| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676216 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Remington Transitional Care of San Antonio | 5423 Hamilton Wolfe Rd<br>San Antonio, TX 78229 |

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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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for 1 (Resident #28) out of 8 residents reviewed for environmental concerns.<br><br>The facility failed on 06/03/2025 when Resident #28's window (1 of 2) would not close all the way in his room remaining open approximately 1-inch, which could have resulted in damage to the interior windowsill according to the Maintenance Director.<br><br>The facility failed on 06/03/2025 when Resident #28's room refrigerator had not been functioning for an unknown amount of time resulting in Resident #28's RP not being able to bring in outside food for Resident #28.<br><br>This failure could place residents at risk of a diminished quality of life due to exposure to an environment that was unpleasant, unsanitary, and unsafe.<br><br>The findings included:<br><br>Record review of Resident #28's admission record, dated 06/03/25, reflected Resident #28 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include repeated falls, weakness, and dementia (decline in cognitive functioning, including memory, thinking, and reasoning, to the extent that it interferes with daily life and activities).<br><br>Record review of Resident #28's admission MDS assessment, dated 05/05/25, reflected Resident #28 had a BIMS score of 09 out of 15, indicating moderate cognitive impairment. It reflected no weight changes in the past 6 months.<br><br>Observation and combined interview with Resident #28 and Resident #28's RP on 06/03/25 at 11:07 AM reflected, one of his windows (1 of 2) was slightly open. They stated they could not close it before today and demonstrated they could not close it by trying to close it again unsuccessfully. They stated they had put a towel to cover the crack so bugs and rain could not get in. They revealed this window had been cracked for at least last week. They stated when it rained last week water got in and this was when they told a staff member, who they were unable to identify. Observation of the interior windowsill revealed the top of the windowsill near the window was slightly warped.<br><br>(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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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation and interview on 06/03/25 at 11:12 AM, reflected Resident #28's refrigerator was empty and was 58 degrees Fahrenheit. Resident #28's RP stated she had not used the refrigerator since Resident #28 was admitted to the facility and because the refrigerator had been broken so she could not store cold food properly in it. Resident #28's RP stated she had not told anyone about the broken refrigerator.<br><br>Observation on 06/04/25 at 8:27 AM revealed that 1 of Resident #28's window (1 of 2) was slightly open approximately 1-inch.<br><br>Interview and observation on 06/04/2025 at 2:58 PM revealed one of Resident #28's windows was cracked open approximately 1-inch. Observation revealed the vinyl material constructed on the windowsill to be warped along the window side of the windowsill. The Maintenance Director closed the window. The Maintenance Director confirmed damage to the windowsill. He stated he was not aware of the window being cracked open or the water damage to the windowsill. He stated he was not notified of Resident #28's room window was having issues closing, and he was not aware of how long the window had been cracked open. The Maintenance Director stated he was aware of the requirement to ensure walls are maintained, cleanable and in good repair. He further stated as the Maintenance Director it was his responsibility to maintain the building wall conditions. Maintenance Director understood and agreed not maintaining the walls could cause deterioration of the walls, leaving the walls uncleanable which could cause water penetration promoting mold growth, causing air-borne illnesses with the potential to expose the residents to unsanitary conditions, affecting the health and safety of the residents.<br><br>Observation on 06/05/25 at 8:27 AM, reflected Resident #28's refrigerator was empty and was 60 degrees Fahrenheit.<br><br>Interview on 06/05/25 at 4:21 PM, SW I, who was the ambassador for Resident #28's room, meaning he did morning rounds to make sure there weren't any concerns for Resident #28, to include anything that may need repair in his room. SW I stated the refrigerator this morning was 45 degrees Fahrenheit, so he let the Maintenance Director know and expected this to be fixed. He revealed he was not aware that Resident #28's window was unable to be closed. SW I stated anyone who went in Resident #28's room and noticed anything out of the ordinary, should report it to someone so they could find out who could fix any issue that came up.<br><br>Interview on 06/05/25 at 4:44 PM, the ADM revealed the thermometer was broken in Resident #28's refrigerator which was why it was showing a wrong number. She was aware Resident #28's refrigerator was replaced earlier this week, but was not aware of why it was replaced. She stated the refrigerator felt cool when she assessed today and the thermometer had to be broken. The ADM revealed the facility placed 3 thermometers in the refrigerator to see if it was working.<br><br>Interview and observation on 06/06/25 at 9:41 AM, Resident #28's RP stated Resident #28's refrigerator was replaced last night (06/05/2025) because it had not been working. It was observed that the refrigerator was functioning and maintaining proper temperature (less than 40 degrees Fahrenheit). Resident #28's RP stated Resident #28 had been progressing at this facility to include increased appetite, increased food consumption, and strength due to therapy. Resident #28's RP revealed they were satisfied with the nutritional interventions the facility implemented because it had helped Resident #28.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 06/06/25 at 9:53 AM, the SW H stated she knew people wanted the windows open to get fresh air, but it was hard to close the windows sometimes. She stated it was important for windows to close so things like insects would not come in. She stated it was important for Residents' refrigerator to work so food would not get spoiled. She stated it was important to provide a homelike environment because it made the facility feel like home and helped with residents' dignity. SW H further stated the facility did not want the facility to be institutionalized looking, so the residents were not scared of staying in this facility and not being at home.<br><br>Interview on 06/06/25 at 1:00 PM, the Maintenance Director revealed Monday 06/02/25 there was a work order for Resident #28's refrigerator. The Maintenance Director said the refrigerator was not at temperature because the temperature control was turned really low, but they decided to replace the refrigerator anyway. He revealed on Tuesday, 06/03/25, they found the refrigerator door was not closing all the way. They revealed they did not know how long Resident #28's refrigerator was broken before Monday. Maintenance Director stated ambassadors did morning rounds where they checked the refrigerator temperatures and this was one opportunity to catch if the refrigerator was broken, but anyone who visited resident rooms could have caught this. The Maintenance Director further stated Resident #28's window was slightly open, but he just had to push it down to close it. He revealed there was water damage on the windowsill, inside Resident #28's room and this could have happened last week.<br><br>Interview on 06/06/25 at 1:30 PM, the Maintenance Director revealed the facility could not calibrate the thermometers, but they would compare it to a digital thermometer before they put it in the refrigerator. He stated the thermometers they used were not reliable and would break. He expected the facility staff to know if a thermometer was broken if the temperature read too high. He said if the thermometer read too high, this meant the thermometer was broken. He stated when they put a new refrigerator into a resident's room, they had to monitor it to ensure it was functioning correctly.<br><br>Record review of work order created 06/02/25, reflected the refrigerator was not working even though it was plugged in, and they replaced the refrigerator on 06/02/25.<br><br>Record review of work order created 06/05/25 at 8:04 AM by SW I for Resident #28's refrigerator reflected there was a refrigerator temperature issue, and he was continuing to monitor refrigerator temperature.<br><br>Record review of Statement of Resident Rights, provided by the facility and undated, reflected You have a right to: . safe, decent and clean conditions. Facility did not have a policy for homelike environment or functioning equipment.<br><br>Record review of facility's policy, Potluck Meals and Foods from Home, dated 10/01/18, reflected 2. The facility must ensure safe food handling techniques once the food is brought into the facility including . holding cold items <41 degrees .<br><br>Record review of facility's policy, Food Safety for Residents, dated 2018, reflected Keep Food out of the Danger Zone . 2. Cold perishable food . should be kept at 40 degrees Fahrenheit or below. Discard any cold leftovers that have been left out for more than 2 hours at room temperature.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the FDA Food Code 2022 reflected, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3- 403.11(E) may be held at a temperature of 54°C (130°F) or above; or (2) At 5°C (41°F) or less. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to electronically transmit encoded, accurate, and complete MDS data to the CMS System, within 14 days, upon a resident's transfer, reentry, discharge, and death, for 2 of 2 residents (Resident #22 and #272) reviewed for transmitted MDS data to the CMS System.<br><br>The facility failed to transmit a discharge MDS assessment to the CMS system for Resident #22 who discharged on 03/01/25 and #272 who discharged on 05/14/25 within 14 days of the discharge date .<br><br>This failure could place residents at risk of not having assessments completed and submitted in a timely manner as required.<br><br>The findings included:<br><br>1. A record review of Resident #22's admission record dated 06/06/24, revealed a [AGE] year-old male with an admission date of 12/16/24 and a discharge date of 03/01/25 with diagnoses that included pneumonia (infection that inflames air sacs in one or both lungs), acute respiratory failure with hypoxia (a condition where lungs are unable to adequately transfer oxygen into the bloodstream, leading to a dangerously low blood oxygen level), sepsis unspecified organism (a life-threatening complication of an infection), dysphagia (difficulty swallowing) and gastrostomy status (the presence of a gastrostomy tube going into the stomach to provide nutritional support).<br><br>A record review of Resident #22's medical record revealed an entry MDS dated [DATE] and an admission MDS assessment dated [DATE] which revealed a BIMS score of 13 which indicated no impairment to his cognition. Further review of Resident #22's medical record revealed a 5-Day PPS MDS assessment dated [DATE].<br><br>A note on the MDS list in the medical record indicated Discharge - ARD 03/01/25 - 83 days overdue.<br><br>2. Record review of Resident #272's admission record, dated 06/03/25, reflected Resident #272 was an [AGE] year-old female admitted to the facility on [DATE] and discharged with home health services on 05/14/25, with diagnoses to include skin transplant.<br><br>Record review of Resident #272's MDS assessment, dated 05/06/25 and no type selected, reflected Resident #272 had a BIMS score of 15 out of 15, indicating intact cognition.<br><br>A note on the MDS list in the medical record indicated Discharge - ARD 05/14/25 - 9 days overdue and Discharge Return Not Anticipated MDS assessment, dated 05/14/25, was In Progress.<br><br>An interview with the DON on 06/06/25 at 10:00 am, the DON was asked about 2 residents (Resident #22 and Resident #272) who did not have discharge MDS assessments. The DON stated he does not review the MDS assessments and that was done by someone at their corporate office.<br><br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the two MDS Coordinators, LVN B and LVN C, on 06/06/25 at 10:22 am, revealed the 2 residents who did not have a discharge MDS were just missed and they will do a Discharge Return Anticipated for Resident #22 and Discharge Return Not Anticipated for Resident #272. The MDS Coordinators stated it was important to do Discharge MDS assessments so that CMS and insurance would be notified of changes.<br><br>A facility policy titled Assessment Frequency/Timeliness dated 10/24/24 stated:<br><br>The purpose of this policy is to provide a system to complete standardized assessments in a timely manner according to the current RAI Manual.<br><br>6. An OBRA discharge assessment will be completed within 14 days of the discharge date .<br><br>Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual Version 1.19. 1, dated October 2024, revealed 10. Discharge Assessment Return Anticipated [ .] Must be submitted within 14 days after the MDS completion<br><br>date. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 2 (Residents #23 and 52) of 8 residents reviewed for care plans.<br><br>The facility failed to update Resident #23's care plan, undated, included his need for set up and clean-up assistance with eating and Resident #52's care plan, undated, failed to include his ADL self-performance deficit for eating when Resident #52 needed extensive help and needed to be fed.<br><br>This failure could place residents at risk of not receiving care and services related to their identified needs to maintain or reach their highest practicable physical, mental, and psychosocial wellbeing.<br><br>The findings included:<br><br>Record review of Resident #23's admission record, dated 06/03/25, reflected Resident #23 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include type 2 diabetes.<br><br>Record review of Resident #23's admission MDS assessment, dated 03/25/25, reflected Resident #23 had a BIMS score of 12 out of 15, indicating moderate cognitive impairment. It reflected no weight changes in the past 6 months. It reflected Resident #23 needed set up or clean-up assistance with eating, where the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.<br><br>Record review of Resident #23's comprehensive care plan did not reflect interventions for EATING (set up or clean-up assistance with eating), under the problem The resident has an ADL self-care performance deficit., which was initiated 03/24/25.<br><br>Record review of Resident #52's admission record, dated 06/03/25, reflected Resident #52 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (weakness on half of body) follow cerebral infarction (ischemic stroke) affecting right dominant side.<br><br>Record review of Resident #52's admission MDS assessment, dated 03/25/25, reflected Resident #52 had a BIMS score of 12 out of 15, indicating moderate cognitive impairment. It reflected no weight changes in the past 6 months. It reflected Resident #52 needed substantial/maximal assistance with eating, where the Helper does MORE THAN HALF the effort<br><br>Record review of Resident #52's comprehensive care plan did not reflect interventions for EATING (set up or clean-up assistance with eating or needing to be fed, under the problem The resident has an ADL self-care performance deficit., initiated 05/01/25.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview and observation on 06/05/25 at 12:28 PM, Resident #23 was struggling to peel off the plastic covering over his soup. He stated he did not like when he had to take off the plastic covering over food products because it was too hard for him. Observation revealed his dessert also had plastic wrapping over it.<br><br>Interview on 06/05/25 at 12:33 PM, CNA D and CNA E stated Resident #23 needed set up for eating, which would include taking the wrap off his food products. They stated Resident #52 needed extensive help with eating and needed to be fed. They revealed they knew this because it was spread by word of mouth. They relied on therapy to keep in contact with them. They stated their nurses and other CNAs would also let them know about this.<br><br>Interview on 06/05/25 at 10:30 AM, MDS Coordinator B and MDS Coordinator C revealed to code MDS assessment for ADLs they speak with the therapy department and nursing staff. They revealed they would educate staff if there were any updates. They revealed the IDT oversaw the care plans to make sure the care plans were updated. They revealed it was important update the care plans as this updated the Kardex, which listed tasks for the CNAs to complete, that the CNAs access. They revealed this was important for resident care and resident safety.<br><br>Record review of facility's policy Care Plan Revisions Upon Status Change, dated 10/24/22, reflected 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 17.24% based on 5 out of 29 opportunities, which involved 2 of 6 Residents (Resident #161 and Resident #171) reviewed for medication administration, in that:<br><br>1. The facility failed on 6/5/25 to ensure RN F observed if Resident #171 took her metoclopramide (used to treat various gastrointestinal conditions), pantoprazole (decreases the amount of acid produced in the stomach), and sucralfate (to treat an active duodenal ulcer. Sucralfate works mainly in the lining of the stomach and is not highly absorbed into the body.) medications.<br><br>2. The facility failed on 6/5/25 to ensure LVN G observed if Resident #161 took her docusate (stool softener used to treat constipation) and liquid protein (concentrated liquid protein supplement) medications.<br><br>These failures could place residents at risk for not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions.<br><br>The findings included:<br><br>1. Record review of Resident #171's admission Record, dated 6/6/25, revealed an [AGE] year-old female admitted on [DATE] with diagnoses of Type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood) with diabetic chronic kidney disease, wheezing, cough, end stage renal disease, malignant neoplasm of pancreas (Pancreatic cancer), and diverticulitis of intestine (inflammation of irregular bulging pouches in the wall of the large intestine).<br><br>Record review of Resident #171's admission MDS assessment, dated 5/31/25, revealed the resident's cognition was moderately impaired for daily decision making.<br><br>Record review of Resident #171's care plan, revised on 6/5/25, revealed the resident had an ADL self-care performance deficit and required limited assistance x1 by staff with personal hygiene and oral care.<br><br>Record review of Resident #171's physician order summary, dated 6/6/25, revealed orders for:<br><br>- Metoclopramide HCl Oral Tablet 10 MG give 1 tablet by mouth before meals and at bedtime for GERD, with a start date of 5/28/25 and no end date.<br><br>- Sucralfate Suspension 1 GM/10ML give 1 gram by mouth before meals for gastric protection, with a start date of 6/5/25, and no end date.<br><br>- Pantoprazole Sodium Oral Tablet Delayed Release 40 MG give 1 tablet by mouth two times a day for acid reflux, with a start date of 5/28/25, and no end date.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 6/5/25 at 8:03 a.m. RN F planned to administer medications to Resident #171. Resident #171 was sitting up in a chair and stated she was not able to sleep all night due to her stomach bothering her. RN F handed Resident #171 a medicine cup with the metoclopramide and pantoprazole in it. The resident held the medication cup in her hands and continued speaking to the nurse. RN F placed a medication cup with the liquid sucralfate in it on the resident's bedside table. RN F then stated he was running behind. RN F then left the resident's room without observing if she took the medications or not.<br><br>2. Record review of Resident #161's admission Record, dated 6/6/25, revealed a [AGE] year-old female admitted on [DATE] with diagnoses of gram negative sepsis (bacteria entering the blood stream), cellulitis of left limb (bacterial infection of the skin), and gout (a form of arthritis that causes sudden, sever pain and inflammation in one or more joints).<br><br>Record review of Resident #161's BIMS assessment, dated 5/28/25, revealed her cognition was fully intact.<br><br>Record review of Resident #161's care plan, initiated 5/28/25, revealed the resident had an ADL self-care performance deficit and required x2 staff for personal hygiene and oral care.<br><br>Record review of Resident #161's Physician orders, dated 6/6/25, revealed orders for:<br><br>- Protein Oral Liquid give 30 ml by mouth two times a day for supplement to promote wound healing, with a start date of 5/28/25, and no end date.<br><br>- Docusate Sodium Capsule 100 MG Give 1 capsule by mouth two times a day for constipation, hold for loose stools, with a start date of 5/28/25, and no end date.<br><br>During an observation on 6/5/25 at 9:07 a.m. LVN G planned to administer medications to Resident #161. LVN G handed Resident #161 a cup of pills. Resident #161 took the docusate pill out of the medicine cup and placed it on her bedside table. She stated she did not know if she wanted to take that one. Resident #161 then asked LVN G to split the other pills in half for her. LVN G split them in half and Resident #161 took them. LVN G mixed the protein liquid with water and left it on the resident's bedside table. It was unknown if the resident ever took the docusate or drank the liquid protein.<br><br>During an interview on 6/5/25 at 3:25 p.m. the DON stated staff had to observe residents taking their medications for patient safety and to make sure they are getting the treatments as ordered. The DON stated they did not have any residents who could administer their own medications.<br><br>Record review of the facility's document titled Medication Pass Competency Assessment revealed RN F completed assessments on 7/2/24 and LVN G completed assessments on 5/27/25. The competency stated . 17. The resident is observed to ensure the medication is swallowed and not left at the bedside .<br><br>(continued on next page) |

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| | 676216 | A. Building<br>B. Wing | 06/06/2025 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the facility's policy titled Medication Administration, dated 10/01/19, stated Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 2 of 3 medication cart (200 hall east and west carts) reviewed for labeling and storage of drugs.<br><br>1. The facility failed to ensure Resident #31's furosemide package directions matched the physician orders blood pressure parameters on the 200-hall east cart.<br><br>2. The facility failed to ensure 200-hall west medication cart was not left unlocked and out of sight from the nurse.<br><br>3. The facility failed to provide change direction labels for Resident #161's medication package of allopurinol which had medication order change from 100 mg (1 tablet) to 150 mg (1.5 tablets) on the 200-hall west cart.<br><br>This deficient practice could place residents at risk of medication misuse and diversion.<br><br>The findings were:<br><br>1. During an observation on 6/5/25 at 8:18 a.m. the 200-hall east medication cart contained Resident #31's furosemide. The pharmacy label stated furosemide 20 tablet give 1 by mouth. Call for SBP less than 10 or DBP less than 60 before administration.<br><br>Record review of Resident #31's physician orders, dated 6/5/25, revealed an order Furosemide Tablet 20 MG Give 1 tablet by mouth one time a day for CHF Contact MD for SBP<100 or DBP<60 before administering diuretic, with a start date of 5/23/25, and no end date.<br><br>During an interview on 6/5/25 at 8:46 a.m. RN F stated the label should say less than 110 or 100. He stated he would call the pharmacy if he was unsure, but he thought it should say less than 100. RN F stated he would always call the provider if it was less than 100.<br><br>2. During an observation on 6/5/25 at 8:59 a.m. the 200-hall-west cart was unlocked and unattended. LVN G was in a resident room with his back turned away from the cart in the hallway.<br><br>3. During an observation on 6/5/25 at 9:07 a.m. revealed the 200-hall west medication cart contained Resident #161's allopurinol. The pharmacy label stated 100 mg of allopurinol give 1 tablet by mouth daily.<br><br>Record review of Resident #161's physician orders, dated 6/6/25, revealed an order for Allopurinol Tablet 100 mg Give 1.5 tablet by mouth one time a day for Gout Give 1.5 tablet to equal 150mg, with a start date of 5/29/25, and no end date.<br><br>During an interview on 6/5/25 at 9:41 a.m. LVN G stated they could add a change direction label on the resident's medication, but he was unsure if they had any. LVN G stated he should keep his cart lock for patient safety.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 6/5/25 at 3:27 p.m. the DON stated staff should lock carts when they walk away to prevent anyone from taking something from it or moving things around. The DON stated the facility had stickers to put on the medication packages if there was a correction for the label or a change in direction sticker. The DON stated they also could obtain a new label from the pharmacy or verify the parameters for the medication in the EMR. The DON stated the medication package label should match the current orders to ensure patient safety and to ensure the nurse is triggered to check parameters for safe medication administration.<br><br>Record review of the facility's document titled Medication Pass Competency Assessment LVN G completed assessments on 5/27/25. The competency stated .10. The medication cart and medication room are free from any pre-poured medications .<br><br>Record review of the facility's policy titled Medication Administration-Medication Cart and Supplies for Administering Meds, dated 10/01/2019, stated .Med CARTS: 3. Do not leave the medication cart unlocked or unattended in the resident care areas . |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure each resident received, and the facility provided food prepared in a form designed to meet resident choices for 2 of 8 residents (Resident #24 and #172) and 1 of 1 kitchen reviewed for dietary needs.<br><br>The facility failed to ensure there was not a repetitive menu for the residents resulting in complaints about the lack of variety in food options.<br><br>This deficient practice could place residents at risk for poor food intake, weight loss, and not having their religious nutritional preferences met.<br><br>Record review of Resident #24's admission record, dated 06/03/25, reflected Resident #24 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include constipation.<br><br>Record review of Resident #24's admission MDS assessment, dated 04/20/25, reflected Resident #24 had a BIMS score of 09 out of 15, indicating moderate cognitive impairment. It reflected no weight changes in the past 6 months.<br><br>Record review of Resident #24's comprehensive care plan reflected problem The resident has nutritional problem or potential nutritional problem r/t refusal of meals . with goal The resident will maintain adequate nutritional status .<br><br>Record review of Resident #172's admission record, dated 06/06/25, reflected Resident #172 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses to include major depressive disorder and dementia (decline in cognitive functioning, including memory, thinking, and reasoning, to the extent that it interferes with daily life and activities).<br><br>Record review of Resident #172's admission MDS assessment, dated 05/19/25, reflected Resident #172 had a BIMS score of 12 out of 15, indicating moderate cognitive impairment. It reflected no weight changes in the past 6 months.<br><br>Record review of Resident #172's comprehensive care plan did not reflect anything related to food intake or diet.<br><br>Record review of facility's Week 1 through Week 5 Spring/Summer 2025 menu reflected every morning refried beans was on the menu.<br><br>It further revealed the following meals also included beans, which would have the residents eating beans 2 times a day on these days:<br><br>In Week 1, pinto beans were served in Thursday's lunch, red bean soup was served in Saturday's dinner, and refried beans were served in Sunday's dinner. This equated to 10 out of 21 meals in Week 1 including beans.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In Week 2, pinto beans were served in Tuesday's dinner. This equated to 8 out of 21 meals in Week 2 including beans.<br><br>In Week 3, refried beans were served in Wednesday's dinner, pinto beans were served in Saturday's lunch, and lentil soup was served in Sunday's dinner. This equated to 10 out of 21 meals in Week 3 including beans.<br><br>In Week 4, black beans were served in Wednesday's dinner, and 3 bean salad was served in Saturday's dinner. This equated to 9 out of 21 meals in Week 4 including beans.<br><br>In Week 5, pinto beans were served in Tuesday's lunch, pinto beans were served in Friday's dinner, and seasoned beans were served in Saturday's lunch. This equated to 10 out of 21 meals in Week 5 including beans.<br><br>Record review of grievance for Resident #24, dated 05/30/25, reflected he complained about too many beans being served on menu with a final resolution of updating tray care to reflect no beans.<br><br>Interview on 06/03/25 at 11:33 AM, Resident #24 revealed the facility served beans a lot and he had trouble with constipation and diarrhea, so he did not want to eat beans.<br><br>Interview on 06/04/25 at 10:04 AM, Resident #172 revealed the facility served beans too much.<br><br>Interview on 06/06/25 at 10:07 AM, the RD and CDM revealed there were some days where beans were served two times in a one day, because refried beans were served every morning. They revealed this was a new menu so they mentioned they would adjust the menu according to the feedback they had from the residents. They revealed if there were complaints, they would adjust the menu to not include certain items. The RD revealed she understood why someone would not want beans 2 times a day.<br><br>Interview on 06/06/25 at 12:37 PM, the ADM revealed they reviewed the menu before they used it in the facility. She revealed she was not aware there were beans in the menu 2 times in one day. She revealed she would get with the RD to find better alternatives because it would help to have a variety of foods in the menu.<br><br>Record review of facility's policy, Menu Planning, dated 06/01/19, reflected, The facility believes that nutrition is an important part of maintaining the well-being and health of its residents and is committed to providing a menu that is well-balanced, nutritious, and meets the preferences of the resident population.<br><br>No other policy was provided in regard to menus. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>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 for 1 of 1 kitchen.<br><br>The facility failed to label their food products with their respective discard dates.<br><br>These failures could place residents at risk for food borne illness.<br><br>The findings included:<br><br>Interview and observation on 06/03/25 at 09:55 AM, all packaged foods in the fridge, located off the tray line, had dates: 06/02/25 and 06/03/25 with no discard dates. The CDM and RD revealed they did not have to put the discard dates on the labels, but the kitchen staff knew to discard food products after 3 days.<br><br>Interview and observation on 06/04/25 at 11:10 AM, all packaged food in the fridge, located off the tray line, reflected prepared date and discard dates. The CDM and RD revealed they put discard dates on the labels just to be safe, but their policy did not tell them to put discard dates. They revealed they do follow the FDA Food Code. The RD revealed it could be helpful to put discard dates, so staff knew when to discard food products with a quick glance. The RD further revealed they did not have updated policies after the food code was updated in 2022.<br><br>Interview on 06/06/25 at 02:25 PM, [NAME] A revealed he did not write discard dates on food products for food storage in the refrigerators because they knew to throw the food out after 72 hours. He revealed he was in-serviced this week and he knew to write discard dates on food products that were stored in the refrigerator.<br><br>Record review of facility's policy Food Storage, revised June 1, 2019, reflected, 2. Refrigerators d. Date, label, and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. e. Use all leftovers within 72 hours. Discard items that are over 72 hours old.<br><br>Record review of the FDA Food Code 2022 reflected, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**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 disease and infection for 2 of 4 staff (RN F and LVN G) and 5 of 8 Residents (Resident #40, Resident #161, Resident #165, Resident #166, and Resident #217) reviewed for infection control:<br><br>1. The facility failed to ensure RN F sanitized the blood glucose monitor between use for Resident #166 and Resident #165.<br><br>2. The facility failed to ensure RN F did not touch pills with his bare hands and then administer the medication to Resident #40.<br><br>3. The facility failed to ensure RN F cleaned an insulin pen's rubber stopper with an alcohol swab prior to insulin administration for Resident #165.<br><br>4. The facility failed to ensure LVN G used a clean paper towel to turn of the sink after washing his hands during medication pass for Resident #161.<br><br>5. The facility failed to ensure Resident #217 was on EBP due to her surgical wound.<br><br>These failures could place residents at-risk for infection due to improper care practices.<br><br>The findings included:<br><br>1. During an observation on 6/5/25 at 8:25 a.m. RN F checked Resident #166's blood glucose. RN F then returned to his medication cart and placed the monitor on top of the cart. RN F did not sanitize the monitor and continued passing medications to other residents.<br><br>During an observation on 6/5/25 at 8:33 a.m. RN F used the same blood glucose monitor to check Resident #165's blood glucose. RN F did not sanitize the monitor before or after use.<br><br>During an interview on 6/5/25 at 8:48 a.m. RN F stated he should sanitize the blood glucose monitor between residents to prevent the spread of potential pathogens from staff to residents or from residents to residents.<br><br>2. During an observation on 6/5/25 at 8:30 a.m. RN F used his keys to open the medication cart, opened his medication cart, looked for a medication, touched his keyboard to look for an order on the computer, and then RN F dispensed a medication from a blister package for Resident #40. RN F grabbed the pill from the back of the package with is bare hand and put in it in medication cup. Resident #40 then took the pill.<br><br>During an interview on 6/5/25 at 8:50 RN F stated he was told he could touch pills with his fingers, and he did not need to wear gloves when handling medications. RN F stated on further thought he could have contaminated his hands prior and then touched the pill.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. During an observation on 6/5/25 at 8:33 a.m. RN prepared an insulin glargine (a long action insulin) pen injection for Resident #165. RN F stated he needed to prime the pen with 5 units of insulin prior. RN F then placed the needle on the pen and did not clean the rubber stopper area with an alcohol pad prior.<br><br>During an interview on 6/5/25 at 3:32 p.m. the DON stated staff should clean the glucose monitors with a wipe after each resident. The DON stated each cart had two monitors so they could clean one monitor, allow it to sit, meet the contact time with the cleaner, and use the other clean monitor in the meantime. The DON stated he thought the insulin pen should be cleaned prior to placing the needle on the end just like you would an insulin vial. The DON stated he did not think it specified in the insulin administration competency to clean the pen prior, but it would be important to ensure there is no cross contamination. The DON stated cleaning with an alcohol swab prior to placing the needle on the pen would ensure you remove any potential pathogens from the pen.<br><br>4. During an observation on 6/5/25 at 9:25 a.m. LVN G went into Resident #161's bathroom to wash his hands during medication administration. LVN G washed his hands at the sink and turned off the faucet with his barehand. LVN G then dried his hands with a paper towel. LVN G returned to his medication cart and split pills for Resident #161. LVN G then administered the medications to Resident #161. LVN G then returned to wash his hands at the sink and again turned off the faucet with his barehand.<br><br>During an interview on 6/5/25 at 9:41 a.m. LVN G stated the paper towels were across the room and not easily accessible when washing his hands. LVN G stated he should use a clean paper towel to turn off the faucet because there could be bacteria on the handle when he turned it to begin with.<br><br>During an interview on 6/5/25 at 3:36 p.m. the DON stated staff should use a clean paper towel to turn off the water to prevent infection.<br><br>5. Record review of Resident #217's Face Sheet, dated 6/6/25, reflected a [AGE] year-old female resident initially admitted to the facility on [DATE] with diagnoses of aftercare following a joint replacement surgery, presence of right artificial hip joint, and type 2 diabetes mellitus (a group of diseases that result in too much sugar in the blood).<br><br>Record review of Resident #217's BIMS Assessment, dated 6/2/25, reflected her cognition was fully intact for daily decision making.<br><br>Record review of Resident #217's Comprehensive Person-Centered Care Plan, revised on 6/5/25, reflected the resident was at risk for impaired skin integrity related to impaired mobility and recent surgical procedure/hospitalization. The interventions included conduct skin inspections / examinations weekly and as needed and document findings.<br><br>Record review of Resident #217's physician orders, dated 6/4/25, revealed orders for:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Wound care order: Right hip surgical site dressing with PICO drain (a device that provides negative pressure wound therapy to draw out excess fluid from a wound and protect the incision or wound.) is not to be removed until follow up is complete and or NPWT (negative pressure wound therapy) is complete. May change dressing if soiled and or dislodged. For treatment, refer to PRN order. If dressing change is provided, assess pain level pre and post treatment and every day shift, with an order date of 6/2/25, and no end date.<br><br>- Wound care order: Right hip surgical site dressing with PICO drain is not to be removed until follow up is complete and or NPWT is complete. May change dressing if soiled and or dislodged. For treatment, refer to PRN order. If dressing change is provided, assess pain level pre and post treatment and as needed, with an order date of 6/2/25, and no end date.<br><br>During an observation and interview on 6/3/25 at 9:52 a.m. Resident #217 stated she just had hip replacement surgery. She stated she had been assessed by therapy and had taken one shower since being admitted a few days prior. She stated a staff member helped her cover her surgical wound dressing with a waterproof dressing so she could shower. She stated no one had provided wound care since her admission because she had a wound vacuum device covering the surgical incision that was not supposed to get wet. She stated they would only do the wound care if it became dislodged. Resident #217's room did not have any signage for EBP.<br><br>During an interview on 6/5/25 at 3:18 p.m. the DON stated EBP was used for any wounds and no wounds were excluded unless they were minor skin tears or stage 1 pressure wounds with no skin breaks. The DON stated Resident #217 should be on EBP due to the potential of infection to her wound.<br><br>During a follow up interview on 6/6/25 at 9:51 a.m. the DON stated their policy for insulin administration stated the did not need to disinfect the insulin pen prior to placing the needle on the pen. The DON stated he thought the policy was acceptable.<br><br>Record review of insulin glargine infection 100 units/mL manufacturer guidelines, dated 08/22, stated .Step 2 . Wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle straight with the pen, and screw the needle on .<br><br>Record review of the facility's policy titled Medication Administration Injectable Administration, dated 10/01/19, stated Procedure . Clean stopper with alcohol pad and allow to air dry (except on pen devices and pre-filled syringes) .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676216 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Remington Transitional Care of San Antonio | 5423 Hamilton Wolfe Rd<br>San Antonio, TX 78229 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the facility's policy titled Enhanced Barrier Precautions, dated 4/5/24, stated Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines . 2. Initiation of Enhanced Barrier Precautions . b. An order for enhanced barrier precautions will be obtained for residents with any of the following:1. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO . 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. c. Ensure access to alcohol-based hand rub . 4. High-contact resident care activities include: a. Dressing b. Bathing . h. Wound care: any skin opening requiring a dressing 5. Enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility . Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk .<br><br>Record review of the facility's policy titled Hand Hygiene, dated 10/24/22, stated Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . 5.Hand hygiene technique when using soap and water . d. Rinse hands with water. e. Dry thoroughly with a single-use towel. f.Use clean towel to turn off the faucet . |