

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675883	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Southeast Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4302 E Southcross Blvd San Antonio, TX 78222	
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on interview and record review, the facility failed to ensure residents' right to formulate an advance directive for 1 of 22 residents (Resident #175) reviewed for advanced directives, in that:</p> <p>The facility failed to ensure Resident #175's signature on his Out-of-Hospital Do Not Resuscitate (OOH DNR) was properly witnessed as Resident #175's signature was dated [DATE], and the two witness's signatures were dated [DATE].</p> <p>This failure could place residents at risk of having their end of life wishes dishonored, and of having Cardiopulmonary resuscitation (CPR) performed against their wishes.</p> <p>The findings included:</p> <p>Record review of Resident #175's admission record, dated [DATE] revealed he was a [AGE] year-old man who had an initial admitted d of [DATE] with re-admission on [DATE], with diagnoses which included: Chronic Kidney Disease, Stage 5 (the most advanced stage of chronic kidney disease and indicates the kidneys are no longer able to perform their essential function), Hemiplegia and Hemiparesis following cerebral infarction affecting right non-dominant side (Partial paralysis or weakness on one side of body: and chronic ischemic heart disease (heard damage caused by poor blood flow to heart. Further review of Resident #175's admission record revealed the resident was identified as DNR status.</p> <p>Record review of Resident #175's discharge MDS assessment dated [DATE] revealed the resident had a BIMS score of 15 indicating intact cognition.</p> <p>Record review of Resident #175's care plan initiated [DATE], revealed the resident had a focus area for: Resident has physician's orders that include an order for DNR. Date initiated: [DATE].</p> <p>Record review of Resident #175's Order Summary Report, dated [DATE], revealed an Order for DNR with start date of [DATE].</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #175's OOH DNR revealed that Resident #175's signature was dated [DATE], and the two witness's signatures were dated [DATE]. Further review of the witness section of the document revealed a statement listed above the witness signatures that read: We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.</p> <p>During an interview with the SW on [DATE] at 12:52 p.m., the SW stated the signature dates of the witnesses on Resident #175's OOH-DNR was not the same date as the Resident's signature, and she noted that the OOH-DNR for Resident #175 was completed and provided to the facility by his Hospice provider. Further interview revealed that even though it was completed by the Hospice Provider it was still the facility's responsibility to ensure there was a valid OOH-DNR for Resident #175, and that having the witness signatures on a different date than the Resident's signature on the DNR could indicate that they did not actually witness the Resident's signature, making it invalid.</p> <p>During an interview with the DON on [DATE] at 3:55p.m., the DON stated she had been made aware of the concerns with Resident #175's DNR, and she had corrected his DNR by re-verifying with the resident his wish for DNR status, asked him to re-sign the DNR with a Notary witness and have his physician sign. The DON provided a copy of the new DNR dated [DATE], but also stated that prior to [DATE], Resident #175 did not have a valid OOH-DNR.</p> <p>Record review of the Texas Department of State Health Services Document titled Honoring an Out-of-Hospital DNR Order A guide for Health Care Professionals, two witnesses or a notary public must sign that they have witnessed the patient's signature or the signature of a person(s) acting on the patient's behalf in sections A-E. Further review revealed Incomplete or incorrect forms: Medical professionals can refuse to honor a OOH-DNR if it is:</p> <ul style="list-style-type: none"> -Not signed properly by all required parties. - Filled out incorrectly. -Suspected to be fraudulent (e.g., unnatural circumstances surrounding death). 		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents had a right to a safe, clean, comfortable, and homelike environment for 2 of 24 residents (Residents #10 and #14) reviewed for a safe, clean, comfortable, and homelike environment, in that:</p> <ol style="list-style-type: none"> 1. The bed-side dresser of Resident #10 was broken with drawers that would not stay closed. 2. Resident #14's bathroom did not have any toilet paper, and her waste basket was filled with used paper towels that she stated she had been using because she had no toilet paper. <p>This failure could result in psychosocial harm due to diminished quality of life.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #10's face sheet, dated 2/12/25, revealed the [AGE] year female resident was originally admitted to the facility on [DATE] with diagnoses including: Parkinson's disease (a disorder of the central nervous system that affects movements), type 2 diabetes mellitus (a condition in which the body has trouble controlling blood sugar), and major depressive disorder (a mental health condition with persistent depressed mood). <p>Record review of Resident #10's Quarterly MDS, dated [DATE], revealed a BIMS score of 12 which indicated mild cognitive impairment.</p> <p>Record review of Resident #10's care plan, initiated 02/1/2024, revealed resident had impaired visual function and was at risk for falls.</p> <p>Observation on 2/10/25 at 11:45 a.m., revealed that a 3 drawer bed-side dresser for Resident #10 had a hand towel placed between the first and second drawer and a hand towel placed between the second and third drawers.</p> <p>During an interview on 2/10/25 at 11:45 a.m., with Resident #10 she stated that the hand towels were placed in her bed-side dresser drawers to keep the drawers from opening on their own. Resident #10 stated that she wanted the drawers fixed and was afraid her belongings would fall out. Resident #10 stated she believed that maintenance was made aware of the broken bed-side dresser.</p> <p>Record review of the Resident Council Meeting notes dated 12/13/24 revealed an entry stating that the bedside dresser for Resident #10 needed balancing.</p> <p>Record review of the Maintenance Log noted an entry for 2/4/25 that the bed-side dresser for Resident #10 was unsteady.</p> <p>During an interview on 2/10/25 at 12:00 noon LVN-B stated she was not aware the bed-side dresser drawers for Resident #10 were broken and would notify maintenance in the work order request log.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/10/25 at 12:10 p.m., the Maintenance Director stated that he was aware of the problem with the bed-side dresser for Resident #10 for about a week and would immediately address the problem.</p> <p>During an interview on 2/11/25 at 12:50 p.m., with the Administrator he stated that he had not reviewed the resident council minute notes dated 12/13/24 which indicated a problem with the bed-side dresser for Resident #10. The Administrator stated that if he had reviewed these notes in December 2024, he would have directed the bed-side dresser for Resident #10 to be fixed at that time.</p> <p>Record review of the facility policy named Maintenance Inspections dated 1/2/25 revealed the Maintenance Director would perform routine inspections and correct all opportunities as soon as possible.</p> <p>2. Record review of Resident #14's face sheet dated 02/09/2025 revealed she was a [AGE] year old woman originally admitted to the facility on [DATE] with re-admit on 08/24/2020 and with diagnoses which included: Conversion Disorder with Seizures (a psychiatric condition where psychological stressors manifest as physical symptoms that can't be explained medically); Dementia (general term for impairment of brain function such as memory, thinking and ability to perform daily activities); Generalized Anxiety Disorder (Severe, ongoing anxiety that interferes with daily activities).</p> <p>Record review of Resident #14's Significant Change MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognition and was assessed as needing supervision or touching assistance for toileting hygiene.</p> <p>Record review of Resident #14's Care Plan initiated 11/29/2019 revealed resident had visual impairment, risk for falls, fragile skin and may require assistance with her activities of daily living.</p> <p>Observation on 02/09/2025 at 10:20 a.m., in room [ROOM NUMBER] revealed the toilet paper holder was empty, the trash can was overflowing with used brown paper towels, and the floor had 4 used paper towels on the floor.</p> <p>During an interview on 02/09/25 at 10:23 a.m., with Resident #14 in room [ROOM NUMBER], she stated she had been without toilet paper for about 4 days and had to use the brown paper towels to wipe herself which she did not like, they felt rough. Resident #14 stated she had asked the Nurse for more toilet paper, but no one has come to bring her more.</p> <p>During an interview on 02/09/2025 at 10:30 a.m. with CNA C, and after observation of the bathroom in room [ROOM NUMBER], CNA C stated that she had not been aware of the condition of the bathroom and found it to be unacceptable. She stated Resident #14 should have been provided with toilet paper, and they were just lucky she had put the used paper towels in the trash can and not try to flush them down the commode as it would cause a clog. CNA C stated that it was housekeeping's responsibility to restock toilet paper in the restrooms and clean the bathrooms.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 02/09/2025 at 10:35 a.m. with Housekeeper D revealed that he stated that the resident has had diarrhea and goes through a lot of toilet paper, but stated it was not acceptable that she had to use paper towels instead because she did not have any toilet paper. He stated that he cleans all the restrooms on the halls he was assigned starting in the morning, and then returns as needed after he has cleaned all the restrooms and rooms. He stated the last time he cleaned and stocked the bathroom in room [ROOM NUMBER] was the prior morning, but he could not remember if he left an extra roll out for the resident. He stated that working today, were 2 full-time housekeepers and 1 just working half-day and one in the laundry.</p> <p>During an interview with the EVS Manager on 02/12/2025 at 11:25a.m., the EVS Manager stated that the housekeepers clean and re-stock the bathrooms with toilet paper as they go room to room down the hallway cleaning. She stated that if the housekeepers are aware the resident has diarrhea, they are to make more frequent rounds to see if they need to be re-stocked and have bathroom cleaned. She stated extra toilet paper rolls are stocked on the housekeepers' carts and in the laundry area, and Nurse's and CNA's could ask the housekeepers for some toilet paper off their housekeeping cart if a resident was requesting additional toilet paper. The EVS Manager stated that the resident should not have been without toilet paper and that by not providing her with toilet paper, it increased the risk that she could clog the toilet which could affect everyone as the system was all connected.</p> <p>Record review of the facility policy titled Resident Rights dated 02/23/2026 revealed The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents.</p> <p>33866</p>		

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<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** 27923</p> <p>33866</p> <p>Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #42) of 8 residents reviewed for care plans.</p> <p>The facility failed to include oxygen treatment in Resident #42's comprehensive care plan initiated 02/10/2022.</p> <p>This deficient practice could affect residents who received oxygen and could result in residents receiving incorrect or inadequate oxygen support and could result in a decline in health.</p> <p>Findings Included:</p> <p>Record review of Resident #42's admission record dated 02/09/2025 revealed he was a [AGE] year-old man initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included: malignant neoplasm of colon (colon cancer); and dementia (a general term to describe loss of memory, thinking, language and ability to perform daily activities).</p> <p>Record review of Resident #42's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 indicating moderate cognitive impairment.</p> <p>Record review of Resident #42's Order Summary Report dated 02/11/2025 revealed an order for May use supplemental oxygen 2-4L NC for SOB dated 01/30/2025.</p> <p>Record review of Resident #42's Care Plan initiated 02/10/2022 revealed there was no focus area for oxygen therapy.</p> <p>Observation on 02/09/2025 at 2:14 p.m. in Resident #42's room revealed an oxygen concentrator not currently in use next to his bed, with no date on the humidifier bottle but the oxygen tubing was dated 2/4/2025. The oxygen tubing and connected nasal cannula were hanging loosely over the humidifier bottle, not in a bag.</p> <p>Observation on 02/11/2025 at 11:05 a.m. in Resident #42's room revealed his oxygen concentrator was next to his bed, the oxygen tubing and nasal cannula were hanging loosely over the concentrator and extending down behind the concentrator almost touching the floor. The oxygen tubing was not dated, and the humidifier bottle was dated 02/01/2025.</p> <p>During an interview with the DON on 02/11/2025 at 11:10a.m., the DON confirmed Resident #42's use of oxygen and stated she would address the problems noted with the oxygen tubing storage and dating.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/11/2025 at 01:04 p.m. with LVN E revealed she was one of 2 MDS Nurse's at the facility. LVN E stated that she was not aware that Resident #42 had been ordered PRN oxygen, and that if he was using oxygen, it should be included in his Care Plan, so that all the staff had the information on the need for and care of his oxygen. She stated she would look into and add it to his Care Plan.</p> <p>Record review of the facility policy titled Comprehensive Care Plans dated 02/10/2021 revealed The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #42) of 3 residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #42's oxygen tubing and nasal cannula were stored properly and that the humidifier bottle or tubing were dated on 02/09/2025 and 02/11/2025</p> <p>This failure could affect residents on respiratory therapy by placing them at risk for respiratory compromise and infection.</p> <p>Findings included:</p> <p>Record review of Resident #42's admission record dated 02/09/2025 revealed he was a [AGE] year-old man initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included: malignant neoplasm of colon (colon cancer); and dementia (a general term to describe loss of memory, thinking, language and ability to perform daily activities).</p> <p>Record review of Resident #42's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 7 indicating moderate cognitive impairment.</p> <p>Record review of Resident #42's Order Summary Report dated 02/11/2025 revealed an order for May use supplemental oxygen 2-4L NC for SOB dated 01/30/2025.</p> <p>Observation on 02/09/2025 at 2:14 p.m. in Resident #42's room revealed an oxygen concentrator not currently in use next to his bed, with no date on the humidifier bottle but the oxygen tubing was dated 2/4/2025. The oxygen tubing and connected nasal cannula were hanging loosely over the humidifier bottle, not in a bag.</p> <p>Observation on 02/11/2025 at 11:05 a.m. in Resident #42's room revealed his oxygen concentrator was next to his bed, the oxygen tubing and nasal cannula were hanging loosely over the concentrator and extending down behind the concentrator almost touching the floor. The oxygen tubing was not dated, and the humidifier bottle was dated 02/01/2025.</p> <p>Observation and interview with the DON on 02/11/2025 at 11:10 a.m. in Resident #42's room revealed she confirmed the oxygen tubing and nasal cannula were hung loosely over the concentrator and she stated they should have been stored in a bag off the floor, and the oxygen tubing should be dated. The DON stated the tubing should be dated because it needs to be changed out once a week, and if not dated cannot tell when it was last changed. She further stated that if the tubing was not stored in a bag it could lead to cross contamination and if the tubing was not changed weekly, it could lead to the tubing becoming a breeding ground for infection.</p> <p>Record review of the facility policy titled Oxygen Administration reviewed 1/5/2020 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Use pre-filled humidifier bottle. Label bottle with date. Change bottle when empty. - When oxygen not in use, store oxygen tubing and nasal cannula or mask in small plastic bag. - Change disposable parts once a week and label with date (tubing, plastic bag, mask or cannula) 		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observation, interviews and record review, the facility failed to provide pharmaceutical eservices (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 1 medication rooms reviewed for pharmacy services.</p> <p>Inspection on 02/11/2025 of the facility medication storage room revealed two expired vials Lorazepam 2mg/ml for Resident #50.</p> <p>This failure could place resident at risk of residents not receiving appropriate therapeutic effects from their medications.</p> <p>The findings include:</p> <p>Record review of Resident #50's admission record dated 01/12/2025 revealed he was a [AGE] year-old man initially admitted on [DATE] with re-admit on 09/12/2024 and with diagnoses which included: Dementia (a condition that causes memory loss and other cognitive decline); Epilepsy (seizure disorder); and Anxiety Disorder (mental health disorder characterized by feelings of worry anxiety, or fear strong enough to interfere with daily activities).</p> <p>Record review of Resident #50's quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 2, indicating severe cognitive impairment.</p> <p>Record review of Resident #50's Order Summary dated 02/12//2025 revealed an order for LORazepam Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth two times a day related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, SEVERE, WITH ANXIETY.</p> <p>Observation with the DON on 02/11/2025 at 3:19 p.m. of the facility's medication storage room revealed inside the locked compartment inside the refrigerator was a sealed bag containing 5 vials of Lorazepam 2mg/ml for Resident #50. Further inspection revealed 2 of the 5 vials of Lorazepam were expired, with expiration dates of 11/2024 on their labels.</p> <p>During an interview with the DON on 02/11/2025 at 3:38 p.m., the DON confirmed the 2 vials of Lorazepam were expired, and she stated that the Pharmacist Consultant had just audited the medication room last Friday and did not find any expired medications. The DON stated that expired medications may not be as effective if administered or could even cause an adverse effect.</p> <p>Record review of the facility policy titled Medication Storage dated 01/20/2021 revealed:</p> <p>-It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart; and</p> <p>- .The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with facility policy.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>33866</p> <p>Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were stored in locked compartments and labeled in accordance with correctly accepted professional principles reviewed for 1 of 4 medication carts (E-Hall Nurse's medication cart) reviewed for secure storage.</p> <p>The facility failed on 02/11/2025 to ensure LVN G secured Resident #13's Fiasp Insulin (a synthetic form of rapid-acting insulin used to treat diabetes mellitus), when it was left unattended on top of the Nurse's medication cart when LVN G entered Resident #13's room and the medication cart remained outside the room out of line of sight from LVN G.</p> <p>This failure could place residents at risk for drug diversion or misuse of medications.</p> <p>Findings include:</p> <p>Observation on 02/11/2025 at 11:44 a.m. revealed LVN G removed from the medication cart all the supplies she would need to do an accu-check on Resident #13, and also removed Resident 13's Flex Touch pen of FIASP insulin, placing it on top of the medication cart. LVN G then gathered up the accu-check supplies, entered Resident #13's room to conduct the accu-check, and left the FIASP insulin Flex Touch pen out on top of the medication cart unsecured. The medication cart was not in line of sight of LVN G during the time she was inside Resident #13's room conducting the accu-check.</p> <p>During an interview with LVN G on 02/11/2025 at 11:49 a.m., LVN G stated she knew she was not supposed to leave the FIASP insulin pen out unsecured on top of the medication cart, but had initially planned to take it inside the room with her in case Resident #13's blood sugar reading was high enough to need an insulin injection based on her sliding scale, but then forgot to take it with her. LVN G stated medications should always be kept locked up when not directly supervised by the Nurse because one of the patients could have walked by and taken in. LVN G stated she had received training in medication administration which included keeping medications locked at all times.</p> <p>During an interview with the DON on 02/11/2025 at 12:15 p.m., the DON, after first questioning the position of the medication cart while LVN G was conducting the accu-check, did state that the insulin should not have been left out unsecured on top of the medication cart while LVN G entered the resident's room at conduct the accu-check. The DON stated not securing medications could result in theft of the medication. The DON stated that LVN G had received training in medication administration and keeping medications secure.</p> <p>Record review of the facility policy titled Medication Storage dated 01/20/2021 revealed:</p> <p>-It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart;</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>36232</p> <p>Based on interview and record review, the facility failed to employ staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required for 1 of 1 facility reviewed for dietary requirements.</p> <p>The DM did not have the appropriate certification, education, or qualifications to serve as the Director of Food and Nutrition Services.</p> <p>This deficient practice could place the residents who consume food prepared from the kitchen at risk of food borne illness and not receiving adequate nutrition.</p> <p>The findings included:</p> <p>During an interview on 02/09/2025 at 10:50 AM, the DM stated he was not a certified dietary manager or certified food service manager, he did not have an associate's or higher degree in food service management or in hospitality, and he had not been a dietary manager in a long-term care facility for over two years. This was his first position as the DM in a nursing facility and his hire date was 01/02/2025. He was enrolled in a certified dietary manager program but had not completed any classes at that time.</p> <p>During an interview on 02/11/2025 at 3:30 PM, the consultant RD stated she did not work at the facility full time. She provided approximately 12 - 16 hours of consultative hours to the facility per month.</p> <p>During an interview on 02/12/2025 at 9:40 AM, the administrator stated he was not aware the DM was not a CDM and was also not aware the requirement had changed requiring the individual in the position to have this certification upon hire. The facility contracted with a foodservice company, and all the dietary staff, including the DM, were employed by the contractor. He understood it was critical the DM be proficient in food sanitation, safety, and how to meet the individual dietary needs of the residents.</p> <p>Record review of the Job Description for Job Title: Director of Food and Nutrition Services provided by the facility, undated, revealed: Qualifications: Must be a Registered Dietitian or CDM or other per Federal and State Regulation.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 1-201.10.10(B) Accredited Program. (1) Accredited program means a food protection manager certification program that has been evaluated and listed by an accrediting agency as conforming to national standards for organizations that certify individuals.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 2-102.12 Certified Food Protection Manager. (A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 2-102.20 Food Protection Manager Certification. (B) A FOOD ESTABLISHMENT that has a PERSON IN CHARGE that is certified by a FOOD protection manager certification program that is evaluated and listed by a Conference for FOOD Protection-recognized accrediting agency as conforming to the Conference for FOOD Protection Standard for Accreditation of FOOD Protection Manager Certification Programs is deemed to comply with S2-102.12.</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>36232</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.</p> <ol style="list-style-type: none"> 1. The facility failed to store plastic bowls to allow for air-drying in the dish room. 2. The facility failed to use the correct log to record the dish machine wash cycle temperatures and chlorine sanitizer concentrations, resulting in no record of chlorine sanitizer concentrations recorded. 3. The facility failed to properly store an opened package of cream cheese and pre-packaged hard-boiled eggs in the reach-in cooler. 4. The facility failed to discard hard-boiled eggs past their use-by date. 5. The facility failed to ensure the tabletop can opener blade and base were free of grime and debris. 6. The facility failed to ensure an opened bag of powdered sugar was properly sealed in the dry storage room. 7. The facility failed to remove a dented #10 can of beans from the rack of canned goods in the dry storage room. <p>These failures could place residents at risk for food borne illness.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation on 02/09/2025 at 10:28 AM revealed a plastic three with nine overturned plastic bowls on the clean side of the dish machine. There was not an air-drying net separating the bowls from the tray to allow for air circulation. <p>During an interview on 02/09/2025 at 10:230 AM, the DM stated the wet, plastic bowls should not have been placed face-down on a wet tray without an air-drying net separating the bowls from the tray to prevent the potential accumulation of bacteria which could lead to food borne illness. Staff working in the dish room were trained on how to store clean but damp dishware. They were trained upon hire and periodically throughout there year. The facility had an adequate supply of air-drying nets.</p> <ol style="list-style-type: none"> 2. Observation of the dish machine in the dish room revealed it utilized a chemical sanitizer (chlorine) used in a sanitizing solution for ware washing. <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>Record review on 02/09/2025 at 10:31 AM of the Dishmachine Temperature Log for the dates 02/03/2025 - 02/09/2025 provided by the facility revealed it stated, High-Temperature Dishmachine Temperature Log and had the following columns: Day (three spaces per day), Time, Date, Final Rinse (Thermolabel or Thermometer Temperature Reading), Wash Water Temperature, Initials and Corrective Action. There was no column to record the concentration of the chemical sanitizer and none were recorded for any day.</p> <p>During an interview on 02/09/2025 at 10:33 AM, the DM stated he understood the facility was using the incorrect temperature log for the type of machine in the dish room, there was no record any measurements of chemical sanitizer concentration recorded, and this failure could result in inadequate or no sanitizing of dishes and flatware, potentially causing foodborne illness. The DM further stated he had been in the position approximately one month and was in the process of resolving issues in the kitchen. Further observation at 10:35 AM revealed the concentration of the chlorine sanitizer in the machine was 50 ppm, which was within the acceptable range.</p> <p>3. Observation on 02/09/2025 at 10:38 AM in the reach-in cooler revealed an opened container of cream cheese stored in a plastic bag that was not sealed. There were also two separate packages of commercially procured hard boiled eggs in packages that were opened and stored in clear plastic bags that were not sealed.</p> <p>4. Observation on 02/09/2025 at 10:38 AM in the reach-in cooler revealed he date on one package containing three hard boiled eggs was 01/30.</p> <p>During an interview on 02/09/2025 at 10:40 AM, the DM stated the packages of cream cheese and hard-boiled eggs should have been sealed, and the eggs dated 01/30 should have been discarded. Ensuring opened foods returned to the cooler for storage were properly labeled, dated and sealed was critical to prevent spoilage and potential foodborne illness. All employees storing food in the coolers were responsible for labeling and dating.</p> <p>5. Observation on 02/09/2025 at 10:41 AM in the kitchen revealed the tabletop can opener was covered with sticky grime that was black and brown in color. The grime covered the blade portion of the can opener, the adjustable bar, and also surrounded the base that was affixed to the table with screws.</p> <p>During an interview on 02/09/2025 at 10:42 AM, the DM stated that the can opener blade, bar and base were covered in sticky grime and should not have been. The DM stated the cooks were responsible for ensuring the can opener and area surrounding the base remained clean and free of debris, and that failing to do so could result in contamination of food from bacteria lingering on the blade and potential foodborne illness.</p> <p>6. Observation on 02/09/2025 at 10:44 AM in the dry storage room revealed an opened 2 lb. bag of powdered sugar on a shelf. The bag was approximately 3/4 full, had been opened, and placed inside a bag with a zip lock that was not sealed.</p> <p>During an interview 02/09/2025 at 10:44 AM, the DM stated the bag of powdered sugar was not sealed, and the bag should have been stored either in a larger bag with a zip lock or a sealed container. All kitchen staff stored food in the dry storage room, and failing to ensure food was properly sealed could result in deterioration in food quality and potential contamination from pests.</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>7. Observation on 02/09/2025 at 10:45 AM in the dry storage room revealed a #10 can (6 lbs.) of pinto beans with a large dent in the bottom third of the can in close proximity to the seal. The can was stored on the same rack with the other cans of various foods.</p> <p>During an interview 02/09/2025 at 10:44 AM, the DM stated the dented can should have been removed from the rack of canned goods and stored separately for return to the facility's food supplier, as dented cans could potentially harbor harmful bacteria that could lead to serious foodborne illness. He did not know why the dented can was in the dry storage room, as all dietary employees were trained to remove them upon identification.</p> <p>Record review of facility policy, Ware Washing dated October 2019 revealed, Action Steps: 3. The Dining Services Director is responsible for insuring appropriate completion of temperature and/ or sanitizer concentration logs as appropriate. 4. The Dining Services Director ensures that all dishware is air dried and properly stored.</p> <p>Record review of the Job Description, Job Title: Director of Food and Nutrition Services, undated, revealed, Essential Duties and Responsibilities: Unit Supervision. Ensures equipment and work areas are clean, safe and orderly; and strict adherence to procedures regarding cleaners or hazardous materials or objects; ensure standard precautions and infection control, isolation, fire, safety and sanitation practices and procedures are followed; and promptly address any hazardous conditions and equipment.</p> <p>Record review of facility policy, Frozen and Refrigerated Storage revised 12/05/2017 revealed, Policy: PHF/TCS (Potentially hazardous/Time temperature control for safety) foods will be properly refrigerated or frozen to reduce the potential for food borne illness and maintain product integrity. 7. Proper labeling of cooked foods includes the date placed in the refrigerator, and an expiration or 'use by' date. Refrigerated products that are opened must be labeled with an 'opened on' date. The 'use by' date is 7 days from when the product was opened, unless there is a manufacturer's use by, expiration or sell by date. 13. On a daily basis the Cooks will: b. Check labeling and dating, use any items that are close to their use by date and discard any items that are past their use by date.</p> <p>Record review of facility policy, Dry Food Supplies Storage revised 11/15/2017 revealed, 9. All opened products must be resealed effectively and properly labeled, dated and rotated for use. This may require storage in an approved NSF container or food grade storage bag. 11. Canned goods that have a compromised seal will be removed from service and stored in a separate area, until they are picked up by the distributor or discarded.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 4-901.11 Equipment and Utensils, Air-Drying Required. Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.</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>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-205.15 Package Integrity. Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food. If the integrity of the packaging has been compromised, contaminants such as Clostridium botulinum may find their way into the food. In anaerobic conditions (lack of oxygen), botulism toxin may be formed. Packaging defects may not be readily apparent. This is particularly the case with low acid canned foods. Close inspection of cans for imperfections or damage may reveal punctures or seam defects .Suspect cans must be returned and not offered for sale.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>36232</p> <p>Based on observation, interview and record review, the facility failed a to dispose of garbage and refuse properly.</p> <p>The facility failed to ensure the sliding doors on both sides of the dumpster were completely closed.</p> <p>This deficient practice could place residents at risk for exposure to germs and diseases carried by vermin and rodents.</p> <p>The findings were:</p> <p>Observation on 02/11/2025 at 12:13 PM revealed the sliding doors on both sides of the facility's dumpster were completely open, exposing bags of refuse reaching approximately halfway up the inside of the dumpster.</p> <p>During an interview on 02/11/2025 at 12:14 PM, the Regional DM stated the doors on the sides of Dumpster #1 were both open and should not have been. It was important for the doors to be completely shut to prevent pests from entering the dumpsters and potentially spreading foodborne illness.</p> <p>During an interview on 02/12/2025 at 9:30 AM, the Administrator and DON stated the facility had a resident with a behavior of frequently opening the dumpster doors when they were shut, as he believed this made the staff's job easier. They understood the doors needed to remain shut and would seek a solution to ensure they remained closed.</p> <p>Record review of facility policy Dispose of Garbage and Refuse dated October 2019 revealed, It is the center policy all garbage and refuse will be collected and disposed in a safe and efficient manner. 2. The Dining Services Director will ensure proper practice for handling garbage and refuse.</p> <p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 5-501.113 Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the food establishment. 5-501.114 Using Drain Plugs. Drains in receptacles and waste handling units for refuse, recyclables, and returnables shall have drain plugs in place.</p>		

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<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** 33866</p> <p>Based on observation, interview, and record review, the facility failed to establish and 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 8 residents (Resident #43) reviewed for infection prevention.</p> <p>The facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented and used when LVN B provided Enteral feeding via a G-tube (a gastrostomy tube - a flexible tube inserted through abdominal wall and into stomach to provide a direct route for delivering food and medications) to Resident #43.</p> <p>This deficient practice could place residents at-risk for spread of infection.</p> <p>Findings include:</p> <p>Record review of Resident #43's admission record dated 02/10/2025 revealed a [AGE] year old man, with an initial admitted [DATE] and re-admit on 12/17/2024. Resident #42 had diagnoses which included: Cerebral Palsy (a congenital disorder of movement and muscle tone); [NAME] Syndrome (disorder which mimics intestinal blockage without a physical blockage) and Gastrostomy status (presence of a G-tube for nutrition and medication).</p> <p>Record review of Resident #43's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 0, which indicated severe cognitive impairment. Resident #43 was assessed as receiving 51% or more of his total calories and fluid intake through tube feeding.</p> <p>Record review of Resident #43's Order Summary dated 02/10/2025 revealed orders which included: .NPO [Nothing by Mouth] diet; and Enteral Feed Order three times a day for feeding and fwf [free water flush] bolus intermittent Gravity (Bolus) Enteral Feeding: Formula Jevity 1.5 Amount: 30ml. Frequency q 4 hr. Followed by 120ml free water flush.</p> <p>Record review of Resident #43's Care Plan with focus areas which included: requires the use of a feeding tube and is at risk for aspirations, weight loss and dehydration r/t dx of [NAME]'s Syndrome initiated 06/06/2023 and the resident requires Enhanced Barrier Precautions d/t Feeding tube initiated 04/01/2024.</p> <p>Observation on 02/10/2025 at 04:01 p.m. of Resident #43's G-tube feeding and water flush by LVN B revealed LVN B sanitized his hands and put on gloves but did not put on a gown to administer the feeding via his G-tube. Further observation revealed there was an Enhanced Barrier Protection sign posted on Resident #43's door, as well as a supply of PPE.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/10/2025 at 4:36 p.m. with LVN B revealed he stated that he realized that he forgot to wear a gown while administering Resident #43's G-tube feeding and stated wearing a gown and gloves was part of Enhanced Barrier Precautions and was needed to help stop the spread of infection when working directly with residents who had in-dwelling devices such as G-tubes. LVN B stated he had worked at the facility less than a week, but had received training in EBP, and just got nervous and forgot to put on a gown.</p> <p>During an interview with the DON on 02/10/2025 at 4:42p.m., the DON stated LVN B should have followed EBP precautions while administering Resident #43's G-tube feeding, which included wearing both a gown and gloves, and stated LVN B was a new hire and had just received training in infection control, which included EBP precautions.</p> <p>Record review of the facility's policy titled Infection Prevention and Control Program dated 10/24/2022 revealed EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. Further review revealed EBP are indicated for residents with any of the following: b. Wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. and During high-contact resident care activities: Device care of use: central line, urinary catheter, feeding tube .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675883	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER Southeast Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4302 E Southcross Blvd San Antonio, TX 78222	
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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866</p> <p>Based on observations, interviews, and record review, the facility failed to ensure resident rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area for one (Resident #14) of 8 residents reviewed for resident call system.</p> <p>The facility failed to ensure Resident #14's call light system was working properly.</p> <p>This failure could place resident at risk for delay in assistance and decreased quality of life, self-worth, and dignity.</p> <p>Findings included:</p> <p>Record review of Resident #14's face sheet dated 02/09/2025 revealed she was a [AGE] year old woman originally admitted to the facility on [DATE] with re-admit on 08/24/2020 and with diagnoses which included: Conversion Disorder with Seizures (a psychiatric condition where psychological stressors manifest as physical symptoms that can't be explained medically); Dementia (general term for impairment of brain function such as memory, thinking and ability to perform daily activities); Generalized Anxiety Disorder (Severe, ongoing anxiety that interferes with daily activities); and repeated falls.</p> <p>Record review of Resident #14's Significant Change MDS assessment dated [DATE] revealed a BIMS score of 15 indicating intact cognition and was assessed as needing supervision or touching assistance for toileting hygiene.</p> <p>Record review of Resident #14's Care Plan initiated 11/29/2019 revealed resident had visual impairment, risk for falls, fragile skin and may require assistance with her activities of daily living.</p> <p>Observation and interview with Resident #14 on 02/09/2025 at 10:14 a.m. revealed she was sitting on the side of the bed, and stated that her bathroom did not have any toilet paper and she wanted staff to bring her some. She stated she could not call for staff because her call light was broken and had been broken for 3-4 days. She pressed the call light next to her bed, and the red light inside her room did light up, but the light outside above her door did not come on, and the hall call light did not have a cover over the light, revealing exposed light bulb and wires.</p> <p>During an observation and interview with CNA C on 02/09/2025 at 10:30 a.m., CNA C tested Resident #14's call light in the room and confirmed the call light in the hall did not activate and did not have a cover over the light. She stated that she had not been aware the call light was not working and will notify the Nurse.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Southeast Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4302 E Southcross Blvd San Antonio, TX 78222	
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with the Maintenance Director on 02/09/2025 at 10:42 a.m. revealed that he stated the Nurse had contacted him to check the call light in Resident #14's room. He pressed the call light in Resident #14's room, stated the red light came on inside the room indicating it activated, but confirmed that the call light in the hallway did not come on, did not have a cover over the light and did not activate at the Nurse's station. He stated all the call lights were supposed to have covers on them and he had some on order. He left briefly and returned quickly with a replacement light bulb and cover and replaced both. The call light still did not work, and after the Maintenance Director investigated further, he stated he found that the emergency light button in the bathroom was pressed partially down and that was blocking the signal, and that he had fixed it. The Maintenance Director stated that he had not been informed of the call light not working, and there had been no work orders placed in the maintenance log kept by the Nurse's station. He further stated he does not make routine checks of the call lights, but staff were supposed to record any problems with call lights in the maintenance log which he checked frequently. The Maintenance Director further stated that it was important to have a functioning call light so the resident could call for help if needed.</p> <p>Record review of the maintenance book hanging on the wall across from the Nurse's station revealed that there were no notations regarding a malfunctioning call light in Resident #14's room.</p> <p>Record review of the facility's policy on Maintenance Inspection dated 01/02/25 revealed that the Director of Maintenance Services will perform routine inspections of the physical plant and opportunities will be corrected as soon as possible.</p>		

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NAME OF PROVIDER OR SUPPLIER Southeast Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4302 E Southcross Blvd San Antonio, TX 78222	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923</p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 2 of 6 resident hallways (Hallway A and Hallway F) reviewed for environmental concerns.</p> <p>1. The facility failed to ensure resident rooms #104 and #107, located on hallway A, had back lids covers for the toilet bowl and room [ROOM NUMBER], also located on hallway A, did not have a 2 foot strip of floor baseboard molding attached to the wall.</p> <p>2. The facility failed to ensure the bottom half of the bathroom door in room [ROOM NUMBER], on hallway F, was repaired and did not have numerous horizontal linear scrapes and a jagged opening near the door hinge where the outer cover of the door was partially missing, and failed to ensure the wall opposite the toilet inside the bathroom did not have numerous scrapes and small holes in the wall.</p> <p>These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe.</p> <p>The findings included:</p> <p>1. During an observation on 02/10/25 from 11:00 a.m. to 11:05 a.m. with LVN A revealed the following:</p> <p>a. In room [ROOM NUMBER] on Hallway A the bathroom toilet had no back lid cover for the toilet bowl.</p> <p>b. In room [ROOM NUMBER] on Hallway A there was a 2-foot strip of floor baseboard molding in the bathroom that was not attached to the side of the wall.</p> <p>c. In room [ROOM NUMBER] on Hallway A the bathroom toilet had no back lid cover for the toilet bowl.</p> <p>During an interview with LVN A on 02/10/25 at 11:10 a.m. revealed that repairs were needed in room #'s 104, 106, and 107 for a more pleasant environment for the residents.</p> <p>During an observation with the Maintenance Director on 02/10/25 from 11:10 a.m., to 11:15 revealed the following:</p> <p>a. In room [ROOM NUMBER] on Hallway A the bathroom toilet had no back lid cover for the toilet bowl.</p> <p>b. In room [ROOM NUMBER] on Hallway A there was a 2 foot strip of floor baseboard molding in the bathroom that was not attached to the side of the wall,</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Southeast Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4302 E Southcross Blvd San Antonio, TX 78222	

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. In room [ROOM NUMBER] on Hallway A the bathroom toilet had no back lid cover for the toilet bowl.</p> <p>During an interview with the Maintenance Director on 02/10/25 at 11:20 a.m., he stated the process of being alerted to a problem that needed repair required a staff member to tell him about it or to write it down in the Maintenance Book kept at the Nurses station; the Maintenance Director stated he had not been made aware of the problems on the secure unit and would address the repairs immediately.</p> <p>2. Observation on Hallway F on 02/09/2025 at 12:32 p.m., revealed in room [ROOM NUMBER], the bottom part of the bathroom door had numerous horizontal linear scrapes and a jagged opening near the door hinge where the outer cover of the door was missing which revealed the hollow inside of the door; and numerous scrapes and small holes in the wall opposite the toilet.</p> <p>Interview on 02/10/2025 at 12:32 p.m. with the Maintenance Director revealed that he was made aware the day before (02/09/2025) of the condition of the bathroom door and wall in room [ROOM NUMBER] after the State Surveyor had been observed looking at it and had replaced the door with another door that he had available and patched the wall. The Maintenance Director stated the resident in room [ROOM NUMBER] uses a wheelchair and had impaired vision and would frequently run into the door and wall with his wheelchair causing damage to the door and wall, and frequent repair was needed. He stated he was in the process of updating and making repairs to the entire facility, noting that it was an old building, and he had just not gotten to room [ROOM NUMBER] yet for needed repairs.</p> <p>Record review of the facility maintenance request log did not reveal any requests logged for repair of the door and wall in room [ROOM NUMBER].</p> <p>Record review of the facility's policy on Maintenance Inspection dated 1/2/25 stated the Director of Maintenance Services will perform routine inspections of the physical plant and opportunities will be corrected as soon as possible.</p>