

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/05/2025
NAME OF PROVIDER OR SUPPLIER  The Enclave		STREET ADDRESS, CITY, STATE, ZIP CODE 18803 Hardy Oak San Antonio, TX 78258	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26481</p> <p>Based on interview and record review the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 4 of 5 residents (Resident #1, #2, #4, and #5) reviewed for accuracy of records.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure Resident #1's bath or shower was documented as given or as refused 9 times in April and May 2025.</li> <li>The facility failed to ensure Resident #2's bath or shower was documented as given or as refused 6 times in April and May 2025.</li> <li>The facility failed to ensure Resident #4's bath or shower was documented as given or as refused 11 times in April and May 2025.</li> <li>The facility failed to ensure Resident #5's bath or shower was documented as given or as refused 8 times in April and May 2025.</li> </ol> <p>These failures could place residents at risk for improper care due to inaccurate records.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Record review of Resident #1's Admission Record (face sheet) dated 05/04/2025 revealed she was admitted to the facility on [DATE] with diagnoses which included heart failure, stroke, hemiparesis (partial weakness on one side of the body), hemiplegia (partial paralysis on one side of the body), high blood pressure, memory deficit following stroke, and vascular dementia (brain damage caused by decreased blood flow).</li> </ol> <p>Record review of Resident #1's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 10 out of 15, indication her cognitive skills for daily decision making were moderately impaired; and the resident was dependent on staff to be showered or bathed.</p> <p>Record review of Resident #1's Care Plan for Self-Care deficit related to hemiplegia and hemiparesis, initiated on 09/09/2024 and revised on 03/21/2025, revealed under interventions the resident would be showered 2-3 times weekly by the CNA.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's undated Kardex revealed the resident preferred to be bathed 2-3 times a week.</p> <p>Record review of Resident #1's nurses' notes from 04/04/2025 to 05/04/2025 revealed no notation of Resident #1 had refused to be bathed.</p> <p>Record review of the undated Shower Schedule revealed Resident #1 was to be bathed on Monday, Wednesday, and Friday on the 6 am - 2 pm shift.</p> <p>Record review of Resident #1's electronic clinical record for the Bathing Task from 04/03/2025 to 05/03/2025 revealed Resident #1 had only been bathed 5 times on 04/08/2025, 04/15/2025, 04/22/2025, 04/24/2025, and 04/29/2025; there was no documentation the resident had refused to be bathed; and there was no documentation if Resident #1 was bathed or refused on her scheduled shower days on 04/03/2025, 04/05/2025, 04/10/2025, 04/12/2025, 04/17/2025, 04/19/2025, 04/26/2025, 05/01/2025, and 05/03/2025.</p> <p>In an interview on 05/04/2025 at 5:04 PM, the DON stated she spoke with the CNAs who were to have bathed Resident #1 on 04/03/25, 04/05/2025, 04/10/2025, 04/12/2025, 04/17/2025, 04/19/2025, 04/26/2025, 05/01/2025, and 05/03/2025 who reported the resident was bathed on 04/03/2025, 04/05/2025, 04/10/2025, and 04/19/2025 but had refused to be bathed on the other days (04/12/2025, 04/17/2025, 04/26/2025, 05/01/2025, and 05/03/2025). The DON said if a resident refused to be bathed, the CNA should document it in the Point of Contacts Tasks and inform the nurse.</p> <p>In a further interview on 05/04/2025 at 5:23 PM, the DON said the nursing staff should document in the nurses' progress notes if a resident had refused to be bathed.</p> <p>In a further interview on 05/05/2025 from 12:01 PM to 12:25 PM, the DON said after she spoke with the CNAs who worked the days the resident was to have been showered, Resident #1 had refused to be bathed on 04/12/2025, 04/17/2025, 04/26/2025, and 05/01/2025 and confirmed it was not documented in the resident's electronic Point of Care Tasks the resident had refused to be bathed.</p> <p>2. Record review of Resident #2's Admission Record (face sheet) dated 05/04/2025 revealed he was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included morbid obesity (excessive body weight), cognitive communication deficit (difficulty communicating), stroke, hemiparesis (partial weakness on one side of the body caused by the stroke), hemiplegia (partial paralysis on one side of the body caused by the stroke), and high blood pressure.</p> <p>Record review of Resident #2's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 10 out of 15, indication his cognitive skills for daily decision making were moderately impaired; and the resident was dependent on staff to be showered or bathed.</p> <p>Record review of Resident #2's Care Plan for Self-Care deficit related to hemiplegia and hemiparesis, initiated on 06/21/2023 and revised on 07/14/2024, revealed under interventions the resident would be showered 2-3 times weekly by the CNA.</p> <p>Record review of Resident #2's undated Kardex revealed the resident preferred to be bathed 2-3 times a week.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's nurses' notes from 04/04/2025 to 05/04/2025 revealed no notation of Resident #2 had refused to be bathed.</p> <p>Record review of the undated Shower Schedule revealed Resident #2 was to be bathed on Monday, Wednesday, and Friday on the 6 am - 2 pm shift.</p> <p>Record review of Resident #2's electronic clinical record for Bathing Tasks from 04/03/2025 to 05/03/2025 revealed Resident #2 had only been bathed 6 times on 04/09/2025, 04/14/2025, 04/18/2025, 04/21/2025, 04/23/2025, and 04/25/2025; and it was not documented if Resident #2 was bathed or had refused on his scheduled shower days on 04/11/2025, 04/16/2025, 04/18/2025, 04/28/2025, 04/30/2025, and 05/02/2025.</p> <p>In an interview on 05/04/2025 at 5:02 PM, the DON stated she spoke with the CNA who was to have bathed Resident #2 on 04/30/25 and 05/02/2025 who reported the resident was bathed on those days but not recorded in his electronic clinical record.</p> <p>In a further interview on 05/05/2025 from 12:01 PM to 12:25 PM, the DON said she spoke to the CNAs who were to shower Resident #2, and they had showered him on 04/11/25, 04/16/2025, 04/18/2025 and on 04/28/2025 but it was not documented that he had received the shower. The DON stated Resident #2's family member would reach out to her if he was not showered, and they did not contact the DON about the resident's showers in April.</p> <p>3. Record review of Resident #4's Admission Record (face sheet) dated 05/04/2025 revealed he was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (irregular heartbeat), heart failure, high blood pressure, morbid obesity (excess body weight) and muscle weakness.</p> <p>Record review of Resident #4's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 14 out of 15, indication his cognitive skills for daily decision making were intact; and the resident was dependent on staff to be showered or bathed.</p> <p>Record review of Resident #4's Care Plan for Self-Care deficit related to weakness and debility, initiated on 12/20/2024 and revised on 12/26/2024, revealed under interventions the resident would be showered 2-3 times weekly by the CNA.</p> <p>Record review of Resident #4's undated Kardex revealed the resident preferred to be bathed 2-3 times a week.</p> <p>Record review of Resident #4's nurses' notes from 04/04/2025 to 05/04/2025 revealed no notation of Resident #4 had refused to be bathed.</p> <p>Record review of the undated Shower Schedule revealed Resident #4 was to be bathed on Monday, Wednesday, and Friday on the 6 am - 2 pm shift.</p> <p>Record review of Resident #4's electronic clinical record for Bathing Tasks from 04/03/2025 to 05/03/2025 revealed Resident #4 had only been bathed 2 times on 04/09/2025, and 04/23/2025; refused to be bathed on 04/11/2025; and it was not documented if Resident #4 was bathed or refused on his scheduled shower days on 04/02/2025, 04/04/2025, 04/07/2025, 04/09/2025, 04/16/2025, 04/18/2025, 04/21/2025, 04/25/2025, 04/28/2025, 04/30/2025, and 05/02/2025.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/04/2025 at 5:04 PM, the DON stated she spoke with the CNA who were to bath Resident #4 on 04/04/2025, 04/16/2025, 04/18/2025, 04/21/2025, 04/25/2025, and 04/30/2025 who reported the resident had been bathed.</p> <p>In an interview on 05/05/2025 at 12:45 p.m., the DON stated she spoke with the CNAs who were to shower Resident #4 on 04/02/2025, 04/07/2025, and 04/09/2025 who reported the resident was bathed but it was not documented in the electronic Point of Care Tasks. The DON reported the resident had refused to be bathed on 04/28/2025 and on 05/02/2025 but it was not documented in his clinical record.</p> <p>4. Record review of Resident #5's Admission Record (face sheet) dated 05/04/2025 revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included heart failure, stroke, high blood pressure, kidney failure, lymphedema (swelling caused a lymphatic system blockage) and muscle wasting and atrophy (progressive loss of muscle mass, strength, and power).</p> <p>Record review of Resident #5's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 12 out of 15, indication her cognitive skills for daily decision making were moderately impaired; and the resident was dependent on staff to be showered or bathed.</p> <p>Record review of Resident #5's Care Plan for Self-Care deficit related to muscle wasting and atrophy, initiated on 12/01/2023 and revised on 05/03/2025, revealed under interventions the resident would be showered 2-3 times weekly by the CNA.</p> <p>Record review of Resident #5's undated Kardex revealed the resident preferred to be bathed 2-3 times a week.</p> <p>Record review of Resident #5's nurses' notes from 04/04/2025 to 05/04/2025 revealed no notation of Resident #5 had refused to be bathed.</p> <p>Record review of the undated Shower Schedule revealed Resident #5 was to be bathed on Tuesday, Thursday, and Saturday on the 6 am - 2 pm shift.</p> <p>Record review of Resident #5's electronic clinical record for Bathing Tasks from 04/03/2025 to 05/03/2025 revealed Resident #5 had only been bathed 6 times on 04/05/2025, 04/08/2025, 04/12/2025, 04/17/2025, 04/22/2025, and 04/29/2025; had not refused to be bathed; and it was not documented if Resident #5 was bathed or had refused on her scheduled shower days on 04/03/2025, 04/10/2025, 04/15/2025, 04/19/2025, 04/24/2025, 04/26/2025, 05/01/2025, and 05/03/2025.</p> <p>In an interview on 05/04/2025 at 5:04 PM, the DON stated she spoke with the CNAs who were to have bathed Resident #5 on 04/10/2025 and 04/26/2025 and who reported they had bathed the resident.</p> <p>In an interview on 05/05/2025 at 2:43 PM, the DON stated she spoke with the CNAs who were to have bathed Resident #5 on 04/03/2025, 04/15/2025, 04/19/2025 and 04/24/2025 who reported the resident was bathed on those days, but it was not documented. The DON said Resident #5 had refused to be bathed on 05/01/2025 and 05/03/2025 but it was not documented that she had refused.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/05/2025 at 2:08 PM, the Administrator said it should be recorded in the residents' clinical record if they had received a bath or had refused the shower. The Administrator stated if it wasn't recorded in the residents' clinical record the resident was bathed or had refused to be bathed, then it would be inaccurate documentation and he could not think of any harm to the resident.</p> <p>Record review of the Medical Records policy, revised January 2023, revealed A medical record is maintained for every person admitted to a community in accordance with accepted professional standards and practices. The administrator has ultimate responsibility for the maintenance of medical records but may delegate this responsibility to another team member. The medical record consists of but not limited to the following: information to identify the resident, a record of the resident's assessments, the plan of care and services provided, the results of any preadmission screening conducted by the state and progress notes.</p>		