

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  07/24/2025
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)
F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.  (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 4 residents (Resident #2) reviewed for pharmacy services. LVN A did not administer Resident #2's Famotidine (Pepcid) 10 mg oral one tablet a day for indigestion on 07/20/2025 because she could not find the medication in the medication cart where it was stored. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings were: Record review of Resident #2's admission Record (Face Sheet), dated 07/21/2025, revealed she was [AGE] years old, was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia (decline in mental ability which can interfere with daily life) and GERD without esophagitis (a chronic condition when stomach acid flows back into the esophagus causing symptoms such as heartburn, regurgitation, and can cause irritation to the esophagus/throat). Record review of Resident #2's MDS, a Quarterly assessment dated [DATE], revealed a BIMS score of 11 out of 15 indication her cognitive skills for daily decision making were moderately impaired. Record review of Resident #2's Care Plan for I have impaired cognitive function/impaired thought process related to dementia initiated 07/27/2023 and for I am at risk for nutritional deficits and or dehydration risks related to diagnosis. GERD initiated 2/26/25, reflected interventions listed which included Administer medications as ordered. Record review of Resident #2's Physician Order Summary, dated 07/21/2025, revealed an order for Famotidine (Pepcid - a medication to treat GERD, heartburn) oral tablet 10 mg give 1 tablet by mouth one time a day for indigestion. Record review of Resident #2's July 2025 MAR revealed on 07/20/2025 the Pepcid/Famotidine 10 mg was not administered by LVN A, and she had coded 9 other: Nurse Verbally Informed. Observation and interview on 07/20/2025 from 10:33 AM to 10:41 AM of LVN A's medication administration to Resident #2, revealed LVN A did not administer Famotidine 10 mg to Resident #2. LVN A stated Resident #2 was to receive Pepcid (Famotidine) 10 mg one tablet once a day, but she didn't have the medication. LVN A looked through the OTC medication bottles in the top drawer of the medication cart, and stated the medication was there yesterday (07/19/2025) when she gave it to Resident #2, but she could not find it today. LVN A locked the medication cart, went into the medication room, came out of the medication room and said the medication was not in there. LVN A then logged into her computer, stated she just ordered it from the pharmacy, and it would be delivered to the facility later in the afternoon. LVN A stated the medication was listed as an OTC medication on the order which was why it wasn't refilled. LVN A then administered the other medications she had prepared to Resident #2 and informed Resident #2 the Pepcid/Famotidine 10 mg was not available, but she had ordered it from the pharmacy. Observation and interview on 07/21/2025 at 8:41 AM with LVN B, who was Resident #2's nurse on 07/21/2025, revealed when she looked through the medication cart for the new blister package of Pepcid/Famotidine 10 mg, she stated it was not delivered yesterday (07/20/2025). LVN B stated when she gave Resident #2 the Pepcid/Famotidine 10 mg, she obtained the medication from an OTC box that was kept with the OTC medication bottles in the top drawer of the medication cart; and showed the surveyor the opened box of Pepcid/Famotidine 10 mg stored in the top draw of the medication cart that she removed the medication from. In an interview on 07/21/2025 at 3:53 PM, the DON stated medications would be ordered from the pharmacy in advance so the resident did not run out of medications and the nurses could pull medications from the Pixis machine (a machine with single doses of assorted medications) so they would be available to the resident. The DON stated there would be no harm to a resident if they missed one dose of Pepcid. In an interview on 07/21/2025 from 5:45 PM to 6:10 PM, the Administrator stated the harm to a resident if they didn't receive their medication would depend on the medication and if the medication was an anti-reflux medication it could cause the possibility of acid reflux in the resident. Record review of the facility's Medication Administration policy, revised January 2024, revealed Resident medications are administered in an accurate, safe, timely, and sanitary manner. 6. administer medications as ordered by the physician. Routine medications shall be administered according to the established medication administration schedule for the community.</p>		