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	04/08/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with profession standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 4 residents (Resident #1) reviewed for pressure ulcers. 1. The facility failed to provide wound care treatments/dressing change to Resident #1' left ischium according to professional standards; in that LVN E did not clean the wound prior to applying clean dressing and did not secure the clean dressing once applied on 4/3/25. 2. The facility failed to provide wound care treatments/dressing change to Resident #1's right glute according to physician order on 4/3/25; in that LVN E applied a wet-to-dry dressing to Resident #1's glute when the order stated to apply hydrofera blue dressing. These deficient practices could place residents at risk for worsening wounds and/or infections. Findings included: 1. Record review of Resident #1's Admission Record revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Quadriplegia (paralysis from the neck down, affecting all four limbs), Morbid Obesity (disorder that involves having too much body fat), Type 2 diabetes (chronic condition that affects the way the body processes blood sugar), Neurogenic Bowel (lack bowel control due to a brain, spinal cord or nerve problem). Record review of Resident #1's quarterly MDS assessment, dated 1/31/25, revealed Resident #1 had a BIMS score of 15, suggesting intact cognition. Further review of the assessment revealed Resident #1 was always incontinent of bowel; had Quadriplegia; a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device; one or more unhealed pressure ulcers/injuries; one Stage 2 (Partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red or pink wound bed, may also present as an intact or open/ruptured blister) present upon admission/entry or reentry; surgical wound(s); required pressure ulcer/injury, surgical wound care, and applications of ointments/medications. Record review of Resident #1's Care Plan, revised 3/25/25, revealed Resident #1 had fragile skin, was at risk for skin injury, and had actual wounds to the left ischium, right glute, and right heel. Interventions included: treatments as ordered and keep clean and dry. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's physician order, dated 4/3/25, revealed: Wound care: left ischium: if wound vac dislodges or malfunctions, may apply wet to dry dressing w/NS. Record review of Resident #1's WCS's Wound Evaluation and Management Summaries, dated 1/8/25, 1/13/25, 1/29/25, 2/5/25, 2/12/25, 2/24/25, 2/26/25, 3/3/25, 3/5/25, 3/10/25, 3/12/25, 3/26/25, 3/31/25, and 4/2/25, revealed: .Cleanse with wound cleanser at time of dressing change . 2. Record review of Resident #1's Order Summary, dated 4/2/25, revealed: .Wound care: right buttock: cleanse with wound cleanser, pat dry, apply hydrofera blue [antibacterial foam wound dressings to create a moist, non-toxic healing environment] and cover with foam dressing as needed . Observation and interview on 4/3/25 beginning at 4:41 pm revealed LVN E performed a wet-to-dry dressing to Resident #1's wounds to the right glute and the left ischium. Further observation revealed LVN E cleaned the peri wound areas of the left ischium and right glute but did not clean the inside the wounds. LVN E packed gauze saturated with NS into the wounds and applied gauze saturated with NS to the peri-wound area of the right glute and the skin surrounding the peri-wound area, which was intact. LVN E applied abdominal pads over the wet gauze to the right glute and the left ischium wounds but did not secure the dressings. LVN E said the DNS told her to do a wet-to-dry because wound vac on both wounds became contaminated with feces. LVN E said she checked the order for Resident #1's wound care to the right glute in PCC and it said to use NS. LVN E further stated the order she received on 4/3/25 for the wet-to-dry dressing did not specify which side the treatment was for. LVN E said the order said to clean the wounds and said she cleaned the wounds using the perineal wipes. LVN E the orders should always be followed. LVN E further stated she was expected to clean the inside of the wounds unless otherwise indicated. LVN E said wounds should be cleaned prior to applying the wet gauze because bacteria could be introduced to the wounds. LVN E said the wet gauze was to be applied on the inside of the wound only and not on the peri-wound area because it would keep the skin moist. LVN E further stated wet gauze on intact can cause maceration. LVN E said she did not secure the dressing because feces could get under the tape and the order did not specify to apply tape. LVN E said not securing the dressing provided better protection from feces because it would not get under the tape. LVN E said she was expected to sanitize or wash her hands after she changed her gloves three times, adding this was recommended by the CDC. LVN E said she did not know what the facility policy was. LVN E further stated she was sure the facility policy was to wash hands after patient care was completed and when her hands were dirty but not every time she changed her gloves. During an interview on 4/7/25 at 3:49 pm, the Treatment Nurse said nurses would be expected to clean wounds prior to applying clean dressings and securing the dressings even if the order does not specify this. The Treatment Nurse further stated the order for received on 4/3/25 for Resident #1's wet-to-dry dressing was for the left ischium only and the nurse should have followed the order for the wound to the right glute. The Treatment Nurse said when performing a wet-to-dry dressing, the wet gauze was to be packed inside the wound only, not the intact peri-wound area because this puts the resident at risk for macerated skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/7/25 at 4:46 pm, the ADNS said she expected the nurses to clean wounds prior to applying clean dressing even if the order does not specify this because it was proper procedure. The ADNS further stated it was the facility's expectation for nurses to review orders prior to any treatment. The ADNS said when applying a wet-to-dry dressing the wet gauze was to be applied to the wound itself. The ADNS further stated the wet gauze should not be applied to the intact peri-wound area because it can macerate the skin. During an interview on 4/8/25 at 9:38 am, the DNS said the order received on 4/3/25 for Resident #1's wound care to the left ischium was a standard order. The DNS further stated she expected a prudent nurse to clean the wounds to get any bacteria or dirty material out of the wound prior to applying a clean dressing. The DNS said she expected a prudent nurse to secure the dressing unless the peri-wound area is not intact to make sure the wound remains covered. The DNS further stated this was important in the coccyx area due to the proximity to the anus and bowel movements. The DNS said it would not be acceptable to her for a nurse to say that this was not in the order because we have basic nursing skills which included cleansing the wound and securing dressings when appropriate. The DNS said she expected nurses to review orders prior to providing any treatment. Attempted interviews with the PCP on 4/4/25 at 1:57 pm and 4/7/25 at 2:45 pm were unsuccessful, there was no return call. Attempted interviews with the WCS on 4/4/25 at 1:59 pm and 4/7/25 at 3:05 pm were unsuccessful, there was no return call. During a telephone interview on 4/7/25 at 2:50 pm, the NP said she did not remember the wet-to-dry dressing order on 4/3/25 for Resident #1. The NP further stated this was a standard order and expected a prudent nurse to clean the wounds prior to applying clean dressings secure the dressings. The NP said any type of dressing needed to be secured to keep it clean, dry, intact and keep the wound from becoming contaminated, especially for a wet-to-dry dressing. the NP said when performing a wet-to-dry dressing, the wet gauze was to be applied to the inside the wound only to keep the moisture inside the wound. The NP further stated applying wet gauze to intact skin can cause breakdown the skin or cause irritation if its directly on good skin. Record review of the facility's policy titled Wound: Clean Dressing Change, revised January 2023, revealed: . EQUIPMENT & SUPPLIES: .Gauze to clean wound .Tape .12. Clean wound as indicated and apply treatment as ordered .15. Apply dressing and secure as ordered .DOCUMENTATION: 1. Document treatment in the Treatment Administration Record (TAR) . Record review of the facility's blank Clean Dressing Change competency list, revealed: .1. Check Physician's order 2. Gather Equipment: dressings, prescribed ointments/medications .cleaning solution .11. Cleanse wound with prescribe [sic] solution, working from the inside out .15. Apply prescribed dressing .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on interview and record review the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for accuracy of records. The facility failed to ensure Resident #1's treatments were documented per facility policy on (2) occasions on 4/3/25. These deficient practices could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #1's Admission Record revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Quadriplegia (paralysis from the neck down, affecting all four limbs), Morbid Obesity (disorder that involves having too much body fat), Type 2 diabetes (chronic condition that affects the way the body processes blood sugar), Neurogenic Bowel (lack bowel control due to a brain, spinal cord or nerve problem). Record review of Resident #1's quarterly MDS assessment, dated 1/31/25, revealed Resident #1 had a BIMS score of 15, suggesting intact cognition. Further review of the assessment revealed Resident #1 was always incontinent of bowel; had Quadriplegia; a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device; one or more unhealed pressure ulcers/injuries; one Stage 2 (Partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red or pink wound bed, may also present as an intact or open/ruptured blister) present upon admission/entry or reentry; surgical wound(s); required pressure ulcer/injury, surgical wound care, and applications of ointments/medications. Record review of Resident #1's Care Plan, revised 3/25/25, revealed Resident #1 had fragile skin, was at risk for skin injury, and had actual wounds to the left ischium, right glute, and right heel. Interventions included: treatments as ordered and keep clean and dry. Record review of Resident #1's Order Summary, dated 4/2/25, revealed: .Wound care: right buttock: cleanse with wound cleanser, pat dry, apply hydrofera blue [antibacterial foam wound dressings to create a moist, non-toxic healing environment] and cover with foam dressing as needed . Record review of Resident #1's physician order, dated 4/3/25, revealed: Wound care: left ischium: if wound vac dislodges or malfunctions, may apply wet to dry dressing w/NS. Record review of Resident #1's April TAR 2025, dated 4/7/25, revealed a blank for 4/3/25 for the order: Wound care: right buttock: cleanse with wound cleanser, pat dry, apply hydrofera blue (antibacterial foam wound dressings to create a moist, non-toxic healing environment) and cover with foam dressing as needed, dated 3/25/25. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's April LNAR 2025, dated 4/7/25, revealed a blank for 4/3/25 for the order: Wound care: left ischium: If wound vac dislodges or malfunctions, may apply wet to dry dressing w/NS, dated 4/3/25. Record review of Resident #1's Progress Notes, dated 4/3/25, revealed there was no documentation of wound care for Resident #1's right glute and left ischium. Observation on 4/3/25 beginning at 4:41 pm revealed LVN E performed wet-to-dry dressing to Resident #1's wounds to the right glute and the left ischium. During an interview on 4/4/25 at 12:50 pm, LVN E said she was expected to document treatments in the TAR or LNAR in PCC. LVN E verified the blank and said that the administration records for Resident #1 must not be the right one because she documented the treatments provided Resident #1's right glute and left ischium on 4/3/25. During an interview on 4/4/25 at 3:22 pm, the Treatment Nurse said nurses were expected to document any treatments provided to the residents in her absence. During an interview on 4/7/25 at 4:46 pm, the ADNS said nurses were expected to document treatments on the administration record in PCC once the treatment was completed. The ADNS further stated if a treatment was not documented it was not consider done. During an interview on 4/8/25 at 9:38 am, the DNS said when a nurse completed a treatment, the nurse was expected to document that treatment on the administration record once the treatment was completed. During an interview on 4/8/25 at 10:42 am, the Administrator said documentation was expected to be completed as soon as possible after a treatment was completed. Record review of the facility's policy titled Wound: Clean Dressing Change, revised January 2023, revealed: . Document treatment in the Treatment Administration Record (TAR) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 1 of 4 residents (Resident #1) reviewed for infection control. The facility failed to ensure LVN E followed infection control practices during wound care for Resident #1 on (3) occasions on 4/3/25. This deficient practice may affect residents who require wound care treatments and could place residents at risk for cross contamination and infections. Findings included: Record review of Resident #1's Admission Record revealed the resident was readmitted to the facility on [DATE] with diagnoses which included: Quadriplegia (paralysis from the neck down, affecting all four limbs), Morbid Obesity (disorder that involves having too much body fat), Type 2 diabetes (chronic condition that affects the way the body processes blood sugar), Neurogenic Bowel (lack bowel control due to a brain, spinal cord or nerve problem). Record review of Resident #1's quarterly MDS assessment, dated 1/31/25, revealed Resident #1 had a BIMS score of 15, suggesting intact cognition. Further review of the assessment revealed Resident #1 was always incontinent of bowel; had Quadriplegia; a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device; one or more unhealed pressure ulcers/injuries; one Stage 2 (Partial thickness loss of dermis (skin) presenting as a shallow open ulcer with a red or pink wound bed, may also present as an intact or open/ruptured blister) present upon admission/entry or reentry; surgical wound(s); required pressure ulcer/injury, surgical wound care, and applications of ointments/medications. Record review of Resident #1's Care Plan, revised 3/25/25, revealed Resident #1 had fragile skin, was at risk for skin injury, and had actual wounds to the left ischium, right glute, and right heel. Interventions included: treatments as ordered and keep clean and dry. Record review of Resident #1's Order Summary, dated 4/2/25, revealed: .Wound care: right buttock: cleanse with wound cleanser, pat dry, apply hydrofera blue [antibacterial foam wound dressings to create a moist, non-toxic healing environment] and cover with foam dressing as needed . Record review of Resident #1's physician order, dated 4/3/25, revealed: Wound care: left ischium: if wound vac dislodges or malfunctions, may apply wet to dry dressing w/NS . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 4/3/25 beginning at 4:41 pm revealed LVN E performed a wet-to-dry dressing to Resident #1's wounds to the right glute and the left ischium. Further observation revealed LVN E removed the contaminated dressings to Resident's #1's right glute and left ischium, removed her gloves and donned clean gloves without performing hand hygiene. LVN E cleansed the peri wound areas of the left ischium and right glute, removed her gloves and donned clean gloves without performing hand hygiene. Further observation revealed LVN E packed gauze saturated with NS into the wounds, applied dressings, removed her gloves, and donned clean gloves without performing hand hygiene. LVN E said she had sanitizer attached to her ID and was expected to sanitize or wash her hands after she changed her gloves three times, adding this was recommended by the CDC. LVN E said she did not know what the facility policy was. LVN E further stated she was sure the facility policy was to wash hands after patient care was completed and when her hands were dirty but not every time she changed her gloves. During an interview on 4/4/25 at 3:22 pm, the Treatment Nurse said nurses were expected to follow the facility's wound care protocols, which included sanitizing hands between glove changes. During an interview on 4/7/25 at 4:46 pm, the ADNS said she expected nurses to perform hand hygiene the proper way, including wetting hands, using soap, vigorously washing for 20-30 seconds, before, during and after care. The ADON hand sanitizer may be used but she preferred staff washed their hands before and after care. The ADON said she expected staff to wash or sanitize hands between glove changes. The ADNS said all staff were responsible for performing proper hand hygiene to prevent the spread of infection/germs. During an interview on 4/8/25 at 9:38 am, the DNS said she expected staff to follow the facility's hand hygiene policy which said hand hygiene should be performed between glove changes, unless your hands were visibly soiled. The DNS further stated residents may be at risk for the spread of infection from improper hand hygiene. During an interview on 4/8/25 at 10:42 am, the Administrator said hand hygiene should be performed when changing gloves and when hands were visibly soiled hands should be washed for at least 20 seconds; otherwise, the staff could use sanitizer. The Administrator further stated this was the facility's policy to prevent the spread of infection from possible dirty hands. Record review of the facility's policy titled Wound: Clean Dressing Change, revised January 2023, revealed: . Follow standard precautions at all times .10. Remove soiled dressing, place in bag for disposal. 11. Remove/dispose of gloves, wash hands, put on clean gloves. 12. Clean wound .14. Remove/dispose gloves, wash hands, put on clean gloves . Record review of the facility's policy titled Handwashing/Hand Hygiene, revised January 2023, revealed: .The facility considers hand hygiene the primary means to prevent the spread of infections .2. All personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors .7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap .and water for situations such as this (including but not limited to) .Between glove changes/After removing gloves .The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .