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	03/19/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interviews and record review, the facility failed to ensure a resident's responsible party was informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose alternative options is he or she preferred for 1 (Resident #3) of 6 residents reviewed for the right to be informed and make treatment decisions. The facility failed to notify Resident #3's responsible party on 09/20/2024, prior to Resident #3 being referred to a Wound Care Physician for an evaluation and received a wound debridement. This failure could affect residents and/or responsible parties by placing them at risk of not receiving treatments or being informed of treatment options. Findings included: Record review of Resident #3's undated face sheet revealed Resident #3 was an [AGE] year old female who admitted to the facility for hospice respite services on 09/18/2024 and discharged from the facility on 09/25/2024 with diagnoses that included Cerebral Atherosclerosis (a buildup of plaque in the blood vessels of the brain), Dementia (a general term for impaired ability to remember, think, or make decisions) and Depression (a persistent feeling of sadness and loss of interest). Record review of Resident #3's admission MDS assessment, dated 09/24/2024, revealed Resident #3 had a BIMS score of 4, indicating severe cognitive impairment. Section M - Skin Conditions revealed Resident #3 had an unstageable wound, described as a wound that cannot be staged due to the wound bed being covered in slough (dead tissue that can impede the healing process) and/or eschar (thick black tissue that can impede the healing process). Record review of Resident #3's care plan, date initiated 09/19/2024, revealed Resident #3 had a skin impairment to the right gluteus (buttocks). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a document titled, Specialty Physician Initial Wound Evaluation and Management Summary revealed Resident #3 as the patient and was dated 09/20/2024. The document stated, Chief Complaint: Patient present with a wound on her coccyx. At the request of the referring provider, [facility physician name], a thorough wound care assessment and evaluation was performed today. She has condition listed above. Details about current wound and any skin conditions are outlined below. There is no indication of pain associated with this condition. The document listed the wound as unstageable (due to necrosis) coccyx full thickness. The wound size was 2.4 x 1.5 x 0.3cm and necrotic tissue was 100%. The document stated a surgical excisional debridement was performed to remove necrotic tissue and establish the margins of viable tissue and stated, treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 09/20/2024 to the patient who indicated agreement to proceed with the procedure. The document stated under the heading, Coordination of Care, that the data and history pertinent to Resident #3's care was obtained by nursing facility records, Resident #3 and nursing staff. During an interview with Resident #3's responsible party, 03/17/2025 at 5:50 p.m., the responsible party stated Resident #3 had a cauterization of a bed sore by a physician and the facility did not notify her or [Hospice Company name]. The responsible party stated she was notified a few days after the procedure and she was unsure when, or if hospice was ever notified. The responsible party stated Resident #3 had Dementia and could not consent to a procedure and the Responsible Party stated she should have been notified in order to consent to the procedure. During an interview with the facility Physician, 03/18/2025 at 2:28 p.m., the Physician stated hospice and Resident #3's responsible party should have been notified of the evaluation and provided consent for the debridement procedure. The Physician stated the purpose of a debridement was to clean up a wound and improve the wound bed. During an interview with the Wound Care Physician, 03/19/2025 at 12:41 p.m., The Wound Care Physician stated she was made aware of new referrals by the facility wound care nurse or the DON and the referrals were generated by the resident's primary care physician at the facility. The Wound Care Physician stated she would consult with hospice residents on a case-by-case basis and the facility was responsible for consulting with Hospice and the responsible parties to obtain consent for the referral or debridement. The Wound Care Physician stated she still would have performed the debridement to remove the necrosis if Hospice and the family was consulted and agreed with the procedure and stated they should have been involved in the decision. During an interview with the DON, 03/19/2025 at 1:18 p.m., the DON stated she did not know who referred Resident #3 to the Wound Care Physician and stated she thought the previous Wound LVN, who has not worked at the facility since January 2025, completed the referral. The DON stated the Wound LVN was responsible for and should have contacted Hospice to get approval to make a referral to the Wound Care Physician and should have notified the responsible party of the referral and debridement. The DON stated it was important for Hospice and the responsible party to be notified of the referral and debridement because the patient could receive something the family or hospice would not approve of. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled, End of Life Care and Coordination-Hospice/Palliative Care, dated implemented 03/13/19 and date revised January 2023, revealed Compliance Guidelines: To provide supportive care for residents and their families during the end stages of life by enabling them to participate in interactions of their choice in a supportive environment with the assistance of compassionate caregivers and interdisciplinary teams. The Process listed 1. Physician orders should be obtained to clarify specific treatments, procedures and activity. 2. The resident and family should participate in developing the plan of care, where appropriate. 3.b. All treatments and interventions should be representative of current standards of care and the individual resident's and/or family's decision.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team determined an individual may self-administer drugs in a safe practice for 1 of 6 residents (Resident #1) reviewed for administration of medications. The facility failed to ensure Resident #1 has a specific written order to self-administer her own medications on 03/18/2025 as per the facility policy for a nasal spray and eye drops. This failure could affect residents who self-administer medications by placing them at risk of not receiving their physician ordered medication treatment to meet their individual needs. Findings included: During an observation, 03/18/2025 at 9:39 a.m., Resident #1 was observed with Refresh Tears eye drops and Fluticasone Propionate (nasal spray) on Resident #1's bed side table. The Fluticasone Propionate had a pharmacy label and was prescribed to Resident #1. Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of Acute or Chronic Respiratory Failure (occurs when the lungs cannot get enough oxygen into the blood), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities once enjoyed) and Paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease). Record review of Resident #1 quarterly MDS assessment, dated 02/13/2025, revealed a BIMS score of 15, indicating no cognitive impairment. Record review of Resident #1's comprehensive care plan revealed a care plan, date initiated 10/24/2024, that revealed Resident #1 had impaired cognitive function or impaired thought process. Record review of Resident #1's March 2025 MAR revealed and order for Flonase allergy relief nasal suspension 50mcg in each nostril one time a day for congestion. Resident #1's MAR did not reveal an order for Refresh Tears eye drops. Record review of Resident #1's Self Administration of Medications Assessment, dated 01/12/2023, revealed Resident #1's ability to self-administer eye drops or inhalant medications was coded No. Record review of Resident #1's Self Administration of Medications Assessment, dated 12/26/2023, revealed Resident #1's ability to self-administer eye drops or inhalant medications was coded not applicable. During an interview, 03/18/2025 at 9:39 a.m., Resident #1 stated she used the eye drops approximately 4 times a day for dry eyes and stated she keeps the eye drops at bedside so I don't have to ask for them all day. Resident #1 stated she self-administered the nasal spray once a day and Resident #1 stated she had received education on administering the medication safely from facility staff. Resident #1 stated she received the medications from the facility. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MA A, 03/18/2025 at 12:11 p.m., MA A stated he was responsible for passing medications to Resident #1 and MA A stated he was not aware of any residents who were allowed to self-administer their own medications and was unaware of what the facility policy was regarding self-administration of medications. MA A stated all medications including over the counter medications had to have an order to administer. MA A stated he had not observed medications in any resident rooms. During an interview with the facility DON, 03/19/2025 at 1:18 p.m., the DON stated residents who self-administer medications must be assessed to determine if the resident is safe and must have an order to self-administer and a way to secure the medications. The DON stated she was notified of Resident #1 having eye drops and nasal spray at the bed side on 03/18/2025 and the DON assessed Resident #1 for safe administration of the eye drops and nasal spray. The DON stated resident #1 did not have an order for the eye drops and an order was added to Resident #1's MAR that included the resident could self-administer the medication. The DON stated the nasal spray was ordered and self-administration was added to the order. The DON stated Resident #1 was also provided a container to store the medications safely in her room. The DON stated a resident who self-administers medications without facility knowledge or without an order could become overmedicated if they resident was not aware of how to administer the medication safely. Record review of a facility policy titled, Medication Administration, date implemented March 2019 and date revised January 2024, stated, 7. Avoid leaving medications with the resident to self-administer unless the resident is approved for self-administration of the medication. Record review of a facility policy titled, Medication-Self Administration, date implemented 03/15/2019 and date revised January 2023, stated, Compliance Guidelines: each resident has the right to self-administer medications, if able. The interdisciplinary team evaluates each resident who expressed wishes to self-administer medications to determine if the resident is safe to do so, and if so, provides the education and monitoring necessary to provide safe administration. The policy also stated, 5. The nurse should obtain an order for self-administering medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interview and record review, the facility failed to ensure the accurate administration of medications for 1 (Resident #1) of 6 residents reviewed for medication administration. MA A failed to administer Resident #1's medications and failed to observe Resident #1 take her medications on 03/18/2025. This failure could affect residents who receive medications from MAA by placing them at risk for medication errors and receiving less than therapeutic benefits from medications. Findings included: During an observation, 03/18/2025 at 9:39 a.m., Resident #1 was observed with a medication cup on her bedside table that contained 7 medications. The medications were Midodrine 10mg (prescribed for hypertension- the level of pressure of blood pushing against the heart arteries), Multivitamin (prescribed as a supplement), Tylenol 325mg (prescribed for general pain), Ferrous Sulfate 325mg (prescribed for anemia-reduced red blood cells), Docusate Sodium 100mg (prescribed for constipation), Vitamin C 500 mg (prescribed for immune system support), Lactobacillus (prescribed for antibiotic use). Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of Acute or Chronic Respiratory Failure (occurs when the lungs cannot get enough oxygen into the blood), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities once enjoyed) and Paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease). Record review of Resident #1 quarterly MDS assessment, dated 02/13/2025, revealed a BIMS score of 15, indicating no cognitive impairment. Record review of Resident #1's comprehensive care plan revealed a care plan, date initiated 10/24/2024, that revealed Resident #1 had impaired cognitive function or impaired thought process. During an interview, 03/18/2025 at 9:39 a.m., Resident #1 stated the medications were given to her early in the morning by a medication aide and stated she thought the medications in the cup were a vitamin c, multi-vitamin, iron and something for stomach bacteria. Resident #1 was observed taking the medications in the cup during the interview. During an interview with MA A, 03/18/2025 at 12:11 p.m., MA A stated he was responsible for medication administration for Resident #1 and MA A stated he administered the medications to Resident #1 that morning. MA A stated he witnessed Resident #1 take the medications around 7 a.m. MA A stated he had found medicine cups at bedside for Resident #1 in the past and stated the medications were not from his medication pass. MA A stated he had received training on staying with a resident while they take their medications and he had to visually observe the resident take the medications and MA A stated it was important to observe a resident take the medications because, we want to make sure they are compliant with taking medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #1, 03/18/2025 at 1:30 p.m., Resident #1 stated it was a male medication aide who administered her medications in the morning. Resident #1 stated the medication aide gave her Gabapentin (for pain) and Sertraline (for depression) and then she placed the medication cup on the overbed table while other staff members performed a mechanical liftransfer. Resident #1 stated the medication aide left the room before she finished taking her medications. During an interview with the facility DON, 03/19/2025 at 1:18 p.m., the DON stated the facility's policy for medication administration was a staff member administering medications must always observe a resident take all of the medications before leaving the room and no medications could be left at bedside. The DON stated if medications were left at bedside and the resident was not observed taking the medications, the resident could miss medications and not get the medications they need. Record review of a facility policy titled, Medication Administration, date implemented March 2019 and date revised January 2024, stated, 7. Avoid leaving medications with the resident to self-administer unless the resident is approved for self-administration of the medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interview and record review, the facility failed to ensure coordination of care with the Hospice agency, specific to each patient, for 1 Resident (R#3) of 6 residents reviewed for hospice services. Resident #3 was evaluated by a Wound Care Physician on 09/20/2024 and had a surgical wound debridement without hospice being notified of the evaluation and treatment. This failure could affect residents who received Hospice services by placing them at risk for services and treatments not being coordinated. Findings included: Record review of Resident #3's undated face sheet revealed Resident #3 was an [AGE] year old female who admitted to the facility for hospice respite services on 09/18/2024 and discharged from the facility on 09/25/2024 with diagnoses that included Cerebral Atherosclerosis (a buildup of plaque in the blood vessels of the brain), Dementia (a general term for impaired ability to remember, think, or make decisions) and Depression (a persistent feeling of sadness and loss of interest). Record review of Resident #3's admission MDS assessment, dated 09/24/2024, revealed Resident #3 had a BIMS score of 4, indicating severe cognitive impairment. Section M - Skin Conditions revealed Resident #3 had an unstageable wound, described as a wound that cannot be staged due to the wound bed being covered in slough (dead tissue that can impede the healing process) and/or eschar (thick black tissue that can impede the healing process). Record review of Resident #3's care plan, date initiated 09/19/2024, revealed Resident #3 had a skin impairment to the right gluteus (buttocks). Record review of a Hospice company document titled, Interdisciplinary Plan of Care/Revision/Physician Orders, with Resident #3 name listed as the patient, the document stated, 5. All therapies and orders must have prior authorization from [Hospice company name] before patient is treated or transported and 8. No in house physician consults without pre-approval from [Hospice Company Name]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a document titled, Specialty Physician Initial Wound Evaluation and Management Summary revealed Resident #3 as the patient and was dated 09/20/2024. The document stated, Chief Complaint: Patient present with a wound on her coccyx. At the request of the referring provider, [facility physician name], a thorough wound care assessment and evaluation was performed today. She has condition listed above. Details about current wound and any skin conditions are outlined below. There is no indication of pain associated with this condition. The document listed the wound as unstageable (due to necrosis) coccyx full thickness. The wound size was 2.4 x 1.5 x 0.3cm and necrotic tissue was 100%. The document stated a surgical excisional debridement was performed to remove necrotic tissue and establish the margins of viable tissue and stated, treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 09/20/2024 to the patient who indicated agreement to proceed with the procedure. The document stated under the heading, Coordination of Care, that the data and history pertinent to Resident #3's care was obtained by nursing facility records, Resident #3 and nursing staff. During an interview with Resident #3's responsible party, 03/17/2025 at 5:50 p.m., the responsible party stated Resident #3 had a cauterization of a bed sore by a physician and the facility did not notify her or [Hospice Company name]. The responsible party stated she was notified a few days after the procedure and she was unsure when or if hospice was ever notified. The responsible party stated Resident #3 had Dementia and could not consent to a procedure and the Responsible party stated she should have been notified in order to consent to the procedure. During an interview with the Director of [Hospice Name], 03/18/2025 at 11:40 a.m., the Hospice Director stated, in an effort to coordinate care, the facility should have contacted Hospice for permission to have a wound care physician evaluate Resident #3 and perform any type of procedure. The Hospice Director stated there would have been a conflict for billing services due to hospice providing and billing for wound care. During an interview with the facility Physician, 03/18/2025 at 2:28 p.m., the physician stated he did not recall referring Resident #3 to the Wound Care Physician and stated the hospice team would be the referring entity since Resident #3 was a hospice respite patient. The facility Physician stated he would defer to hospice in regard to treating a wound for a respite patient who was only planning to be in the facility for a few days. The Physician stated hospice and Resident #3's responsible party should have been notified of the evaluation and provided consent for the procedure. The Physician stated the purpose of a debridement was to clean up a wound and improve the wound bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Wound Care Physician, 03/19/2025 at 12:41 p.m., The Wound Care Physician stated she was made aware of new referrals by the facility wound care nurse or the DON and the referrals were generated by the resident's primary care physician at the facility. The Wound Care Physician stated she was also added to a resident's profile in the EMR system and when she entered a facility, The Wound Care Physician would request a list of patients from the EMR system that were on her case load. The Wound Care Physician stated she would consult with hospice residents on a case-by-case basis and the facility was responsible for consulting with Hospice and the responsible parties to obtain consent for the referral or debridement. The Wound Care Physician stated she did not recall how she was informed of the referral for Resident #3 and stated, after reviewing her notes, she did not see any documentation in her record that indicated Resident #3 was on Hospice at the time of her services. The Wound Care Physician said, that would be a red flag for me, that I would need more information before proceeding if she was a hospice respite. The Wound Care Physician stated she still would have performed the debridement to remove the necrosis if Hospice and the family was consulted and agreed with the procedure and stated they should have been involved in the decision. During an interview with the DON, 03/19/2025 at 1:18 p.m., the DON stated she did not know who referred Resident #3 to the Wound Care Physician and stated she thought the previous Wound LVN, who has not worked at the facility since January 2025, completed the referral. The DON stated the Wound LVN was responsible for and should have contacted Hospice to get approval to make a referral to the Wound Care Physician and should have notified the responsible party of the referral and debridement. The DON stated it was important for Hospice and the responsible party to be notified of the referral and debridement because the patient could receive something the family or hospice would not approve of. Record review of a facility policy titled, End of Life Care and Coordination-Hospice/Palliative Care, dated implemented 03/13/19 and date revised January 2023, revealed Compliance Guidelines: To provide supportive care for residents and their families during the end stages of life by enabling them to participate in interactions of their choice in a supportive environment with the assistance of compassionate caregivers and interdisciplinary teams. The Process listed 1. Physician orders should be obtained to clarify specific treatments, procedures and activity. 2. The resident and family should participate in developing the plan of care, where appropriate. 3.b. All treatments and interventions should be representative of current standards of care and the individual resident's and/or family's decision.