STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675858	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Nursing & Rehabilitation	5437 Eisenhauer Rd San Antonio, TX 78218

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39075 Based on observation, interview, and record review, the facility failed to 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 infection for 2 of 2 residents (Resident #1 and #2) reviewed for infection control: 1. The facility failed to ensure CNA A wore a gown and gloves when feeding Resident #1 who had been identified as requiring contact isolation. 2. CNA D touched new and clean brief with his old and dirty gloves after cleaning Resident #2's bowel movement when CNA D provided incontinence care to Resident #2 on 02/13/2025. These failures could place residents at-risk for infection due to improper care practices. The findings included: 1. Record review of Resident #1's face sheet, dated 2/12/25, revealed a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included quadriplegia (a condition characterized by the partial or complete loss of movement and sensation in all four limbs and the torso), urinary tract infection, and hematuria (presence of blood in the urine). Record review of Resident #1's most current quarterly MDS assessment, dated 11/5/24, revealed the resident was cognitively intact for daily decision-making skills and was dependent on staff for eating. Record review of Resident #1's Order Summary Report dated 2/12/25 revealed the following: - CONTACT ISOLATION Q SHIFT DUE TO UTI/VANCOMYCIN RESISTANT every shift for UTI for 10 days, with order date 2/4/25 and stop date 2/14/25 Record review of Resident #1's comprehensive care plan, with revision date 2/11/25, revealed the resident was at risk for infection or recurrent/chronic infection related to compromised medical condition with interventions that included to provide education to team members, resident and/or visitors regarding infection prevention practices as indicated. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Nursing & Rehabilitation	5437 Eisenhauer Rd San Antonio, TX 78218

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 2/12/25 at 12:21 p.m. revealed CNA A in Resident #1's room feeding the resident at the bedside and not wearing a gown or gloves. CNA A was observed leaning on the right side of the resident's bed while spoon feeding the resident. Further observation revealed a fully stocked PPE cart outside of Resident #1's room and signage posted on the bedroom door indicating, STOP, CONTACT PRECAUTIONS, EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Do no wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. During an observation and interview on 2/12/25 at 12:22 p.m., Medication Aide B stated Resident #1 was on contact isolation related to an infection and observed CNA A in Resident #1's room feeding the resident without wearing a gown and gloves. Medication Aide B stated CNA A was an Agency CNA. Medication Aide B stated, CNA A should have been wearing a gown and gloves when feeding Resident #1 because there would be a risk of spreading infection. Medication Aide B stated, CNA A could spread infection from one resident to another. During an observation and interview on 2/12/25 at 12:28 p.m., LVN C stated Resident #1 was on contact isolation related to a urinary tract infection. LVN C stated, anyone entering the resident's room should be wearing PPE that included a gown and gloves. LVN C observed CNA A in Resident #1's room feeding the resident without wearing a gown and gloves. LVN C stated, that is a break in infection control and could result in staff passing an infection to others. LVN C stated CNA A was an Agency CNA. During an interview on 2/12/25 at 12:32 p.m., CNA A stated she had not worked for the facility before and was on the floor for the first time. CNA A revealed she was given a meal tray to feed Resident #1 and believed the tray was given to her late and wanted to give Resident #1 her meal as soon as possible so as not to make the resident upset. CNA A stated she was distracted because of that and did not notice the signs on the resident's door or the PPE cart outside the room. CNA A stated she should have been wearing the gown and gloves when feeding Resident #1 who was on contact isolation because it could possibly lead to spread of infection. CNA A further stated the use of PPE was to protect her and the resident. During an interview on 2/12/25 at 6:10 p.m., the DON stated, CNA A had been in-serviced on the facility infection control policy prior to working on the floor. The DON revealed CNA A, although an Agency CNA should have been wearing the proper PPE when feeding Resident #1 who was on contact isolation. The DON stated, not wearing proper PPE could lead to spread of infection. Record review of CNA A's Licensing Credentials document revealed CNA A had passed the requirements for Enhanced Barrier Protection Assessment valid through 7/6/2025. 2. Record review of Resident #2's face sheet, dated 02/14/2025, revealed the resident was a [AGE] year old male, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with the diagnoses of paraplegia (inability to voluntarily move the lower part of the body), muscle wasting and atrophy (decrease in size and wasting of muscle tissue), neurogenic bowel (loss of normal bowel function), neuromuscular dysfunction of bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain do not work the way they should), and cervicalgia (neck pain). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Heritage Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5437 Eisenhauer Rd San Antonio, TX 78218	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's most current annual MDS, dated [DATE], revealed the resident's BIMS score was 15 which indicated the resident's cognitively was intact. In Section GG (Functional abilities), Resident #2 was dependent (Helper does all of the effort) for toilet transfer and sit-to-stand, and the resident had frequently bowel incontinent and had indwelling urinary catheter for bladder. Record review of Resident #2's comprehensive care plan, revision date 02/01/2025, revealed the resident required indwelling urinary catheter care and bowel incontinence care every shift and as indicated. Observation on 02/13/2025 at 1:57 p.m. revealed CNA-D cleaned Resident #2's bottom area because the resident had bowel movement. CNA-D cleaned all bowel movement completely, and then touched new and clean brief with old and dirty gloves without changing gloves and without sanitizing his hands. CNA-D put the new and clean brief under the resident's bottom area and closed the new and clean brief with old and dirty gloves without changing gloves and without sanitizing his hnads. During an interview on 02/13/2025 at 2:10 p.m. with CNA-D stated he touched new and clean brief with his old and dirty gloves after cleaning Resident #2's bowel movement. CNA-D said he should have changed his old and dirty gloves and should have sanitized his hands before touching a new and clean brief to prevent possible infection. He said he was nervous so forgot to change gloves and received in-services related to infection control sometimes. Record review of the facility policy and procedure titled, Infection Control, dated February 2017 revealed in part, .The community establishes and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection .Preventing spread of infection .Procedures are followed to prevent cross-contamination, including handwashing or changing gloves after providing personal care or when performing tasks among individuals who provide the opportunity for cross-contamination to occur .