

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 06/28/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 44020</p> <p>Based on observation, interview and record review the facility failed to ensure residents received services in the facility with reasonable accommodation of resident needs for 2 of 23 Residents (Resident #4 and Resident #49) who were observed for call light placement.</p> <p>Nursing staff failed to ensure the call light was within reach for Resident #4 and Resident #38.</p> <p>This deficient practice could affect any resident and keep them from calling for help as needed.</p> <p>The findings were:</p> <p>1. Review of Resident #4's face sheet, dated 6/28/24, revealed she was admitted to the facility on [DATE] with diagnoses including Aphasia following Cerebral Infarction, other recurrent Depressive Disorders and Persistent Mood (Affective) Disorder.</p> <p>Review of Resident #4's quarterly MDS assessment, dated 2/8/24, revealed Resident #4 was usually understood and usually understood, her BIMS was 11 out of 15 reflecting moderate cognitive impairment and she required assistance with all ADL's by 1 to 2 person's except for eating.</p> <p>Review of Resident #4's Care Plan, revised 1/25/24, revealed she was at risk for falls related to muscle wasting and atrophy, impaired mobility and chronic pain. One of the interventions was to anticipate and meet her needs and to keep the call bell was within reach. Further review revealed Resident #4 required assistance with all ADL's by 1 or 2 person's except for eating.</p> <p>Observation and interview on 6/25/24 at 10:38 AM revealed Resident #4 was sitting up in bed with the HOB at 45 degrees watching TV and snacking. Resident #4's speech was slurred. She asked for a soda out of the refrigerator and asked for it to be poured in her glass which she pointed to on the countertop. Resident #4 was asked how she would usually call for staff's help. Observed Resident #4 looking around her bed. Further observation revealed the call light was on top of the nightstand behind Resident #4; out of her sight and out of reach.</p> <p>Interview on 6/25/24 at 10:45 AM with LVN R and LVN S revealed LVN S stated the call light was on the nightstand and not within Resident #4's reach. She stated it should be because Resident #4 used it regularly to get staff's assistance.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #49's face sheet, dated 06/27/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: neurocognitive disorder with Lewy bodies, age-related osteoporosis without current pathological fracture, overactive bladder, bipolar disorder, current episode mixed, mild, and Parkinson's disease with dyskinesia with fluctuations.</p> <p>Record review of Resident #49's Quarterly MDS assessment, dated 06/11/2024, revealed the resident's BIMS score was 05, which indicated severe cognitive impairment. The Quarterly MDS assessment further revealed Resident #49 required substantial/maximal assistance (helper does more than half the effort) for upper body dressing, lower body dressing, putting on/taking off footwear, sit to stand, chair/bed-to-chair transfer, and dependent (helper does all of the effort) with personal hygiene.</p> <p>Record review of Resident #49's care plan, revision date of 05/28/2024, revealed Resident #49 had a focus of I am at risk for falls r/t: Debility & Weakness, Parkinson's, osteoporosis . and interventions revealed to anticipate & meet needs & keep call bell within reach.</p> <p>Observation on 06/25/2024 at 11:11 a.m. revealed Resident #49 sleeping in her wheelchair on the opposite side of the bed from her call light which was pinned to Resident #49's bed cover.</p> <p>Observation and interview on 06/26/2024 at 9:20 a.m. revealed Resident #49 sitting again on the opposite side of her bed with her over bed table in front of her. Resident #49 stated her button was used when she needed help or someone. Resident #49 further stated she was not able to reach it all the way over there.</p> <p>During an interview and observation on 06/26/2024 at 9:25 a.m. CNA W stated she was not sure if Resident #49 would use her call light as she had not seen Resident #49 use her call light. CNA W revealed Resident #49's call light was placed where she would not be able to reach. CNA W then reached down and moved the call light closer to Resident #49.</p> <p>During an interview on 06/28/2024 at 11:35 a.m. ADON H revealed all call lights should be placed near the residents. ADON H further stated all staff were responsible for call light placement.</p> <p>During an interview on 06/28/2024 at 2:44 p.m. with the social worker she revealed Resident #49 was able to use her call light.</p> <p>During an interview on 06/28/2024 at 4:04 p.m. with the DON revealed she had not recently asked Resident #49 to demonstrate the ability to use her call light however, in the past she had been able to demonstrate that she was able to use it when she asked. The DON further stated the call light should be within reach of the resident and the importance of a call light was so residents could notify the nurse if they needed something.</p> <p>Record review of the facility's Routine Resident Care policy, review date January 2023, revealed under Compliance Guidelines: Residents should receive the necessary assistance to maintain good grooming and person/oral hygiene.Care is taken to maintain resident safety at all times. Guidelines: #8 Resident call lights should be answered timely and resident requests are addressed, if permitted. Call lights should be placed within easy reach of the resident .</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 44020</p> <p>Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident's status for 2 of 10 Residents (Resident #38, and Resident #116) whose MDS records were reviewed for accuracy.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #38's Quarterly MDS assessment dated [DATE] documented Resident #38 received a therapeutic diet while a resident at the facility. 2. The facility failed to ensure Resident #116's discharge MDS assessment, dated 04/29/2024, accurately reflected the resident's discharge status. <p>This failure could place residents at risk for inadequate care due to inaccurate assessments.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Record review of Resident #38's face sheet dated 06/27/2024, revealed Resident #38 was admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus without complications, dysphagia, oropharyngeal phase, and unspecified protein-calorie malnutrition. <p>Record review of Resident #38's physician order summary dated 06/27/2024, revealed order dated 10/28/2023, Regular diet Soft and Bite Sized texture, Thin/Regular consistency, Large Protein Portions.</p> <p>Record review of Resident #38's Quarterly MDS assessment, dated 05/19/2024, documented the resident while a resident had not received a therapeutic diet within the last 7 days.</p> <p>Record review of Resident #38's care plan, dated 05/13/2024, revealed Resident #38 had a focus of I am on a therapeutic diet.</p> <p>During an interview on 06/28/2024 at 2:29 p.m. MDS L stated Resident #38 was on a regular soft and bite size diet with large protein portions. MDS L further stated Resident #38's MDS assessment was not accurate due to her order for the large protein portions making the diet therapeutic. MDS L stated she miscoded the MDS assessment. MDS L stated the accuracy of the MDS assessment was important to ensure the care was being provided and to capture the care that was being provided.</p> <p>During an interview on 06/28/2024 at 3:59 p.m. the DON revealed the MDS coordinators were responsible for the accuracy. The DON further stated the importance of the MDS accuracy was for billing purposes for CMS. The DON revealed the MDS assessment reflected the care that was necessary, provided for the resident and identified the resident's needs.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Record review of Resident #116's electronic face sheet, dated 06/27/2024, reflected she was female, and admitted to the facility on [DATE] and discharged from the facility on 04/29/2024. Her diagnoses included: displaced fracture of base of neck of left femur (left hip fracture), spondylopathy in disease (inflammation in the spine), hypertension (high blood pressure), and Alzheimer's disease (A progressive disease that destroys memory and other important mental functions).</p> <p>Record review of Resident #116's discharge MDS assessment with an ARD of 04/29/2024 reflected she scored a 03/15 on her BIMS which signified she had severe cognitive impairment, and discharge status in the section A (Identification Information) was marked as discharge to short-term general hospital.</p> <p>Record review of Resident #116's Discharge Summary, dated 04/29/2024, revealed the resident was discharged to home with home health.</p> <p>Record review of Resident #116's nursing progress note, dated 04/29/2024, revealed the resident discharged to home with home health by ambulance with all meds and personal belongings. [Resident #116] responsible party received all remaining meds and education done on medication administration.</p> <p>Interview of MDS RN K and MDS LVN J on 06/27/2024 at 4:28 p.m. confirmed Resident #116 was discharged to home with home health on 04/29/2024; therefore, the discharge status in the section A (Identification Information) to Resident #116's discharge MDS on 04/29/2024 should have been marked Home under care of organized home health service organization. However, the discharge MDS of 04/29/2024 was marked Short-term general hospital, and it was not accurate. MDS RN K and MDS LVN J said they made a mistake, and they would modify it.</p> <p>Record review of the facility's Comprehensive Assessments policy, revision date March 2023, revealed, Components of a Comprehensive Resident Assessment: The interdisciplinary assessment team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment. The multidisciplinary team may use other assessment forms in addition to the MDS form.</p> <p>Record review of the CMS MDS 3.0 Manual dated October 2023 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS .</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on interview and record review, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with a PASRR Evaluation assessment for 1 of 2 residents (Residents #13) reviewed for PASRR screening, in that:</p> <p>Resident #13's PASRR Level 1 assessment did not accurately capture the resident's diagnosis of mental illness.</p> <p>These failures could put residents with inaccurate PASRR Level 1 Evaluations at risk of not receiving care and services to meet their needs.</p> <p>The findings were:</p> <p>Record review of Resident # 13's face sheet dated 6/26/24 revealed a [AGE] year-old female admitted to the facility 5/3/24 with diagnoses that included Post Traumatic Stress Disorder (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event), Hypertension (a condition where the pressure in your blood vessels is consistently too high), and Peripheral vascular disease,(is a progressive disorder that affects blood vessels outside of the heart and brain).</p> <p>Record review of Resident #13 Admission MDS Assessment, dated 5/13/24, revealed a BIMS score of 12, which indicated cognition was moderately impaired.</p> <p>Record review of Resident # 13 care plan, dated 5/3/24, did not reveal a care plan with focus area of Post Traumatic Stress Disorder.</p> <p>Record review of Resident #13's PASRR I screening, completed by the referring entity dated 05/02/24, before admission on 05/3/24 indicated in Section C PASRR Screen questions C0100 asks, is there evidence or an indicator this individual has Mental Illness? The answer was 0 (0. No).</p> <p>On 6/24/24 at 10:08 a.m., during an interview with MDS Coordinator K, it was stated that [Name of Facility] works with the local mental health authority to discuss PASRRs. The local authority can provide the person's history. MDS Coordinator K acknowledged that Resident #13 has a diagnosis of post-traumatic stress disorder and that the resident's PASRR #1 screening should have been marked as positive.MDS Coordinator K mentioned that Resident #13 possibly overlooked the opportunity to be screened by the local health authority for potential services and assured that they would correct and resubmit the PASRR 1.</p> <p>Interview with Resident # 13 on 6/24/24 at 10:20 a.m., confirmed she had a diagnosis of Post Traumatic Stress Disorder ,that had been diagnosed some [AGE] years ago.</p> <p>Record review of Resident #21's care plan, dated 03/14/3024, revealed requires anti-psychotic medications, interventions administer medication as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Psychotropic drug use related to bipolar disorder with interventions that included administering medications as ordered.</p> <p>Record review of Resident #21's PASRR I screening, completed by the referring entity and dated 03/12/24, before admission on 03/14/24 indicated in Section C PASRR Screen questions C0100 asks, is there evidence or an indicator this individual has Mental Illness? The answer was 0 (0. No).</p> <p>During an interview with the MDS Coordinator K on 5/29/24 at 3:08 p.m., MDS Coordinator K stated, I work together with the local mental health authority to discuss PASRRs. The local authority can often give us the history of the person. MDS Coordinator K acknowledged Resident #13 had a diagnosis of bipolar disorder and post-traumatic stress disorder and the resident's PASRR 1 screening should have been redone as positive. MDS Coordinator K stated Resident #13 risked the opportunity to be screened by the local health authority for possible services offered, and she would get the PASSR 1 corrected and resubmitted.</p> <p>During an interview with the DON on 6/24/24 at 1:10 p.m., she stated she was responsible for overseeing PASRRs and was currently monitoring this at random, which is why Resident's # 13 PASRR assessment was possibly missed. The DON added that she expected MDS Coordinator K to review all residents' medication orders and face sheets for mental illness diagnosis to ensure no possible PASRR-positive resident was missed, as Resident #13 risked the possibility of not receiving beneficial services offered by the local health authority.</p> <p>Record review of facility policy titled, Comprehensive Assessments , dated February 2017 revealed The community coordinates resident assessments -Pre Admission screening to maximize the resident assessment process.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520</p> <p>Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good personal and oral hygiene for 1 of 7 Residents (Resident 51) whose records were reviewed for ADL care.</p> <p>Nursing staff failed to wash his face, apply cream to his face, to clean his lips and cut his finger nails for 1 of 4 observations.</p> <p>These deficient practices could affect any dependent resident and could lead to the resident's decline in their physical health.</p> <p>The findings were:</p> <p>Review of Resident #51's face sheet, dated 6/28/24, revealed he was admitted to the facility on [DATE], with diagnoses of Traumatic Brain Injury (TBI) without loss of consciousness, sequela, Narcolepsy in conditions classified elsewhere with cataplexy and Gastrostomy Status.</p> <p>Review of Resident #51's annual MDS assessment, dated 3/14/24, revealed he was unable to complete the BIMS because he was rarely/never understood. His BIMS was severe cognitive impairment related to the fact he rarely/never made decisions and he was dependent for all ADL's by 1 or 2 persons.</p> <p>Review of Resident #51's Care Plan, revised on 4/2/24, revealed he had a self-care performance deficit and required assistance with all ADL's from 1 to 2 staff.</p> <p>Observation on 6/25/24 at 11:50 AM revealed Resident #51 lying in bed with call light was draped over his chest. He had a left- hand contracture and long finger nails; nails were about 1 inch beyond his finger tips. Resident #51 had dry patches on the left side of his face by his temple. He had dry, cracked lips; caked on white residue.</p> <p>Observation on 6/26/24 at 11:20 AM revealed Resident #51 lying in bed. He had a left- hand contracture and long finger nails; nails were about 1 inch beyond his finger tips. Resident #51's face did not have as many dry patches on his face, lips did not have white build up on them. Observation revealed left hand contracture and he had long finger nails on both hands.</p> <p>Interview on 6/27/24 at 12:05 PM with charge nurse, LVN U, revealed he worked PRN and had worked with Resident #51 several times. He stated he worked on 6/25/24 and commented Resident #51 looked a little rough when he first reported to work but could not remember if Resident #51 had build up on his lips. LVN U stated the CNA's were responsible for providing Resident #51 with ADL care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 6/27/24 at 1:31 PM revealed Resident #51's face was clean, moisturized and he did not have build up on his lips. Resident # 51 had a left-hand contracture, his finger nails were still long; about 1 inch beyond his finger tips. Interview with OT T revealed she was performing passive range of motion on Resident #51's arms and hands. She stated his nails were long and were digging into his left -hand which was contracted. She stated she provided therapy on 6/25/24 and noted he had dry patches on his face, his lips were dry, cracked with white build up and left side of his mouth had brown spots on it along with the collar of his trachea had brown spots on it. OT T stated he was not well groomed and expected nursing staff to provide ADL care. She stated he looked much better on this date.</p> <p>Observation on 6/28/24 at 12:35 PM revealed Resident #51 sitting in a wheelchair with left hand contracture. His finger nails were shorter than on the previous observations. Resident #51's face was clean, no dry patches and moisturized. Interview with ADON H stated Resident #51 was not diabetic and the CNA's and nurses could cut his nails so they were not digging into his skin. She further stated the CNA's were responsible for providing daily ADL care and the charge nurse was responsible for talking to the CNA's when ADL care was not provided.</p> <p>Interview on 6/28/24 at 4:22 PM with the DON revealed nursing staff was responsible for Resident #51's ADL care including cutting his nails and maintaining them short. She stated the ADON's would make regular rounds; she was always on the floor and provided oversight by monitoring the Resident's condition. She stated she had never seen Resident #51 have dry patches on his face, with build up on his lips and had not noticed he had long finger nails.</p> <p>Record review of the facility's Routine Resident Care policy, review date January 2023, revealed under Compliance Guidelines: Residents should receive the necessary assistance to maintain good grooming and person/oral hygiene.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications from enteral feeding for 1 (Resident #103) of 2 residents reviewed for enteral feeds.</p> <p>The facility failed to ensure Resident #103's water with enteral feed was properly administered at the correct rate of infusion.</p> <p>This failure could place residents at risk of not receiving the proper hydration requirements prescribed by the physician.</p> <p>Findings included:</p> <p>Record review of Resident #103's electronic face sheet, dated 06/28/2024, reflected he was male and originally admitted to the facility on [DATE], and readmitted on [DATE]. His diagnoses included: muscle wasting and atrophy (decrease in size and wasting of muscle tissue), type 2 diabetes mellitus (trouble controlling blood sugar), cirrhosis of liver (chronic liver damage), pressure ulcer of sacral region (bedsore to buttock), dysphagia (difficulty swallowing), and gastrostomy status (opening into stomach).</p> <p>Record review of Resident #103's quarterly MDS assessment with an ARD of 05/18/2024 reflected he scored a 14/15 on his BIMS which signified he had intact cognition, and nutritional approaches in the section K (Swallowing/Nutritional Status) was marked as Feeding tube.</p> <p>Record review of Resident #103's comprehensive care plan, dated 11/21/2023, revealed Tube feeding: Provide enteral feedings and flushes as recommended by my physician.</p> <p>Record review of Resident #103's physician order, dated 04/04/2024, revealed Jevity 1.5 calories 70 milliliters per hour continuous for 20 hours (4 hour down time from 09:00 am to 1:00 pm) and flush 275 milliliters of H2O every 4 hours via gastrostomy tube.</p> <p>Observation on 06/27/2024 at 1:28 p.m. revealed LVN N connected Resident #103's gastrostomy tube to the feeding tube, set the feeding rate to the pump machine to 70 milliliters per hour, and water flush rate to the same pump machine to 175 milliliters every 4 hour.</p> <p>Observation on 06/27/2024 at 2:00 p.m. revealed Resident #103 was receiving continuous feeding Jevity 1.5 calories with rate of 70 milliliters per hour and water flush with rate of 175 milliliters every 4 hours via gastrostomy tube.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/27/2024 at 2:00 p.m. with LVN N confirmed Resident #103 was receiving continuous feeding Jevity 1.5 calories with rate of 70 milliliters per hour and water flush with rate of 175 milliliters every 4 hours via gastrostomy tube. The LVN N stated per the physician order, the resident was supposed to receive water flush with rate of 275 milliliters every 4 hours via gastrostomy tube, instead of 175 milliliters. Further interview with LVN N stated she was very nervous so forgot checking the physician order when setting up the rate of water flush to the feeding pump, and that was why LVN N set up the rate of water flush to 175 milliliters, instead of 275 milliliters.</p> <p>Interview on 06/28/2024 at 3:10 p.m. with the DON confirmed Resident #103 should have received water flush with rate of 275 milliliters every 4 hours via gastrostomy tube because the physician order indicated flush 275 milliliters of H2O every 4 hours via gastrostomy tube. The potential harm was it might cause a dehydration.</p> <p>Record review of the facility policy, titled Medication Administration via Enteral Tube, revised on 01/2023, revealed To administer medications through an enteral tube in an accurate, safe, timely and sanitary manner.</p>		

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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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that Residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #66) of 3 residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #66's nebulizer mask was properly stored and dated.</p> <p>These failures could place the residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings included:</p> <p>Record review of Resident #66's electronic face sheet, dated 06/28/2024, reflected she was female and originally admitted to the facility on [DATE], and readmitted on [DATE]. Her diagnoses included: displaced trimalleolar fracture of right lower leg (right ankle fracture), asthma (airway becomes inflamed, narrow, and swells, which makes it difficult to breathe), muscle wasting and atrophy (decrease in size and wasting of muscle tissue), and cerebral infarction (disrupted blood flow to the brain).</p> <p>Record review of Resident #66's quarterly MDS assessment with an ARD of 04/28/2024 reflected she scored a 13/15 on her BIMS which signified she had intact cognition, and pulmonary in the section I (Active Diagnosis) was marked as Asthma.</p> <p>Record review of Resident #66's comprehensive care plan, dated 08/22/2023, revealed Asthma: Administer my respiratory treatments/nebulizers as ordered by my doctor.</p> <p>Record review of Resident #66's physician order, dated 02/07/2024, revealed Ipratropium-Albuterol Solution 0.5-2.5, 3 milligrams per 3 milliliters. Give 3 milliliters inhale orally every 6 hours as needed for short of breath or wheezing via nebulizer.</p> <p>Observation and interview on 06/25/2024 at 10:39 a.m. revealed Resident #66 was on her bed resting, and her nebulizer mask was on the night stand, not bagged. It was also noted there was no date on the mask. According to Resident #66, she had breathing treatment as needed, and nurses changed the mask every week, but she did not know why the mask was not covered in the plastic bag when it was not used and when the mask was changed.</p> <p>Interview on 06/25/2024 at 10:40 a.m. with LVN M confirmed Resident #66's nebulizer mask was on the nightstand, not covered in a plastic bag. It was also noted there was no date. LVN M stated the nurse did not give a breathing treatment yet, and she did not know when the nebulizer mask was changed because there was no date. Further interview with LVN M stated the nurse should cover a nebulizer mask in a plastic bag when it was not used and write the date when nurses changed the mask. Nurses should change the mask once a week per the facility policy. Not covering the mask with a plastic bag when the mask was not used or not changing the mask every week could cause respiratory infection.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/28/2024 at 3:10 p.m. with the DON confirmed nurses should have covered Resident #66's nebulizer mask in a plastic bag when it was not used and should have written the date on the plastic bag when changing the mask once a week. The potential harm was it could cause respiratory infection.</p> <p>Record review of the facility policy, titled Respiratory Tubing/Equipment Management, revised on 01/2022, revealed All respiratory tubing and humidifier bottles - 1. Change tube weekly and provide storage receptacle for proper storage when not in use.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520</p> <p>Based on observation, interview and record review the facility failed to ensure If a bed or side rail was used, the facility must ensure resident assessment of the resident for risk of entrapment from bed rails for 2 of 7 Residents (Resident #4 and Resident #33) whose records were reviewed for side rail use.</p> <p>Nursing staff did not assess Resident #4 and Resident #33 periodically per facility policy since initial assessment upon admission to the facility.</p> <p>This deficient practice could affect any resident using a side rail and could contribute to avoidable incidents of entrapment.</p> <p>The findings were;</p> <p>1. Review of Resident #4's face sheet, dated 6/28/24, revealed she was admitted to the facility on [DATE] with diagnoses including Aphasia following Cerebral Infarction, other recurrent Depressive Disorders and Persistent Mood (Affective) Disorder.</p> <p>Review of Resident #4's quarterly MDS assessment, dated 2/8/24, revealed Resident #4 was usually understood and usually understands, her BIMS was 11 out of 15 reflective of moderate cognitive impairment and she required assistance with most ADL's by 1 to 2 person's.</p> <p>Review of Resident #4's Care Plan, revised 6/28/24, read: I use assist/enabler bar or rail to aid in my ability to participate in my care when in bed. Aid in turning and repositioning efforts. The use of the assist rail/bars will not hinder my ability to access care, my needs or my wants and it will not result in any physical or emotion distress that may affect my overall well-being. Educate resident and family that grab bar may be removed from bed if resident no longer wishes to use it. IDT to review to ensure assistive device is not preventing or restraining resident from ability to access care, needs or wants.</p> <p>Review of Resident #4's consent to the use of side rails was dated 2/13/23. Further review revealed the Side rail Review Tool was updated on 9/28/23 and signed by ADON H.</p> <p>Observation and attempted interview on 6/25/24 at 10:38 AM revealed Resident #4 was sitting up in bed with the HOB at 45 degrees watching TV and snacking. Resident #4's speech was slurred. Further observation revealed two 1/4 side rails up.</p> <p>Interview on 6/25/24 at 10:45 AM with LVN R and LVN S revealed Resident #4 used the side rails for repositioning and to assist during care. LVN S stated Resident #4 had a left hand contracture so she would not be able to lower the left rail down; however, LVN S stated the side rails would not keep Resident #4 from normal movement in bed or prevent her from getting out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident #33's face sheet, dated 6/13/24, revealed she was admitted to the facility on [DATE] with diagnoses including Muscle Wasting and Atrophy, Lack of Coordination and Dementia.</p> <p>Review of Resident #33's quarterly MDS assessment, dated 5/14/24, revealed her BIMS was 11 out of 15 reflective of moderate cognitive impairment, she was dependent on staff for toileting, showers and dressing.</p> <p>Review of Resident #33's Care Plan, revised on 12/7/23, revealed Resident #33 used the side rails as an enabler.</p> <p>Review of Resident #33's consented to the use of side rails on 5/14/20. Further review revealed the Side rail Review Tool was updated on 9/28/23 and signed by ADON H.</p> <p>Observation and interview on 06/25/24 at 12:12 PM revealed Resident #33 sitting in bed with the HOB at about 30 degrees with two 1/4 side rails up. Resident #33 stated she could not lower the side rails but could not get out of bed on her own. She stated she was able to hold on to the rails during care.</p> <p>Interview on 6/28/24 at 12:45 PM with ADON H revealed side rail assessments were completed at the time of admission, change of condition or possibly every 6 months to ensure the resident was still able to use it as an enabler. ADON H stated she was not sure of the specific timeframe the assessment should be updated.</p> <p>Interview on 6/28/24 at 4:10 PM with the DON revealed the facility required a consent and assessment for use of side rails. She stated she thought the assessment was completed yearly and or updated when a resident experienced a change of condition but staff should monitor by reassessing the resident. She stated the purpose was to ensure the resident was able to use the side rail as an enabler; was able to use it safely to prevent accidents and that the side rails were not a restraint.</p> <p>Review of facility policy, 'Restraints: Physical and Chemical & Entrapment Risk revised January 2023, read: Physical and Chemical Restraints: Each resident has the right to attain and maintain his or her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and that limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Consideration of treatment plan: In order for the resident to be fully informed, the community explains the potential risks and benefits of all options under consideration, including using a restraint, not using a restraint, and alternatives to using restraints. Consent for the device should be obtained prior to the implementation of the device utilized. Implementation: The community should complete an evaluation and care planning process prior to using restraints. The community monitors and adjusts care to reduce the potential for negative outcomes while considering less restrictive alternatives. Safety-Entrapment Inspection: The community should implement routine monitoring to evaluate the safety and functionality of beds and the device utilized to include beds with rails of any type, even those rails that are attached to the bed but not utilized, i.e. enabler rail that is not in use per manufacturer's instructions (rail up vertically, not in use).</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</p> <p>Based on interviews and record reviews, the facility failed to ensure each resident was free of any significant medication errors for 1 of 8 residents (Resident #35) reviewed for medications.</p> <p>The facility failed to provide Resident #35 with Diltiazem HCl Oral Tablet 30 MG (treats high blood pressure) as Diltiazem HCl Oral Tablet 30 MG</p> <p>Give 1 tablet by mouth three times a day for heart Monitor BP hold medication if SBP <110 or HR <60 bpm notify MD</p> <p>This deficient practice could result in a risk to the residents' health and complications which can lead to symptoms of heart failure.</p> <p>The findings included:</p> <p>Record Review of Resident #35's admission record, dated 06/27/24, reflected a [AGE] year-old female with an admitted [DATE] and a re-admitted [DATE], reflected diagnoses to include Paroxysmal Atrial Fibrillation (a type of irregular heartbeat that can cause blood clots, stroke and heart failure) and Essential (Primary) Hypertension (high blood pressure).</p> <p>Record review of Resident #35's MDS optional state assessment, dated 06/01/2024, reflected a BIMS score of 11 out of 15, indicating moderate cognitive impairment.</p> <p>Record Review of Resident #35's care plan, dated 06/25/24, reflected a focus of I have Heart Disease. I am at risk for associated cardiac complications such as AFIB with an intervention of Administer my medications as ordered by my physician., created on 09/08/22.</p> <p>Record Review of Resident #35's December 2023 MAR reflected:</p> <p>Diltiazem HCl Oral Tablet 30 MG</p> <p>Give 1 tablet by mouth three times a day for heart Monitor BP hold medication if SBP <110 or HR <60 bpm notify MD with a start date of 12/03/2023 08:00 PM and D/C date 02/12/24 09:26 AM</p> <p>12/08/23 at 08:00 AM: the Medication Administration Record is blank for this date and time</p> <p>12/09/23 at 08:00 AM: BP was 105/63, pulse 72 which B/P was out of parameters, but medication was given.</p> <p>12/09/23 at 02:00 PM: BP was 105/63, pulse 72 which B/P was out of parameters, but medication was given.</p> <p>12/13/23 at 08:00 AM: the Medication Administration Record is blank for this date and time</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12/16/23 at 08:00 AM: BP was 100/61, Pulse 81 which B/P was out of parameters, but medication was given.</p> <p>12/17/23 at 08:00 AM: BP was 102/56, Pulse 79 which B/P was outside of parameters, but medication was given.</p> <p>12/17/23 at 02:00 PM: BP was 104/62, Pulse 78 which B/P was outside of parameters, but medication was given.</p> <p>12/22/23 at 08:00 AM: the Medication Administration Record is blank for this date and time</p> <p>12/25/23 at 02:00 PM: BP was 116/82, Pulse 88 the medication was held when it should have been given.</p> <p>Record Review of hospital records with admitted [DATE] reflected resident was in A-fib RVR (atrial fibrillation with rapid ventricular rate).</p> <p>Record Review of Resident #35's January 2024 MAR reflected the following:</p> <p>Diltiazem HCl Oral Tablet 30 MG</p> <p>Give 1 tablet by mouth three times a day for heart Monitor BP hold medication if SBP <110 or HR <60 bpm notify MD with a start date of 12/03/2023 08:00 PM and D/C date 02/12/24 09:26 AM</p> <p>01/13/24 at 08:00 AM, 02:00 PM, and 08:00 PM: BP was 107/78 with pulse of 77 for all 3 times, which was out of parameters and medication was given.</p> <p>01/14/24 at 08:00 AM, 02:00 PM, and 08:00 PM: BP was 107/67 with pulse of 76 for all 3 times, which was out of parameters and medication was given.</p> <p>01/16/24 at 08:00 AM: BP was 89/53, Pulse 83 which B/P was out of parameters and medication was given.</p> <p>01/23/24 at 08:00 AM and 02:00 PM: BP was 100/71 with a pulse of 89 both times, which was out of parameters and medication was given.</p> <p>01/26/24 at 08:00 AM: BP was 107/50, Pulse 85 which B/P was out of parameters and medication was given.</p> <p>01/30/24 at 08:00 AM and 02:00 PM: BP was 94/56 with a pulse of 93 both instances, which were out of parameters and medication was given.</p> <p>01/31/24 at 02:00 PM: BP was 95/54 with a pulse of 103 both instances, which were out of parameters and medication was given.</p> <p>Record Review of February 2024 MAR reflected the following:</p> <p>Diltiazem HCl Oral Tablet 30 MG</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give 1 tablet by mouth three times a day for heart Monitor BP hold medication if SBP <110 or HR <60 bpm notify MD with a start date of 12/03/2023 08:00 PM and D/C date 02/12/24 09:26 AM</p> <p>02/01/24 at 08:00 AM and 02:00 PM: BP was 100/60 with a pulse of 70 both instances, which were out of parameters and medication was given.</p> <p>02/06/24 at 08:00 PM the Medication Administration Record is blank for this date and time</p> <p>02/09/24 at 08:00 AM and 02:00 PM: BP was 104/68, Pulse 60 which B/P was out of parameters and medication was given.</p> <p>Record Review of hospital records with admitted [DATE] reflected resident was in A-fib RVR (atrial fibrillation with rapid ventricular rate).</p> <p>Record Review of February 2024 MAR reflected Diltiazem HCL Oral Tablet 30MG was discontinued on 02/12/24 and Resident #35 was prescribed Amiodarone HCl Oral Tablet 200MG Give 200 mg by mouth one time a day for Heart Rhythm, with a start date of 02/14/24.</p> <p>During an interview on 06/28/24 at 02:45 PM, ADON I confirmed Resident #35's December 2023, January 2024, and February 2024 MARs for Diltiazem HCl Oral Tablet 30 MG showed times when medication was given outside of parameters and times where the blood pressure did not appear to be taken. She further revealed this was unacceptable and will be working on this. She further revealed if this medication was given outside of parameters, it could lower blood pressure more and the resident could bottom out. When asked to explain further, ADON I said well, you know and would not elaborate further.</p> <p>During an interview on 06/28/24 at 02:50 PM, RN U, who had given Resident #35 Diltiazem HCl Oral Tablet 30 MG, not as prescribed (12/09/23 at 8AM and 2PM, 12/16/23 at 8AM, 01/13/24 at 8AM/2PM/8PM, 01/14/24 at 8AM/2PM/8PM), revealed she knew she only gave this medication to Resident #35 per doctor's orders even though her documentation in the MAR did not reflect this. RN U could not produce her physical documentation of Resident #35 BP readings. She further revealed if this was given and her BP was out of parameters, Resident #35's blood pressure would go even lower.</p> <p>During an interview on 06/27/24 at 10:33 AM, NP V revealed if diltiazem was given outside of BP parameters, it would affect her BP. He revealed I am not going to go into what the extreme would be in reference to how being giving this medication could affect Resident #35.</p> <p>During an interview on 06/27/24 at 03:47 PM, MD T revealed if blood pressure was outside of parameters and a medication was still given, it was concerning. When asked what consequences could occur if diltiazem was not given as prescribed, MD T responded, Is this a gotcha moment? He further revealed this could cause the resident to become hypotensive (lower blood pressure) and could make them dizzy and a fall risk. He revealed he was okay if residents had their blood pressure taken once a week per the American Heart Association. He further revealed he could not say not taking this medication caused Resident #35 to be hospitalized .</p> <p>During an interview on 06/27/24 at 05:45 PM, Resident #35's cardiologist revealed she could not say not taking Diltiazem caused hospitalization for Afib. She further revealed there were a lot of factors that could have caused a hospitalization for Afib like dehydration, age, and more.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's in-service, titled Vital and BP Parameters, 05/14/24 and 05/20/24, reflected the nursing staff was trained on When administering medication for antihypertensive meds we make sure we document the BP. Make sure when vitals are taken and BP is out of parameters we hold the medication we notify provider and follow doctor orders.</p> <p>Record review of facility policy titled, Medication Administration, revised January 2024, reflected Resident medications are administered in an accurate, safe, timely, and sanitary manner . administer medications as ordered by the physician. Routine medications shall be administered according to the established medication administration schedule for the community .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131</p> <p>Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were secured properly for 1 of 5 residents (Resident #52) reviewed for medication storage, in that:</p> <p>The facility failed to ensure medications were not left on Resident #52's bed side table.</p> <p>This failure could place residents at risk for not receiving the intended therapeutic benefit of their medications as ordered.</p> <p>The findings were:</p> <p>Record review of Resident # 52's electronic face sheet dated 6/25/24, revealed a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis that included Benign Prostatic Hyperplasia (prostatic enlargement that can cause urinary difficulty), Hyperlipidemia (condition in which there are high levels of fat particles in blood) and Diabetes Mellitus (condition that can result in too much sugar in the blood).</p> <p>Record review of Resident #52's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated intact cognition.</p> <p>Record review of Resident #52's physician monthly orders for June 2024, reviewed on 6/25/24 did not reveal an order to self-administer medications.</p> <p>Record review of Resident # 52's physician monthly orders for June 2024, reviewed on 6/25/24 , reviewed order for Ciprofloxacin ophthalmic eye drops .</p> <p>Observation on 06/25/2024 at 09:47 a.m. of Resident #52's room revealed there was a bottle of Ciprofloxacin ophthalmic eye drops with Resident # 52's name on the bedside table.</p> <p>Interview with Resident # 52 on 6/25/24 at 09:50 he stated nurse left eye drops on his bed side table so that he could place them in his eyes after breakfast.</p> <p>During an interview with LVN C on 6/25/24 at 10:15 a.m., she mentioned that she was responsible for Resident #52 and had left a bottle of Ciprofloxacin ophthalmic eye drops on his nightstand for self-administration after breakfast. She also stated that she did not have an order for Resident #52 to self-administer medication and risked over-administering the prescribed eye drops dose.</p> <p>During an interview with the DON on 06/25/24/ at 11:53 a.m., the DON stated that a bottle of Ciprofloxacin ophthalmic eye drops should not have been left at bed side table of Resident #52 without a self-medication assessment, and a signed physician order as lack of risked resident taking more than the prescribed dosage. DON stated her ADON's over see that there is no medicaion at Residents bed side and she monitors this at random .</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy , Medication Self -Administration , dated 3/15/19 , revised January 2023 , revealed If a resident desires to participate in Self -Medication Administration , the clinical team should complete a Self-Medication review.

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 06/28/2024
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</p> <p>Based on observation, interviews, and record review, the facility failed to follow menus for 1 of 1 resident meals (lunch meal on 06/25/2024) reviewed for menus in that:</p> <p>1. The facility failed to follow the menu for residents on regular and modified diets for the lunch meal on 06/25/2024.</p> <p>This failure could place residents who consume food prepared by the facility kitchen at risk of not having their nutritional needs met and/or weight loss.</p> <p>The findings included:</p> <p>Record review of Week 2 menu reflected Tuesday 06/25 lunch comprised of lemon pepper chicken, buttered corn, and roasted broccoli for Tuesday 06/25 lunch, and not carrots.</p> <p>Record review of Resident #79's admission record, dated 06/25/2024, reflected the resident was admitted to the facility on [DATE] with diagnoses to include: muscle wasting and atrophy and mild protein-calorie malnutrition.</p> <p>Record review of Resident #79's MDS optional state assessment, dated 06/01/2024, reflected a BIMS score of 15 out of 15, indicating intact cognition.</p> <p>Record review of Resident #79's care plan, dated 06/25/24, reflected a focus of I am at risk for nutritional deficits and/or dehydration r/t malnutrition with interventions to include Provide meals, snack and fluids within my dietary recommendations.</p> <p>1.</p> <p>Record review of the Menu Substitution Approval provided by the facility reflected substitutions on 06/25: Item on Menu carrots had Substitution mixed veggie and rice.</p> <p>During an interview and observation on 06/25/24 at 12:16 PM, Resident #79's 06/25 lunch meal tray comprised of mixed vegetables, rice, and bread with no protein. Observation of Resident #79's lunch meal tray ticket revealed he disliked chicken. Resident #79 was observed not eating any of his 06/25 lunch meal and was offered 2 peanut butter and jelly sandwiches instead. He said it made him feel mad that he wasn't served corn and broccoli as posted and he would have eaten those instead of what he was served today.</p> <p>During an interview and observation on 06/25/24 at 12:35 PM 06/25/24, RN L confirmed the 06/25 lunch included mixed vegetables and rice. She found out the kitchen ran out of corn and the kitchen served rice instead of corn.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/26/24 at 11:50 AM, the CDM revealed he knew they would not have corn or broccoli for 06/25/24 lunch meal and did not update the lunch menu that was displayed for the residents.</p> <p>During an interview on 06/27/24 at 09:07 AM, the RD revealed the menu should be updated when there were changes to the menu due to ordering. She further revealed it was important for the residents to know what they were eating so the resident knew if they needed to adjust according to posted menu, like ask for a substitute. She further revealed this could affect the residents' intake.</p> <p>During an interview with the RD on 06/27/24 at 04:45 PM, the RD confirmed the 06/25 lunch menu said corn and broccoli and not carrots for 06/25 lunch.</p> <p>Record review of the facility policy, Menu Substitutions, policy number 01.007, revised 06/01/2019, reflected: Policy: The facility believes that a well-balanced menu, planned in advance and served as posted, is important to the well-being of its residents. The menus will be served as planned except for emergency situations when a food item is unavailable. Procedure: 1. The menu will be served as written unless an emergency situation arises. 3. All substitutions will be made in accordance with the Menu Substitution Guide to ensure that the meal is well-balanced and adequate.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366</p> <p>Based on observations, interviews, and record reviews, the facility failed to accommodate residents' food preferences and allergies for 2 of 8 (Residents #35 and #79) residents reviewed for food preferences and allergies, in that:</p> <ol style="list-style-type: none"> 1. The facility failed to provide Resident #79 with a protein, when he had a listed dislike for the protein served for 06/25/24 lunch. 2. The facility failed to ensure Resident #35 did not receive fish for 06/28/24 lunch, which was listed as a food allergy in her medical record. <p>These failures could cause an allergic reaction, a decrease in resident choices, a diminished interest in meals, placing them at risk for contributing to poor intake and/or weight loss.</p> <ol style="list-style-type: none"> 1. <p>Record review of Resident #79's admission record, dated 06/25/2024, reflected the resident was admitted to the facility on [DATE] with diagnoses to include: muscle wasting and atrophy and mild protein-calorie malnutrition.</p> <p>Record review of Resident #79's MDS optional state assessment, dated 06/01/2024, reflected a BIMS score of 15 out of 15, indicating intact cognition.</p> <p>Record review of Resident #79's care plan, dated 06/25/24, reflected a focus of I am at risk for nutritional deficits and/or dehydration r/t malnutrition with interventions to include Provide meals, snack and fluids within my dietary recommendations.</p> <p>Record review of Resident #79's weight history x6 months revealed relatively stable weight.</p> <p>Record review of Week 2 menu reflected Tuesday 06/25 lunch comprised of lemon pepper chicken, buttered corn, and roasted broccoli, and not carrots.</p> <p>During an interview and observation on 06/25/24 at 12:16 PM, Resident #79's 06/25 lunch meal tray ticket reflected Resident #79 had dislikes: Meat (ground meat) and chicken. His 06/25/24 lunch meal comprised of mixed vegetables, rice, and bread with no protein. He further revealed he hadn't had a protein for a long time.</p> <p>During an interview and observation on 06/25/24 at 12:19 PM 06/25/24, RN L confirmed Resident #79's 06/25 lunch comprised of mixed vegetables, rice, and bread. When asked what the protein was on Resident #79's tray, she said she thought it was the greens. She said she went to ask the kitchen and they confirmed to her that the greens counted as protein. After this surveyor's interview with RN L, she asked Resident #79 what alternate he would like instead.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/26/24 at 11:50 AM, the CDM revealed he had a hard time finding a protein option for Resident #79. He further revealed there were a limited amount of protein options and he tried them all.</p> <p>During an interview on 06/28/24 at 01:42 PM, the RD revealed protein was important for muscle maintenance and calories. She further revealed Resident #79 ended up getting 2 peanut butter and jelly sandwiches for 06/25/24 lunch meal and this provided a protein source.</p> <p>2.</p> <p>Record review of Resident #35's admission record, dated 06/27/2024, reflected the resident was readmitted to the facility on [DATE] with diagnoses to include: muscle wasting and atrophy and mild protein-calorie malnutrition. Her admission record further reflected allergies to include fish and seafood, lactose intolerant.</p> <p>Record review of Resident #35's MDS optional state assessment, dated 06/01/2024, reflected a BIMS score of 11 out of 15, indicating moderate cognitive impairment.</p> <p>Record review of Resident #35's care plan, dated 06/25/24, reflected a focus of I am at risk for nutritional deficits and/or dehydration risks . with interventions to include Provide meals, snack and fluids within my dietary recommendations.</p> <p>Record review of Resident #35's lunch meal tray ticket, dated 06/28/24, reflected Dislikes: Fried Fish with no alerts for allergies or dislikes to include fish or seafood.</p> <p>Record review of Resident #35's cardiology prescription, dated 4/23/24, reflected Pt need high calorie diet that does not include Fish (rash) .</p> <p>During an interview on 06/26/24 at 11:50 AM, the CDM revealed the dietary aide, the cook, and the nursing staff review meal tickets to make sure they were being followed.</p> <p>During an interview on 06/27/24 at 09:07 AM, the RD revealed not following food preferences could affect intake. She further revealed she worked with Resident #35 a lot due to her preferences and malnutrition diagnosis. She revealed she had not looked at Resident #35's cardiologist note for Resident #35's food preferences, but will look at that. She revealed the nursing staff relayed any information about food to the kitchen in order to update meal tickets. She futher revealed Resident #35 was not allergic to fish.</p> <p>During an interview on 06/27/24 at 10:07 AM, the DON revealed it was the nursing staff who were responsible for relaying doctor's orders for dietary interventions and recommendations to the RD for her RD assessments.</p> <p>During an interview and observation on 06/28/24 at 01:15 PM, Resident #35 did not have her main entree in front of her. She expressed her frustration saying they served her fish again and she cannot have fish. She apologized for being upset while voicing her concerns.</p> <p>During an interview on 06/28/24 at 01:25 PM, CNA Q confirmed she had to take Resident #35's lunch entree back to the kitchen because she did not want the fish that was served.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility policy, Menu Substitutions, policy number 01.007, revised 06/01/2019, reflected: Policy: The facility believes that a well-balanced menu, planned in advance and served as posted, is important to the well-being of its residents. The menus will be served as planned except for emergency situations when a food item is unavailable. Procedure: 1. The menu will be served as written unless an emergency situation arises. 3. All substitutions will be made in accordance with the Menu Substitution Guide to ensure that the meal is well-balanced and adequate.</p> <p>Record review of the facility policy, Alternate Food Choices and Substitutions and Honoring Preferences, policy number 02.004, approved 10/01/2018, reflected, The facility believes that adequate nutrition is essential to each resident's well-being and good health.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48366</p> <p>Based on observations, interviews, and record reviews, 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:</p> <ol style="list-style-type: none"> 1. The CDM wore a hair restraint that did not cover all his hair. 2. In the freezer, there was frozen raw beef stored over fully cooked frozen pies. 3. In the walk-in cooler, there were: <ol style="list-style-type: none"> a. Uncovered foods of 3 trays of pie desserts, 2 trays of bowls of fruits, and 1 tray of plates of salad. b. Cheese that was inappropriately stored. c. The CDM revealed he did not label prepare foods with a discard date. 4. In the dish room, the temperature log of the dishwashing machine had the wrong temperature 5. For 06/28/24 lunch, fortified shakes and yogurt temperatures were taken by touching the thermometer outside of the food product and not inside of the food product. 6. The refrigerators' temperature in the kitchen were only checked one time a day. <p>These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. During an interview and observation on 06/25/24 at 09:17 AM-09:42 AM (initial tour of the kitchen), the CDM had his hairnet covering only the top half of his hair. When this surveyor pointed out the hairnet was not covering all of his hair, the CDM revealed it was okay because his hair was short. He further revealed it was the long hair that got into foods because the weight of the long hair was more than the weight of short hair. <p>Record review of facility's policy 04.001 Employee Sanitation, approved 10/01/18, reflected 3. Employee Cleanliness Requirements b. Hairnets . or other effective hair restraints must be worn to keep hair from food and food-contact surfaces.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, 2-402.11, revealed, (A) Except as provided in (B) of this section, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single service and single-use articles.</p> <p>2. During an interview and observation of the freezer on 06/25/24 at 09:17 AM-09:42 AM (initial tour of the kitchen), Observation revealed raw beef was placed above boxed of pies. The CDM revealed this was not appropriate and moved the boxes of frozen pies onto another shelf that was no longer under these boxes of raw beef boxed. he moved the boxes of raw beef on the bottom shelf.</p> <p>Record review of facility's policy 03.003 Food Storage, revised 06/01/19, reflected Store raw meats and eggs on the bottom shelf to prevent contamination of other foods. To avoid cross-contamination, store raw or uncooked food and produce away from and below prepared or ready-to-eat food.</p> <p>3.</p> <p>a. During an interview and observation of the refrigerator on 06/25/24 from 09:17 AM-09:42 AM (initial tour of the kitchen), 2 food carts that contained 06/25/24 lunch had uncovered foods of: 3 trays of pie desserts, 2 trays of bowels of fruits, 1 tray of plates of salad. The CDM revealed this should be covered so it can maintain it's quality and not be contaminated.</p> <p>During an interview on 06/28/24 at 01:43 PM, the RD revealed the foods that were uncovered in the walk-in refrigerator on 06/25/24 were for 06/25/24 lunch and this was okay because they were about to be served. She further revealed if they were not going to be served, uncovered foods could be exposed to air causing their quality to diminish.</p> <p>b. During an interview and observation of the refrigerator on 06/25/24 fro, 09:17 AM-09:42 AM (initial tour of the kitchen), observation revealed cheese was in a bag that was not properly closed all the way. The CDM revealed the bag that the cheese was in clicked to let one know that the bag was fully closed and this specific bag that was found may not have been closed all the way.</p> <p>c. During an interview and observation on 06/25/24 at 09:17 AM-09:42 AM (initial tour of the kitchen), observation of all prepared foods in walk-in refrigerator reflected no discard date.</p> <p>Record review of facility's policy 03.003 Food Storage, revised 06/01/19, reflected Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage.</p> <p>Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed, 3-305.1, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exsposed to splash, dust, or other contamination.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 U.S. Department of H&HS, revealed 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.</p> <p>4. Record review and interviews on 06/28/24 at 11:49 AM, revealed record review of Dish Machine temperatures and sanitizing log, dated June 2024, reflected temperature for AM Wash temp, Noon Wash Temp, and PM Wash temp to be 100 degrees for about 69 out of 82 occurrences. Record Review of this machine's operational requirements reflected this temperature should have been a minimum of 120. The CDM revealed the dishwashers (dishwasher staff spoke Spanish) wrote the temperature before the machine started and did not reflect the appropriate temperature. The CDM revealed he checked the dish machine frequently and it had been reaching appropriate temperatures. The RD revealed contamination could occur if the dish washing machine did not reach the machine's operational requirements.</p> <p>Record review of facility policy 04.006, approved 10/01/2018, revealed: Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment. Policy: The facility will follow the cleaning and sanitizing requirements of the state and US Food Codes for mechanical cleaning in order to ensure that all utensils and equipment are thoroughly cleaned and sanitized to minimize the risk of food hazards.</p> <p>5. Observation and interviews on 06/28/24 at 11:30 AM revealed the temperature for health shakes and yogurt were taken by touching the thermometer to the outside container of these food products. The CDM and RD revealed this was okay.</p> <p>Record review of facility's policy 03.008 Taking Temperatures, revised 06/01/19, reflected Insert the sensing element of the thermometer into the center of the thickest part of the food.</p> <p>6. Observation and interview on 06/28/24 at 11:00 AM, revealed temperature logs for all of the refrigerators had only one temperature that was being taken per day. The RD and CDM revealed this was okay and they needed to check if more temperatures needed to be taken per day.</p> <p>Interview on 06/28/24 at 01:43 PM, the RD revealed taking temperatures appropriately ensured the refrigerator maintained it's appropriate temperature. She further revealed this was to ensure food would not spoil.</p> <p>Record review of facility's policy 04.035 Cleaning & Sanitation of Refrigerators & Freezers on Units, approved 10/01/18, reflected Temperatures in the refrigerators and freezers will be checked once on the day shift and once on the night shift and recorded on a temperature log by the nutrition and foodservice staff.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 39049</p> <p>Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 4 (Resident #29, #228, #2, #100 and #4) of 23 residents reviewed, in that:</p> <ol style="list-style-type: none"> 1. Resident #29's personal refrigerator was dirty with old and brown colored food debris. 2. Resident #228's personal refrigerator had undated soup with rice. 3. Resident #2's personal refrigerator's door was broken and not closed perfectly, and there was one opened food item unlabeled and undated in the refrigerator. 4. Resident #100's personal refrigerator had undated fried chicken. 5. Resident #4's personal refrigerator had expired foods in it. <p>The findings were:</p> <ol style="list-style-type: none"> 1. Record review of Resident #29's electronic face sheet, dated [DATE], reflected she was female and admitted to the facility on [DATE]. Her diagnoses included: critical illness myopathy (disease that affects the muscles), type 2 diabetes mellitus (trouble controlling blood sugar), hypertension (high blood pressure), pressure ulcer of right buttock (bedsore), encephalopathy (brain dysfunction), and muscle wasting and atrophy (decrease in size and wasting of muscle tissue). <p>Record review of Resident #29's quarterly MDS assessment with an ARD of [DATE] reflected she scored a , d+[DATE] on her BIMS which signified she had intact cognition, and eating in the section GG (Functional abilities and goals) was marked as 4, which was supervision or touching assistance, helper cues or touching/steadying assistance as resident completes activity.</p> <p>Observation on [DATE] at 9:49 a.m. revealed Resident #29 was on the bed and watching television in her room, and there was a personal refrigerator in the resident room. There was an old and brown colored stain on the bottom floor inside the refrigerator. The refrigerator had several sodas.</p> <p>Interview on [DATE] at 9:49 a.m. with Resident #29 revealed the resident sometimes drank sodas from the refrigerator, and she did not realize her refrigerator was dirty with old and brown colored stain on the bottom floor of the refrigerator. Resident #29 stated nurses usually checked the refrigerator every day.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on [DATE] at 11:37 a.m. with LVN O confirmed Resident #29's refrigerator had old and brown colored stain on the bottom floor inside the refrigerator, and the stain was food debris. LVN O stated nurses had responsibility of checking the temperature of all residents' personal refrigerators and cleaning them if refrigerators were dirty. LVN O stated she checked Resident #29's refrigerator temperature around 7:00 a.m. on [DATE] and saw the old and brown colored food debris but did not clean because the nurse was busy.</p> <p>Interview on [DATE] at 3:10 a.m. with the DON confirmed nurses should have cleaned Resident #29's refrigerator when nurses checked the refrigerator's temperature if the refrigerator was dirty. The potential harm was it might cause food-borne illness.</p> <p>2. Record review of Resident's # 228's electronic face sheet dated [DATE] , revealed a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease(condition in which the kidneys loose ability to remove waste from body) , Type II Diabetes (long term condition in which the body has trouble controlling blood sugar and using it for energy) and Left Femur Fracture(a break in the thigh bone).</p> <p>Record review of Resident's 228 Admission MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated intact cognition .</p> <p>Observation on [DATE] at 11:05 a.m., revealed Resident # 228 in room on his wheel chair watching television and there was a personal refrigerator in room with soup and rice on bottom shelf undated.</p> <p>Interview with Resident # 228 on [DATE] at 11:10 a.m., he stated that his wife had prepared the soup and rice some days ago and he forgot to eat it .</p> <p>Interview with LVN A on [DATE] at 11:15 a.m. she stated she was the assigned nurse for Resident # 228 and the soup and rice in Resident 228's personal refrigerator should have been thrown out by nursing staff because it was undated</p> <p>Interview with ADON G , on [DATE] at 11:30 a.m., she stated she was responsible for overseeing Resident's personal refrigerators on second floor and was also responsible for monitoring it daily . She stated that Resident # 228 risked possible food - illness by consuming undated food in personal refrigerator.</p> <p>3. Record review of Resident #2's electronic face sheet, dated [DATE], reflected she was [AGE] years old, female, originally admitted to the facility on [DATE], and readmitted on [DATE]. Her diagnoses included: lack of coordination (impaired balance), type 2 diabetes mellitus (trouble controlling blood sugar), chronic obstructive pulmonary disease (lung disease that block airflow and make it difficult to breathe), hypertension (high blood pressure), dementia (impaired ability to remember), Parkinson's disease (disorder of the central nervous system that affects movement), and muscle wasting and atrophy (decrease in size and wasting of muscle tissue).</p> <p>Record review of Resident #2's quarterly MDS assessment with an ARD of [DATE] reflected she scored a , d+[DATE] on her BIMS which signified she had moderate cognitive impairment, and eating in the section GG (Functional abilities and goals) was marked as 4, which was supervision or touching assistance, helper cues or touching/steadying assistance as resident completes activity, however for mobility, the resident was dependent to bed to chair transfer.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Enclave		STREET ADDRESS, CITY, STATE, ZIP CODE 18803 Hardy Oak San Antonio, TX 78258	
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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on [DATE] at 9:59 a.m. revealed Resident #2 was on the bed and watching television in her room, and there was a personal refrigerator in the resident room. The door of Resident #2's refrigerator was broken, and the door did not close well. Water from melting ice located at the top of inside the refrigerator flowed down. There were several sodas and one opened yellow colored food container inside the refrigerator. The opened yellow colored food container did not have a label and open date.</p> <p>Interview on [DATE] at 11:34 a.m. with Resident #2 revealed the resident sometimes drank sodas from the refrigerator, and she did not realize her refrigerator had a broken door and an opened yellow colored food container that was unlabeled and undated. Resident #2 stated she did not have food borne illness.</p> <p>Interview on [DATE] at 11:27 a.m. with ADON RN I confirmed the door of Resident #2's refrigerator was broken, the door did not close well, water from melting ice located at the top of inside the refrigerator flowed down, and there were several sodas and one opened yellow colored food container inside the refrigerator. ADON RN I verified the opened yellow colored food container was apple sauce, and it was unlabeled and undated. ADON RN I stated she checked the temperature around 8 a.m. but did not realize the door was broken, and the opened apple sauce was unlabeled and undated. The ADON RN I stated facility nurses should have labeled and dated opened foods inside residents' personal refrigerators. ADON RN I also confirmed Resident #2 did not have food-borne illness.</p> <p>Interview on [DATE] at 3:10 a.m. with the DON confirmed nurses should have checked residents' personal refrigerators and should have labeled and dated all opened foods. The potential harm was it might cause food borne illness.</p> <p>4. Record review of Resident's # 100 electronic face sheet , dated [DATE] , revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included Asthma (condition in which a persons air ways become narrow and swell , which makes it difficult to breathe), Dementia (group of conditions characterized by memory loss and judgment) and Depression (condition involving symptoms of sadness and loss of interest)</p> <p>Record review of Resident # 100 Admission MDS assessment dated [DATE] revealed a BIMS score of 15 , which indicated intact cognition.</p> <p>Observation on [DATE] at 9:50 a.m., revealed Resident # 100 was in bed reading a book and there was a personal refrigerator in room with undated fried chicken on bottom shelf.</p> <p>Interview with Resident # 100 on [DATE] at 10:05 a.m., she stated that fried chicken was brought in by a friend and could not recall how long ago that was.</p> <p>Interview with LVN A on [DATE] at 10:15 a.m. she stated she was the assigned nurse for Resident # 100 and the Fried chicken in Resident 100's personal refrigerator should have been thrown out by nursing staff because it was undated .</p> <p>Interview with ADON G , on [DATE] at 10:30 a.m., she stated she was responsible for overseeing Resident's personal refrigerators on second floor and was also responsible for monitoring it daily . She stated that Resident # 100 risked possible food - illness by consuming undated food in personal refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Review of Resident #4's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with diagnoses including Aphasia following Cerebral Infarction, other recurrent Depressive Disorders and Persistent Mood (Affective) Disorder.</p> <p>Review of Resident #4's quarterly MDS assessment, dated [DATE], revealed Resident #4 was usually understood and usually understood, her BIMS was 11 out of 15 reflective of moderate cognitive impairment and she required assistance with all ADL's by 1 to 2 person's except for eating.</p> <p>Review of Resident #4's Care Plan, revised [DATE], revealed she was at risk for falls related to muscle wasting and atrophy, impaired mobility and chronic pain. One of the interventions was to anticipate and meet her needs and to keep the call bell was within reach. Further review revealed Resident #4 required assistance with all ADL's by 1 or 2 person's except for eating.</p> <p>Observation and attempted interview on [DATE] at 10:38 AM revealed Resident #4 was sitting up in bed with the HOB at 45 degrees watching TV and snacking. Resident #4's speech was slurred. She asked for a soda out of the refrigerator and asked for it to be poured it in her glass which she pointed to on the countertop.</p> <p>Observation and interview on [DATE] at 10:45 AM with LVN R and LVN S revealed they knew right away that Resident #4 wanted a soda. LVN S opened the door to the refrigerator and observation revealed it was full of food. Further observation revealed a container of Danishes and brownies. LVN S was asked who was responsible for ensuring expired foods were disposed. LVN S stated nursing staff would check them periodically, checked the temperature and would dispose of expired foods. LVN S stated Resident #4's family member brought food in for the Resident to snack on. She pulled the container of Danishes and stated the expiration date was [DATE]. She pulled the pack of brownies and stated the expiration was [DATE]. LVN S stated nursing staff should have checked the food had not expired because the expired foods could make Resident #4 sick. LVN S stated she had not checked for expired foods on this date.</p> <p>Record review of the facility policy, titled Personal Refrigerator, revised ,d+[DATE], revealed Community should place a thermometer in the refrigerator and monitor the temps to confirm that the refrigerator is properly working and maintain food at proper storage temps. Routinely check the refrigerator to identify unsafe for consumption foods and discards any item that appeared to have gone bad or are expired.</p> <p>46131</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 39049</p> <p>Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 Residents (Residents #103 and Resident #51) of 23 residents reviewed for infection control.</p> <p>1. LVN P entered Resident #103's room, who was on EBP, on 06/26/2024 at 04:10 p.m., and failed to put on a gown when the nurse performed wound treatment for Resident 103.</p> <p>2. ADON entered Resident #51's room, who was on EBP and failed to wash or sanitize her hands, put on a gown when checking to ensure the G-Tube was connected when the G-Tube pump shut off.</p> <p>These deficient practices affect residents who require direct care and could place residents at risk for cross contamination and infections.</p> <p>The findings were:</p> <p>1. Record review of Resident #103's electronic face sheet, dated 06/28/2024, reflected he was male, originally admitted to the facility on [DATE], and readmitted on [DATE]. His diagnoses included: muscle wasting and atrophy (decrease in size and wasting of muscle tissue), type 2 diabetes mellitus (trouble controlling blood sugar), cirrhosis of liver (chronic liver damage), pressure ulcer of sacral region (bedsore to buttock), dysphagia (difficulty swallowing), and gastrostomy status (opening into stomach).</p> <p>Record review of Resident #103's quarterly MDS assessment with an ARD of 05/18/2024 reflected he scored a 14/15 on his BIMS which signified he had intact cognition, and moisture associated skin damage in the section M (Skin conditions) was marked as Yes.</p> <p>Record review of Resident #103's comprehensive care plan, dated 11/21/2023, revealed Skin fragile and risk for skin injury - apply treatment as ordered and keep clean and dry and apply skin barrier cream as indicated.</p> <p>Record review of Resident #103's physician order, dated 04/04/2024, revealed Ammonium Lactate External cream 12% Apply to bilateral lower extremities two times a day for dry skin and Enhanced Barrier Precaution every shift.</p> <p>Observation on 06/26/2024 at 4:09 p.m. revealed there was a sign posted on Resident #103's door, and the sign was Enhanced Barrier Precaution - EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Wear gloves and a gown for the following High-Contact Resident Care Activities . Changing briefs and assisting with toileting . Wound Care: Any skin opening requiring a dressing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 06/26/2024 at 4:10 p.m. revealed LVN P sanitized his hands outside Resident #103's room and put on gloves. LVN P entered to Resident #103's room and applied Ammonium Lactate External cream 12% to both of the resident's legs, which had several skin abrasions on the legs, without putting on a gown, then the nurse went out of the resident's room, and took off the dirty gloves and sanitized his hands.</p> <p>Interview on 06/26/2024 at 4:15 p.m. with LVN P confirmed he did not wear a gown when he applied a cream to both of Resident #103's legs, and Resident #103 had Enhanced Barrier Precaution, so LVN P should have put on a gown when applying the cream to prevent possible contamination. LVN P stated he was nervous and forgot wearing a gown, and the potential harm was Resident #103 might have infection.</p> <p>Interview on 06/28/2024 at 3:10 p.m. with the DON confirmed LVN P should have put on a gown when entering Resident #103's room to apply a cream because the resident had Enhanced Barrier Precaution.</p> <p>2. Review of Resident #51's face sheet, dated 6/28/24, revealed he was admitted to the facility on [DATE], with diagnoses of Traumatic Brain Injury (TBI) without loss of consciousness, sequela, Narcolepsy in conditions classified elsewhere with cataplexy and Gastrostomy Status.</p> <p>Review of Resident #51's annual MDS assessment, dated 3/14/24, revealed he was unable to complete the BIMS because he was never/rarely understood. His BIMS was severe cognitive impairment related to the fact he never/rarely made decisions and he received nutritional and fluid intake via tube feeding.</p> <p>Review of Resident #51's Care Plan, revised on 4/2/24, read: I require a feeding tube r/t Dysphagia, Swallowing problems; Tracheotomy r/t TBI; I am at risk for significant infections and/or recurrent infections r/t compromised</p> <p>medical condition. One of the interventions was Enhanced Barrier Precautions practices as clinically indicated.</p> <p>Observation on 06/25/2024 at 11:50 AM revealed there was a sign posted on Resident #51's door, and the sign was Enhanced Barrier Precaution - EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Wear gloves and a gown for the following High-Contact Resident Care Activities . Changing briefs and assisting with toileting .Wound Care: Any skin opening requiring a dressing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 6/27/24 at 1:31 PM revealed ADON I, responded to Resident #51's G-tube sounding because it shut off. ADON I walked into the room with a mask on; she took 2 clean gloves, put them on and reached under Resident #51's gown and was handling the G-tube. Further observation revealed ADON I did not wash her hands upon entering the room, before putting on the gloves and did not put a gown on. Interview with the ADON I revealed she was making sure it was connected and then turned the G-tube pump back on. When asked, ADON I stated Resident #51 was on enhanced barrier precautions but was not sure if she had to put on a gown before checking the G-tube. ADON I commented out loud that everything looked good. When asked again if Resident #51 was on enhanced barrier precautions related to trachea and G-tube, ADON I commented, you're right, I should put on a gown before providing direct care. ADON I stated she did not wash or sanitize her hands before putting a clean set of gloves on. She stated following enhanced precautions and practicing good hand hygiene helped to prevent cross contamination and infections.</p> <p>Record review of the facility policy, titled Infection Prevention and Control Program, revised 04/2024, revealed page 6 - Enhanced Barrier Precautions - during high-contact resident care activities: dressing, bathing/showering/transferring, changing linens, changing briefs, device care or use, and wound care: any skin opening requiring a dressing. Gloves and gown prior to the high contact care activity.</p>		