beard restraint on covering his mustache before walking into the kitchen to prevent from hair falling into the food.</p> <p>Interview on 04/23/24 at 10:30 AM with the Dietician revealed it was standard practice to ensure staff wore beard/facial restraints before walking into the kitchen to prevent hair falling into the food which would contaminate it.</p> <p>Observation and interview on 04/25/24 at 11:10 AM revealed the DW in the satellite kitchen had facial hair and had a beard restraint pulled under his chin. Interview with the DW revealed he had stepped out of the kitchen and forgot to put it back on. He stated he should have it on while in the kitchen.</p> <p>Interview with the DS K on 04/25/24 at 11:20 AM revealed she did not notice the DW did not have a beard restraint on. She stated she would reinforce the use of a hair restrain or beard restraint anytime she saw a staff member walk into the kitchen without one on. DS K stated she was focused on prepping for lunch.</p> <p>Interview on 04/24/24 at 1:10 PM with the DM revealed hair and beard restraints were used to ensure hair did not fall into the food. She stated it could contaminate the food and make the residents sick. She stated she talked to the dietary staff who said they had put a thermostat in the freezer. She stated there was not a thermostat in the freezer and there should have been one. The purpose was to make sure they had a second reading in the event the digital thermostat located outside the freezer was not working. The goal was to ensure the food was maintained at 41 degrees or under. The DM confirmed some of the sheet pans were wet and confirmed both she and the DA G touched the inside of some of the pans to feel if they were wet. She stated DA G dried the pans with a clean cloth towel but they typically air dried all dishes, pots and pans. The DM stated they had their linens laundered and they received them back in a sealed plastic bag. Each bag had multiple towels in it and staff pulled them from the bag as needed.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of a facility policy, Uniform Dress Code revised 1/24, read: Personal cleanliness and a neat appearance are essential for the food service worker. Associates Working with Food, Wear the approved hair restraint when on duty regardless of length or presence of hair. Restrain all facial hair with a beard net/restraint.</p> <p>Review of facility policy, Sanitation and Infection Prevention/Control, revised 1/23 read Pots, dishes, and flatware are stored in such a way as to prevent contamination by splash, dust, pests, or other means. Air dry all food contact surfaces including pots, dishes, flatware, and utensils before storage, or store in a self-draining position. Do not stack or store when wet. Wash hands before touching clean flatware.</p>		