

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER Hunters Pond Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9903 Hunters Pond San Antonio, TX 78224	
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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess each resident using the quarterly review instrument specified by the State and approved by CMS in a timely manner for 5 of 9 residents (Resident #47, #60, #62, #131, and #153) reviewed for timely completion of MDS assessments. The facility failed to transmit an MDS assessment in a timely manner for Resident #47, #60, #62, #131, and #153. This failure could lead to residents not receiving necessary, complete, or correct care due to lack of current information. The findings included: 1. Record review of Resident #47's Face Sheet, dated 8/13/25, reflected an [AGE] year-old female resident initially admitted to the facility on [DATE] with diagnoses of spinal stenosis (narrowing of spinal canal), type 2 diabetes mellitus (high blood sugar levels due to insulin resistance), and lymphedema (swelling in various areas of the body). Record review of Resident #47's MDS assessments showed an annual MDS was in progress dated 7/31/25 and a Quarterly assessment was in progress dated 8/2/25. 2. Record review of Resident #60's Face Sheet, dated 8/13/25, reflected an [AGE] year-old male initially admitted [DATE] with the most recent admission on [DATE]. His diagnoses included cerebral infarction (known as ischemic stroke is brain tissue death caused by a blockage of blood flow to the brain), Type 2 Diabetes Mellitus without complications (high blood sugar levels due to insulin resistance) and unspecified dementia without behavioral disturbance (a form of dementia where the specific underlying cause isn't identified, and the individual does not exhibit behavioral symptoms). Record review of Resident #60's last completed MDS assessment reflected it was dated 4/05/25 with the next Quarterly MDS assessment due 7/11/25 showing "in progress". 3. Record review of Resident #62's Face Sheet, dated 8/13/25, reflected an [AGE] year-old female admitted to facility 12/19/24. Her diagnoses included Alzheimer's disease (degenerative brain disorder that primarily affects memory, thinking, and cognitive abilities), Type 2 Diabetes Mellitus with unspecified complications (high blood sugar levels due to insulin resistance with secondary health issues which are not specified in medical record), and adult failure to thrive (progressive decline in a person's physical and functional abilities characterized by poor appetite, weight loss, fatigue, and difficulty with daily activities). Record review of Resident #62's last completed MDS reflected it was dated 4/11/25 with the next Quarterly Assessment due 7/11/25 showing "in progress". 4. Record review of Resident #131's Face Sheet, dated 8/13/25, reflected a [AGE] year-old (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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	female resident initially admitted on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer's disease (degenerative brain disorder that primarily affects memory, thinking, and cognitive abilities) and cognitive communication deficit. Record review of Resident #131's MDS assessments showed a Quarterly MDS assessment was in progress dated 7/12/25. The last Quarterly MDS was completed on 4/11/25. 5. Record review of Resident #153's face sheet dated 8/13/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] and, 3/27/25 with diagnoses that included heart failure, chronic obstructive pulmonary disease (progressive lung disease that makes it hard to breathe), diabetes (chronic medical condition where the body either does not produce enough insulin or cannot use insulin effectively), acquired absence of left leg above the knee and stage 3 chronic kidney disease (condition in which the kidneys are moderately damaged). Record review of Resident #153's MDS assessments showed a Quarterly MDS assessment was overdue and dated 7/3/25. Resident #153's last Quarterly MDS was completed on 4/2/25. During an interview on 08/13/25 at 4:35 PM with the MDS Coordinator, all the MDS dates listed were reviewed. The MDS Coordinator acknowledged that some MDS Assessments had not been completed on time and she stated, "We will make sure they get done immediately." She said they only had 2 MDS Coordinators and each had taken time off in June and July so the MDSs did not get done on time. They also had a large number of admissions and discharges. Record review of Long-Term Care Facility Resident Assessment Instrument 3.0 User 's Manual Version 1.19.1, dated October 2024, [.] Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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, in that: 1. The facility failed to date and label drinks, close sandwich bags and date them, date and label salads, and label and date brown rice. 2. The facility failed to keep boxes of food off the freezer floor. 3. The facility failed to log temperatures for the PM shift of a reach in refrigerator on the 8/7/25, 8/8/25, and 8/9/25. 4. The facility failed to log the sanitizing sink temperature and chemical levels on 8/6/25, 8/7/2, 8/8/25, 8/9/25, and 8/10/25. 5. The facility failed to remove black and brown slimy growth from the ice machine. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: 1. During an observation on 8/10/25 at 9:36 a.m. 3 trays of various drinks were in the reach in fridge with no labels. There were two bags with sandwiches in them. The bags were open and not labeled. The walk-in fridge had two prepared salads that were not labeled. The dry food storage had a container labeled brown sugar and in the container was brown rice. 2. During an observation on 8/10/25 at 9:38 a.m. The walk-in freezer had boxes stacked on the floor. Three of the boxes were directly on the floor. 3. During an observation and record review on 8/10/25 at 9:35 a.m. there was a temperature log for the reach in refrigerator. The log did not contain temperature information or staff initials for 8/7/25, 8/8/25, 8/9/25 during the night shift. The temperature of the thermometer of the reach in refrigerator read 40 F at that time. 4. During an observation and record review on 8/10/25 at 9:44 a.m. there was a sanitizing sink log on the wall next to the 3-compartment dish washing sink. The log was not filled out during breakfast, lunch, or dinner shifts on 8/6/25, 8/7/25, 8/8/25, 8/9/25, and breakfast on 8/10/25. 5. During an observation on 8/10/25 at 9:43 a.m. the ice machine contained an unknown black and brown slimy substance inside the top of the ice machine and on the door mechanism. During an interview on 8/10/25 at 11:00 a.m. the Dietary Manager stated staff should have dated the drinks in the reach in fridge. The DM stated staff who prepare the drinks should place a label on them. The DM stated the two bags of sandwiches needed to be sealed and labeled to ensure they were not old or did not get hard. The DM stated all the salads in the walk-in fridge needed to be labeled and dated. The DM stated each day they prepared a few salads and any that were not used were placed in the walk-in fridge for future use. The DM stated if staff did not label the salads, they could mix them up from other days and not be able to tell what date they were prepared. The DM stated staff should not store food on the floor and she already had the staff take the boxes off the floor. The DM stated it was odd that the container of brown rice had a label that stated brown sugar, and she would discard the contents since they were unsure of the date the brown rice was added. The DM stated staff was expected to fill in the temperature and dish washing logs. The DM stated since it was over the weekend, and she was not there she was not able to remind staff to fill out the logs. The DM stated they were checking temps and the sanitizer levels but just forgot to fill out the log. The DM stated the ice machine should be thoroughly cleaned to prevent anything from contaminating the ice the residents used. During an interview on 8/13/25 at 4:17 p.m. the Administrator stated kitchen staff was responsible for cleaning the ice machine. The Administrator stated if the ice machine had some sort of contamination it would get on the ice and passed on to the residents. The Administrator stated boxes should be off the floor because contaminations could get on them. The Administrator stated staff was expected to label and date all foods and complete any logs in the kitchen to ensure equipment was functioning properly. The Administrator stated kitchen staff, and maintenance tried to clean the ice machine but were not able to get to parts under the door. The Administrator stated a company would come out to disassemble the ice machine and clean it. Kitchen policies were requested from the Dietary Manager on 8/13/25 at 2:05 p.m. The DM stated they used the food code for food storage and labeling. The DM stated maintenance could have policies for cleaning equipment. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM stated they did not have policies for the logs for the refrigerators or the sanitizers logs for the sink. Policies were requested from the Administrator and not provided at the time of exit.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which are complete; and accurately documented for 3 of 24 residents (Resident #135, #25, and #170) reviewed for documentation.1. Resident #135's MAR did not accurately reflect the nurse administered medications on 5/27/25 at 4:00 AM. 2. Resident #25's shower sheets and Task Bathing document did not accurately reflect the resident received a shower. 3. Resident #170's shower sheets and Task Bathing document did not accurately reflect the resident received a shower. These failures placed residents at risk for delayed or inaccurate medication administration and ADL assistance and could result in a decline in health, dignity, and well-being. The findings included:1. Record review of Resident #135's face sheet, dated 8/12/25, reflected resident was a female age [AGE] admitted on [DATE] with diagnoses that included: COPD (chronic obstructive pulmonary disease (lung disease) (primary), narcolepsy (sleeping disorder), dementia, GERD (digestive disorder resulting in acid reflux), Alzheimer's disease (progressive mental deterioration), acute kidney failure, and hypertension. The RP was listed as: self. Record review of Resident #135's Quarterly MDS dated [DATE] reflected the resident had a BIMS score of 11 indicative of mild impairment in cognition. Record review of Resident #135's MD orders dated August 2025 reflected order for Omeprazole Capsule Delayed Release 40 MG, once per day in the morning for GERD and Levothyroxine Sodium Tablet 175 MCG once in the morning for low thyroid hormone. Record review of Resident #135's MAR dated May 2025 reflected: on May 27, 2025 in the early morning medication given were: Levothyroxine (thyroid) was given at 4:00 AM initiated by LVN A and Omeprazole (GERD) at 4:00 AM given by LVN A. Record review of Resident #135's Nurse Statement dated 5/27/25 authored by LVN B reflected: around 4:30-4:50 AM she was contacted by another nurse [LVN A] to help awaken the resident and gave night medications. The resident was difficult to arouse and the medication to be given was for GERD and thyroid. The medication was to be given with apple sauce and not on an empty stomach. The resident took the medication with water. During an interview on 08/10/2025 at 3:59 PM, Resident #135 stated she had narcolepsy and [LVN B] administered medications to her on 5/27/25 at 4:00 AM and she (the resident) took the medication for GERD and thyroid. During an interview on 8/11/25 at 4:10 PM, LVN B stated: she gave the GERD and thyroid medication in a cup to the resident [Resident #135] on 5/27/25 at 4:00 AM and the resident swallowed the medication with water. Observation and interview on 8/12/25 at 11:17 AM, Resident #135 was in her room, eating a fruit and watching TV. Resident was in bed, cleaned and groomed and no injuries, bruises or skin tear present. The resident mood was one of pleasantness. The resident did not reveal any signs or symptoms of fear or anxiety. The resident stated that she suffered from narcolepsy (sleeping disorder), and she had difficulties awakening on 5/27/25 at 4:00 AM. Resident #135 stated that the nurse that gave her the GERD and thyroid medication was LVN B. During an interview on 8/12/25 at 12:05 PM, LVN B stated: LVN [A] tried to awaken the resident at 4:00 AM to give her GERD and thyroid medications as ordered by the MD but the resident would not awaken. LVN B stated that she agreed to awaken the resident and administer the night (early morning) medications. LVN B stated the resident awaken and took the medication herself with cold water. LVN B stated that she physically handed the medication to the resident. LVN B stated that the MAR needed to reflect who administered medications to maintain accuracy of records. LVN B stated that LVN [A] documented the MAR on 5/27/25 when it should have been her [LVN B] as the person documenting the MAR. LVN B stated that LVN [A] documented the MAR because she was the nurse on duty on the day of the incident. During an interview on 8/12/25 at 1:44 PM, the DON stated by nursing practice the MAR was documented by the nurse that gave a medication. The DON stated that on 5/27/25 the LVN B gave the medication to Resident #135, but the administration was documented by LVN A. The (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated, the scenario changed and the LVN B gave the medication to the resident and needed the resident to take the medication. The DON stated that LVN A documented seeing the resident taking the medication. The DON stated LVN A did document the MAR, but her intent was to document that she saw the resident taking the medication. During an interview on 8/12/25 at 2:12 PM, LVN A stated: she was present on 5/27/25 at 4:00 AM in Resident #135's room. LVN A stated that she had difficulties waking up the resident who had a diagnosis of narcolepsy and needed the resident to take her medication. LVN A stated given that LVN B was on site she requested assistance in trying to awaken the resident. LVN A stated, I was physically present and the resident eventually awaken upset and the medication was put in a cup on the bedside table with pudding and a spoon present. LVN A stated she saw the resident taking the medication with pudding that was handed in cup by LVN B. LVN A stated that by nursing practice the nurse that administered the medication was required to document the MAR and could not delegate to another nurse. LVN A stated that she was the nurse on duty and documented the MAR. LVN A stated I understand [to the question on the need for the MAR to reflect the nurse that gave the medication] During an interview on 8/12/25 at 2:47 PM, the Administrator stated that accuracy of clinical records falls under the purview of the Administrator. The Administrator stated that his expectation was that the person who administered medication was licensed and documented accurately. The Administrator stated he had no explanation why LVN B did not document the MAR on 5/27/25 at 4:00 AM. 2. Record review of Resident #25's face sheet dated 8/10/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included urinary tract infection, bacteremia (bacterial, infection in the blood stream), lack of coordination, retention of urine, colostomy status (surgical procedure in which a surgeon brings part of the large intestine [colon] through an opening in the abdominal wall that allows stool to leave the body and be collected in a colostomy bag) and muscle weakness. Record review of Resident #25's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and utilized an indwelling urinary catheter (flexible tube that is inserted through the urethra into the bladder to drain urine continuously) and colostomy. Record review of Resident #25's comprehensive care plan with revision date 1/8/25 revealed the resident had an ADL self-care performance deficit related to muscle weakness, poor mobility and endurance, cognitive impairment, colostomy status, depression, anxiety, and bed confinement with interventions that included to provide extensive assistance by one staff to provide a bath as necessary and provide a shower on Monday, and Friday per the resident's request. Resident #25's comprehensive care plan revealed the resident was resistive to care including refusing showers and ADL care with interventions that included to provide the resident with opportunities for choice during care provision. Record review of Resident #25's undated document, titled Task: Tuesday-Thursday-Saturday 6:00 pm -2:00 pm revealed the question: What type of bathing activity was completed? The Task document revealed: Not Applicable was checked on 7/31/25 (Thursday), 8/1/25 (Friday), 8/2/25 (Saturday), 8/3/25 (Sunday), 8/4/25 (Monday), 8/6/25 (Wednesday), 8/7/25 (Thursday), 8/8/25 (Friday), 8/10/25 (Sunday), 8/11/25 (Monday), 8/12/25 (Tuesday) and 8/13/25 (Wednesday). The Task document revealed Shower was checked on 8/5/25 (Tuesday) at 6:48 a.m., and Resident Refused was checked on 8/5/25 (Tuesday) at 9:07 p.m. Record review of Resident #25's Skin Observation document revealed the following:- 8/7/25 (Thursday): Refused Wants to shower Friday, cause he has a birthday party on Saturday. - 8/9/25 (Saturday): Refused- 8/12/25 (Tuesday): Shower During an observation and interview on 8/10/25 at 11:10 a.m. Resident #25 stated he was supposed to get a shower Saturday 8/9/25 but did not know why he was not given a shower. Resident #25 stated his shower days were on Tuesday, Thursday, and Saturday. Resident #25 stated he did not ask for a shower today, Sunday, 8/10/25 because it was not his shower day and stated, they'll probably say no because it's not my shower day. Resident #25 was observed wearing a hospital gown, and an indwelling urinary catheter bag was seen draining urine to gravity on the right side of the bed. Resident #25 was observed with a plastic wrist band on his left wrist. Resident #25 (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or others for 1 of 8 residents (Resident #111) reviewed for call light placement. The facility failed to ensure the call light was within reach for Resident #111. This deficient practice could place residents at risk of not receiving help as needed. The findings were: Record review of Resident #111's face sheet dated 8/13/25 revealed a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness affecting one side of the body) following cerebral infarction (type of stroke that occurs when blood flow to the brain is blocked) affecting the left non-dominant side, lack of coordination, and weakness. Record review of Resident #111's most current quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and was dependent on staff for transfers. Record review of Resident #111's comprehensive care plan with revision date 6/20/23 revealed the resident had an alteration in musculoskeletal status related to left sided hemiparesis and interventions that included to anticipate and meet the resident's needs and to be sure the call light was within reach and to respond promptly. During an observation and interview on 8/11/25 at 1:59 p.m. Resident #111 was sitting in the wheelchair in her room next to the bed. Resident #111 was heard yelling, nurse, help me! several times. Resident #111's call light had not been activated. Resident #111 stated she wanted to be put in bed and did not know where the call light was. Resident #111 stated she did not know how long she had been sitting in the wheelchair. CNA C and CNA D entered Resident #111's room and Resident #111 told them she wanted to get in bed. CNA C and CNA D stated, Resident #111's call light was clipped to the privacy curtain behind the resident, not within Resident #111's reach. Both CNA C and CNA D stated, Resident #111's call light should have been given to her when she was taken to her room. Both CNA C and CNA D stated the resident was probably taken to her room after lunch, which was over about 1:45 p.m. and they did not know who had helped the resident to her room. Both CNA C and D stated when Resident #111 was taken to the room, the call light should have been placed within the resident's reach to use in case she needed help and for safety purposes. CNA D stated, Resident #111's call light was used to notify the staff and instead she started yelling because she could not get hold of us. During a follow up interview on 8/13/25 at 8:28 a.m., CNA C stated she was unable to determine which staff had left Resident #111 sitting in the wheelchair at the bedside the previous day on 8/12/25. During an interview on 8/13/25 at 3:38 p.m., the DON stated Resident #111 liked to be put in bed as soon as lunch was over. The DON stated they could not determine who left the resident at the bedside without the call light on 8/11/25. The DON stated, Resident #111's call light should be within reach, and it was needed to ask for assistance. The DON stated, the call light needed to be accessible to residents in case there was an accident. Record review of the facility document titled, Care and Treatment, ADL's & Staffing with revision date 5/2020 revealed in part, .It is the policy of this facility to ensure the safety and comfort of the resident and to assist in continuity of care and to identify potential change in condition. Staffing is assigned due to the acuity in the facility. Observed Resident for Privacy, Dignity and Safety. Ensure Call Light is within reach or attached to resident (if indicated) .		

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NAME OF PROVIDER OR SUPPLIER Hunters Pond Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9903 Hunters Pond San Antonio, TX 78224	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 6 residents (Resident #25) reviewed for personal hygiene. The facility failed to provide Resident #25 with scheduled showers between 7/31/25 to 8/4/25, and 8/6/2025 to 8/8/25, and 8/10/25 to 8/13/25. This failure could place residents who require assistance from staff for personal hygiene at risk of not receiving care and services contributing to overall poor hygiene, risk of experiencing a diminished quality of life, and possible skin infections. The findings included: 1. Record review of Resident #25's face sheet dated 8/10/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included urinary tract infection, bacteremia (bacterial, infection in the blood stream), lack of coordination, retention of urine, colostomy status (surgical procedure in which a surgeon brings part of the large intestine [colon] through an opening in the abdominal wall that allows stool to leave the body and be collected in a colostomy bag), and muscle weakness. Record review of Resident #25's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills and utilized an indwelling urinary catheter (flexible tube that is inserted through the urethra into the bladder to drain urine continuously) and colostomy. Record review of Resident #25's comprehensive care plan with revision date 1/8/25 revealed the resident had an ADL self-care performance deficit related to muscle weakness, poor mobility and endurance, cognitive impairment, colostomy status, depression, anxiety, and bed confinement with interventions that included to provide extensive assistance by one staff to provide a bath as necessary and provide a shower on Monday, and Friday per the resident's request. Resident #25's comprehensive care plan revealed the resident was resistive to care including refusing showers and ADL care with interventions that included to provide the resident with opportunities for choice during care provision. Record review of Resident #25's undated document, titled Task: Tuesday-Thursday-Saturday 6:00 am -2:00 pm revealed the question: What type of bathing activity was completed? The Task document revealed: Not Applicable was checked on 7/31/25 (Thursday), 8/1/25 (Friday), 8/2/25 (Saturday), 8/3/25 (Sunday), 8/4/25 (Monday), 8/6/25 (Wednesday), 8/7/25 (Thursday), 8/8/25 (Friday), 8/10/25 (Sunday), 8/11/25 (Monday), 8/12/25 (Tuesday) and 8/13/25 (Wednesday). The Task document revealed Shower was checked on 8/5/25 (Tuesday) at 6:48 a.m., and Resident Refused was checked on 8/5/25 (Tuesday) at 9:07 p.m. Record review of Resident #25's Skin Observation document revealed the following: - 8/7/25 (Thursday): Refused Wants to shower Friday, cause (sic) he has a birthday party on Saturday. - 8/9/25 (Saturday): Refused- 8/12/25 (Tuesday): Shower Resident #25's Skin Observation documents dated 7/31/25 to 8/4/25 were not provided. During an observation and interview on 8/10/25 at 11:10 a.m. Resident #25 stated he was supposed to get a shower Saturday 8/9/25 but did not know why he was not given a shower. Resident #25 stated his shower days were on Tuesday, Thursday, and Saturday. Resident #25 stated he did not ask for a shower today, Sunday, 8/10/25 because it was not his shower day and stated, they'll probably say no because it's not my shower day. Resident #25 was observed wearing a hospital gown, and an indwelling urinary catheter bag was seen draining urine to gravity on the right side of the bed. Resident #25 was observed with a plastic wrist band on his left wrist. Resident #25 stated he had recently been in the hospital and had been diagnosed with a urinary tract infection. Resident #25 had short cut hair, and it appeared greasy. Resident #25 stated he required help with transfers to get into the shower but was able to shower himself. During a follow up interview on 8/11/25 at 8:33 a.m., Resident #25 stated he did not get a shower yesterday, Sunday 8/10/25 and did not ask for one. Resident #25 stated he was scheduled to get a shower tomorrow, Tuesday 8/12/25. During an interview on 8/12/25 at 9:09 a.m., Resident #25 stated he had not received a (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower in four days and wanted to take a shower today, Tuesday 8/12/25. Resident #25 stated he was supposed to get a shower on Saturday 8/9/25 but was told by staff that they had too many to shower that day and did not have time for him. During an interview and record review on 8/12/25 at 11:08 a.m., CNA C stated she was supposed to complete the Task document for bathing activities, which was used to document the type of bath given and whether the resident refused. CNA C stated, in addition to completing the Task document, a shower sheet (Skin Observation Document) was also supposed to be completed. CNA C stated, after she reviewed Resident #25's Task document, the Not Applicable feature was not supposed to be checked because it indicated the task did not occur. CNA C stated, the Task document had a feature that allowed for the aides to document Resident Refused, and checking Not Applicable implied the resident did not get a shower/bath. CNA C stated, the aides needed to document the resident refused if the resident truly refused a shower/bath. CNA C stated, based on the documentation reviewed on Resident #25's Task document, it could not be determined whether the resident received a shower. CNA C stated Resident #25 had shower refusals, but when he did decide to get a shower, he usually did not want to get out and had to be prompted and talked out of the shower. CNA C stated she believed Resident #25 would like to get a shower when he wanted one and if he didn't it probably made him feel dirty. CNA C stated, it appeared Resident #25 last received a shower on 8/5/25 and did not receive a shower on 8/8/25 per the resident's request. During an interview and record review on 8/13/25 at 10:14 a.m., RN F stated, if a resident refused to shower, the CNA staff were supposed to notify the nurse and then the nurse would verbally prompt the resident. If the resident initially refused, and asked to shower later, that information would be passed on to the next shift. RN F stated shower refusals were documented on the shower sheets (Skin Observation Document) and the nurse was supposed to document the refusal in a progress note. RN F stated, after reviewing the Task document for Resident #25, it appeared if the aide marked not applicable on the document it implied the shower wasn't done. During an interview and record review on 8/13/25 at 3:44 p.m., the DON stated, if a resident refused a shower, the aide reported to the nurse and the nurse was supposed to encourage the resident. The DON stated, if the resident did not get a shower, the CNA was supposed to complete the shower sheet and indicate on the shower sheet and the Task document the resident refused. The DON stated, with the bathing task, it had to be assigned, and the task had to be documented otherwise it showed the resident was not getting a shower. Record review of the facility document titled, Care and Treatment, ADL's & Staffing, with revision date 5/2020 revealed in part, .It is the policy of this facility to ensure the safety and comfort of the resident and to assist in continuity of care and to identify potential change in condition, Staffing is assigned due to the acuity in the facility. Note Resident to Ensure Grooming and Dressing has been Completed. Provide ADL Care as Scheduled or Needed. Perform/Provide Showers and Bed Baths as Scheduled/Document as Indicated.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 of 2 dumpsters (Dumpster #1) reviewed for disposal of garbage. The facility failed to ensure Dumpster #1 was closed and trash was not on the ground outside the dumpster. This deficient practice could place residents at risk for exposure to germs and diseases carried by vermin and rodents. The findings were: During an observation on 8/10/25 at 9:32 a.m. revealed the side door to dumpster #1 was open. On the ground beside the dumpster was a wipe, a used glove, and plastic wrapper. During an interview on 8/13/25 at 9:30 a.m. the Dietary Manager stated the dumpster should not be open because it can attract rodents or pest. During an interview on 8/13 at 4:17 p.m. the Administrator stated staff is expected to keep the dumpster closed and trash off the ground. A trash policy was requested from the DM and the Administrator on 8/13/25 and not provided.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 1 of 8 residents (Resident #47) reviewed for infection control: The facility failed to ensure the treatment nurse did not touch her personal cell phone and then grab a handful of clean gloves while preparing supplies to clean Resident #47's pressure wound. These failures could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #47's Face Sheet, dated 8/13/25, reflected an [AGE] year-old female resident initially admitted to the facility on [DATE] with diagnoses of spinal stenosis (narrowing of spinal canal), type 2 diabetes mellitus (high blood sugar levels due to insulin resistance), and lymphedema (swelling in various areas of the body). Record review of Resident #47's quarterly MDS assessment, dated 4/1/25, reflected her cognition was fully intact for daily decision making. Section M revealed the resident had 1 unhealed pressure ulcer. Record review of Resident #47's Comprehensive Person-Centered Care Plan, revised on 1/7/25, reflected the resident had a stage 4 pressure ulcer to sacrum related to history of ulcers and immobility with interventions to administer treatments as ordered and monitor for effectiveness. Record review of Resident #47's physician orders, dated 6/23/25, revealed orders for: - Wound care to sacrum Pressure Injury M-W-F and PRN: cleanse with wound cleanser, pat dry with gauze, apply PolyMem (dressing) to wound bed and secure with bordered foam dressing assess for pain pre, mid and post wound care every day shift every Mon, Wed, Fri for stage 4 pressure injury. Record review of Resident #47's skin assessment, dated 8/8/25, revealed the resident had a stage 4 2.5 cm x 2.5 cm x 2.0 cm with 1.5 cm of undermining (erosion beneath the wound edges) sacrum pressure wound During an observation on 8/13/25 at 10:05 a.m. LVN G prepared supplies to provide wound care to Resident #47. LVN G set up some supplies on a bedside table. LVN G then reached in her pocket and grabbed her cell phone and placed it on the side of the treatment cart. LVN G did not sanitize her hands and then grabbed a handful of gloves from a box and placed them on the bedside table. LVN G then provided wound care to Resident #47's open pressure wound with the gloves she placed on the bedside table after touching her cell phone. During an interview on 8/13/25 at 10:43 a.m. LVN G stated she thought she sanitized her hands after touching her phone but if she had not then she would have contaminated the gloves she touched after touching her phone. During an interview on 8/13/25 at 3:23 p.m. the DON stated she was not there and could not say if LVN G contaminated the gloves after touching her phone and not sanitizing her hands between. The (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated it was unlikely that every glove would be contaminated if LVN G had touched her phone, not sanitized her hands, and grabbed a handful of gloves from a box to use for wound care. The DON stated if they were contaminated the resident would be a risk of infection. Record review of the facility's policy titled Infection Control Prevention and Control Program-Hand Hygiene, No date, stated Policy This facility considers hand hygiene the primary means to prevent the spread of infections. 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 4. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: &hellip; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites); &hellip; g. Before handling clean or soiled dressings, gauze pads, etc.; &hellip;K. After handling used dressings, contaminated equipment, etc.&hellip;&rdquo;		