

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 11/27/2025
NAME OF PROVIDER OR SUPPLIER Heritage Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5437 Eisenhower 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to meet a resident's medical needs that are identified in the comprehensive assessment for 1 of 3 residents (Resident #2) reviewed for care planning. The facility failed to develop a care plan for Resident #2 that included the resident's NPO status. This failure could result in residents not receiving proper care. Findings included: Record review of Resident #2's admission record dated 11/26/2025 reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included cerebral infarction (interruption of blood flow to the brain causing tissue damage), dysphagia (difficulty swallowing), and gastrostomy status (a surgical opening in the abdomen to allow the intake of food and medications). Record review of a significant change MDS submitted on 11/17/2025 for Resident #2, reflected the BIMS score was not assessed due to the resident's cognitive status. Section K0520 of the MDS reflected Resident #2 received nutrition via a feeding tube. Record review of Resident #2's order summary report dated 11/26/2025 revealed the following: Enteral (directly into the digestive tract) feed order every shift Glucerna 1.5 at 60cc via G-tube stationary pump . (start date 11/22/2025). Record review of Resident #2's care plan report printed 11/26/2025 revealed the following: I am at risk for nutritional deficits and/or dehydration risks r/t therapeutic diet, 10/17/25- NPO, G-tube (revision 11/25/2025) . *Nutrition/Hydration risk: Offer me an alternate meal or supplement if I eat less than 50% of my foods at each meal (date initiated 8/01/2025) *Nutrition/Hydration Risk: Encourage/Offer/Assist me to drink fluids during care time opportunities, during activities as well as during therapy as indicated. Ask my nurse if you have any questions (date initiated 8/01/2025) [sic] In an observation on 11/26/2025 at 11:10 AM, Resident #2 was noted to be resting in bed with an enteral feeding pump and nutrition solution attached to a pole near his bed. An interview was attempted, but Resident #2 was unable to participate due to cognitive decline. In an interview with the MDS Nurse on 11/26/2025 at 2:47 PM, she said care plans are updated on a daily basis, after incidents or review by the interdisciplinary team. She said Resident #2 was currently NPO due to dysphagia, and his care plan had not been updated after a recent hospitalization. The MDS Nurse stated the care plan should reflect the NPO status without the interventions of encouraging oral intake and had been mistakenly overlooked. The MDS Nurse stated the importance of an updated care plan was to ensure residents ordered care. In an interview with the DON on 11/26/2025 at 3:51 PM, she said Resident #2 was currently NPO and his care plan should reflect that status. The DON stated she was unaware the care plan included interventions for oral intake, and her expectation was the care plans would be updated with necessary care to ensure proper care. Record review of the facility policy titled Care Planning- Interdisciplinary Team dated March 2022, updated 12/2024 did not reveal guidelines related to ensuring the accuracy of the content of the care plan.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 diseases and infections for 1 of 3 residents (Resident #2) reviewed for infection control. The facility failed to ensure staff implemented EBP when providing care for Resident #2. This failure could lead to infection or illness. Findings included: Record review of Resident #2's admission record dated 11/26/2025 reflected a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included gastrostomy status (a surgical opening in the abdomen to allow the intake of food and medications) and presence of urogenital implants (a catheter to allow the drainage of urine). Record review of a significant change MDS dated [DATE] for Resident #2, reflected the BIMS score was not assessed due to the resident's cognitive status. Section H0100 of the MDS reflected Resident #2 required an indwelling catheter, and section K0520 of the MDS reflected Resident #2 received nutrition via a feeding tube. Record review of Resident #2's order summary report dated 11/26/2025 did not reveal an order for EBP. Record review of Resident #2's care plan report printed 11/26/2025 revealed infection risk: EBP (Enhanced Barrier Precautions) Date initiated: 07/01/2025. In an observation on 11/26/2025 at 11:10 AM, no EBP signage was observed to be present at the entrance to Resident #2's room or within his room. An interview was attempted, but Resident #2 was unable to participate due to cognitive decline. LVN A was observed assisting Resident #2 with a position change in his bed. LVN A donned [put on] gloves to provide care, but she did not don a gown. LVN A departed the facility before a follow-up interview could be conducted. LVN B was interviewed on 11/26/2025 at 4:01 PM and said she was the primary nurse for Resident #2. She was unsure if Resident #2 required EBP, but she said he should be on EBP since he had a foley catheter and a G-tube. She was unable to find a sign in or around Resident #2's room that indicated the implementation of EBP, and she was unable to locate a physician's order for EBP within the medical record. She said she was unsure of the process for implementing EBP at the facility because she was new and only worked occasionally, but she had received training regarding TBP and infection prevention. She said the potential harm to residents of not implementing proper TBP was infection. In an interview with the ADON on 11/26/2025 at 3:06 PM, she said she was responsible for the facility's infection prevention program. She was unaware that Resident #2 did not have a physician's order for EBP, and she said it must have been mistakenly discontinued during a recent hospitalization. She also said Resident #2 previously had a sign indicating the need for EBP, but she was unsure why it was not posted. She said staff should be wearing gloves and gowns when providing direct care to residents on EBP, and the potential harm to residents of not implementing proper TBP was infection. Record review of the facility policy titled Enhanced Barrier Precautions dated 2001, revised March 2024, revealed the following: .EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply . Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required .</p>		