

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

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No. 0938-0391

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 08/27/2025
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide assessments that accurately reflect the resident's status for three (Residents #41, #55 and #34) of 32 residents reviewed for MDS assessment accuracy. 1. Resident #41's MDS assessment did not accurately reflect she had an indwelling urinary catheter. 2. Resident #55's admission MDS assessment did not accurately reflect she had an indwelling urinary catheter. 3. Resident #34's MDS assessment did not accurately reflect she took an opioid medication. This deficient practice affects residents with MDS assessments and could result in missed or inappropriate care. The findings included: 1. Record review of Resident #41's electronic face sheet dated 08/25/2025 reflected she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: muscle wasting and atrophy (decrease in muscle size and mass, which results in reduced muscle strength and function), pain due to internal orthopedic prosthetic devices (can arise from surgical complications, mechanical issues with the implant), diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar (glucose) levels), osteoporosis (a condition that weakens bones, making them more prone to fractures), post viral fatigue syndrome (debilitating state of physical and mental exhaustion that persists for weeks or months after a viral infection has cleared) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning-to such an extent that it interferes with a person's daily life and activities) Record review of Resident #41's quarterly MDS assessment with an ARD of 07/17/2025 reflected she could usually understand and usually be understood. She was not a candidate for a BIMS which indicated she was severely cognitively impaired. She was dependent on staff for ADLs except for eating where she required set up assistance. She was always incontinent of bowel and bladder. An indwelling urinary catheter was not indicated. Record review of Resident #41's comprehensive care plan revised date 12/27/2023 reflected Focus, I have a Self-Care deficit r/t Poor physical functioning, weakness and debility, incontinent of bladder and incontinent of bowel. Record review of Resident #41's physician order dated 07/15/2025 reflected Collect urine via PVR, urethral catheterization. If residual greater than 250ml leave urethral catheter in place. Record review of Resident #41's Nursing Progress Note dated 07/15/2025 written by LVN D reflected Urine sample collected and sent in hand with lab personnel. Residual greater than 250 cc. Foley catheter remains in place with balloon inflated with 10 cc NS via syringe. Record review of Resident #41's Documentation Survey Reports dated July and August 2025 reflected from 07/15/2025 to 08/04/2025 when the resident went out to the hospital for a change in condition, (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she had an indwelling urinary catheter. Observation on 08/24/2025 at 10:30 am revealed Resident #41 was on contact isolation and EBP. She had a bin outside of her room which contained PPE. She was lying in bed and had a covered urinary drainage bag hanging on the side of her bed frame. 2. Record review of Resident #55's face sheet, dated 08/27/2025, revealed the resident was 82-years-old female who was admitted to the facility on [DATE] with diagnosis of muscle wasting and atrophy (loss of skeletal muscle mass), emphysema (air-filled enlargement in the body's tissue causes shortness of breath), dementia (loss of memory and thinking ability), acute kidney failure (kidney lose the ability to remove waste and balance fluids), and neuromuscular dysfunction of bladder (nerves that carry messages back and forth between bladder and the spinal cord and brain do not work the way they should). Record review of Resident #55's admission MDS assessment with an ARD of 07/24/2025 reflected the resident's BIMS was 4 out of 15, which indicated her cognition was severely impaired. The resident required substantial/maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) from staff for sit to stand, chair to bed, and toilet transfer. Resident #55 was always incontinent of bowel and bladder. Further record review of the MDS revealed Resident #55's indwelling urinary catheter was not coded. Record review of Resident #55's comprehensive care plan, revised date 08/02/2025, reflected I [Resident #55] require a catheter at risk for infection and catheter related injury/issues. Providing indwelling Catheter Care. Record review of Resident #55's physician order, dated 07/18/2025, revealed the resident had the order of Foley Catheter 16 French (indwelling urinary catheter) 10 milliliters, change monthly and as needed. Observation on 08/26/2025 at 2:04 p.m. revealed Resident #55 was on the bed in her room with an indwelling urinary catheter hanging to the bed frame. The resident's indwelling urinary catheter was clean, so the resident refused CNAs provided catheter care at that time. An interview on 08/27/2025 at 11:16 a.m. with the DOCR stated Resident #55 had an indwelling urinary catheter from 07/18/2025 per the physician order, but the resident's admission MDS, dated [DATE], reflected Resident #55 did not have an indwelling urinary catheter, and it was not accurate. Resident #55's admission MDS, dated [DATE], should have reflected the resident had an indwelling urinary catheter. Further interview with the director of clinical reimbursement said not reflecting Resident #55's indwelling urinary catheter was her mistake because she supervised MDS accuracy, and the accuracy of an MDS was very important to reflect the resident's status. However, it did not affect Resident #55's care because the resident already received care related to an indwelling urinary catheter. 3. Record review of Resident #34's electronic face sheet dated 08/25/2025 reflected she was an [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: muscle wasting and atrophy (progressive loss or weakening of muscle tissue, characterized by a reduction in muscle size and mass), chronic obstructive pulmonary disease (group of lung diseases that cause airflow obstruction and breathing difficulties), pain (physical suffering or discomfort caused by illness or injury), and major depressive disorder (mood (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder that causes a persistent feeling of sadness or loss of interest and can interfere in daily activities). Record review of Resident #34's annual MDS assessment with an ARD of 07/25/2025 reflected she could understand and be understood. She scored a 13 of 15 on her BIMS which indicated her cognition was intact She required minimal assistance with ADLs. She had an active diagnosis of pain. She had received, was offered, or declined PRN pain medication within the previous five days. Review of section N0415 High-Risk Drug Classes: Use and Indication reflected she was not taking an opioid medication. Record review of Resident #34's comprehensive care plan revised 04/17/2023 reflected Focus, I am at risk for experiencing discomfort or pain r/t: Hx of fractures, co-morbid medical conditions and joint discomfort, Interventions/Tasks, administer my medications to relieve my pain as recommended by my doctor. Record review of Resident #34's Active Orders As of: 08/25/2025 reflected Tylenol with Codeine #3 Oral Tablet 300-30 MG (Acetaminophen w/ Codeine) Give 1 tablet by mouth every 6 hours as needed for SEVERE PAIN related to PAIN, UNSPECIFIED (R52) ***NOT TO TAKE MORE THAN 4000MG (4GRAMS) OF ACETAMINOPHEN/DAY*** Phone Active 01/02/2025 01/02/2025. Record review of Resident #34's MAR dated 07/01/2025 to 07/31/2025 reflected she took a Tylenol with Codeine tablet for pain on Monday July 21, 2025, at 02:09 am with a pain level of 6 which indicated a moderate amount of pain. During an interview on 08/24/2025 at 10:46 am, Resident #34 stated she sometimes had pain in her back and joints. She stated she took pain medication. During an interview on 08/27/2025 at 08:06 am, LVN F stated she was new at doing MDS assessments. She stated she had done them for about six months. She confirmed Resident #41 had an indwelling urinary catheter the week of 07/15/2025 and her quarterly MDS assessment with an ARD of 07/17/2025 did not accurately reflect the catheter. She stated it was important for the MDS assessment to accurately reflect the resident's status or care might be missed. She stated Resident #34 was on an opioid medication and her annual MDS assessment was inaccurate. During an interview on 08/27/2025 at 3:00 pm, CNA K stated she assisted Resident #41 during the last two weeks of July 2025, and the resident had an indwelling urinary catheter. She stated she provided catheter care for the resident. During an interview on 08/27/2025 at 3:10 pm, CNA L stated she assisted Resident #41 during the last two weeks of July 2025, and she had an indwelling urinary catheter. She stated she provided catheter care for the resident. During an interview on 08/27/2025 at 3:20 pm, the DOCR confirmed that the MDS assessment should reflect a resident's status. She confirmed if Resident #41 had an indwelling urinary catheter it should have been reflected on her quarterly MDS assessment dated [DATE]. She confirmed Resident #34 (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had opioid medication ordered and had it administered as needed. During an interview on 08/27/25 at 09:36 am, the DON stated the MDS needed to be accurate to reflect a resident's condition and if it were not accurate, could result in missed or inappropriate care. She stated the indwelling urinary catheter for Resident #41 was missed on her quarterly MDS assessment. She stated Resident #34 was taking an opioid medication and it should have been reflected on her MDS. During an interview on 08/27/2025 at 2:55 pm with the ADM who was accountable for the MDS's, stated the accuracy of an MDS was important to reflect the resident's status and to dictate the accurate care needed. She stated care could be provided to the resident that could be inaccurate. Record review of the facility's policy and procedure titled Comprehensive Assessments revised March 2023 reflected Accuracy of Assessment, each resident receives an accurate team member assessment of relevant care areas that provide team members with knowledge of each resident's status, needs, strengths, and areas of decline.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for three (Residents #17, #41 and #119) of 32 residents reviewed for comprehensive care plans. The facility failed to provide Resident #17 a call bell instead of a call light which was reflected in his comprehensive person-centered care plan. 2. The facility failed to reflect Resident #41 had an indwelling urinary catheter in her comprehensive person-centered care plan. 3. The facility failed to reflect Resident #119 had an oxygen therapy in her comprehensive person-centered care plan. These deficient practices affect residents who require specialized care and could result in inadequate or missed care. The findings included: 1. Record review of Resident #17's electronic face sheet dated 08/24/2025 reflected he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: myopathy (muscle disease which results in spasms, stiffness and cramps), acute respiratory failure with hypoxia (life-threatening condition characterized by insufficient oxygen in the blood), epilepsy (neurological condition characterized by recurrent seizures), suicidal ideations (thoughts or feelings about self-harm) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #17's quarterly MDS assessment with an ARD of 06/23/2025 reflected he could usually be understood and could usually understand others. He scored a 06 of 15 on his BIMS which indicated his cognition was severely impaired. He was dependent on his ADL care except for eating where he required set up assistance. He was always incontinent of bowel and bladder. Record review of Resident #17's comprehensive care plan with an initiated date of 06/27/25 reflected Focus, I am at risk for depression: Chronic poor health, Focus, I am at risk for psychosocial or emotional distress, Goal, I will not experience any distress or discomfort that will affect my functional well-being, I have been noted to chew on call light-bell to be used, revised on 08/19/2025, I will be able to utilize my bell without noted decline, Focus, I am at risk for falls, revised on 05/05/2025, Interventions, Anticipated and meet needs and keep call bell within reach. Record review of Resident #17's Psychiatric Subsequent Assessment dated 08/01/2025 reflected he was treated for major depressive disorder, recurrent, severe with psychotic symptoms (a form of severe depression that includes symptoms of psychosis, a break from reality, such as hallucinations (seeing, hearing, or feeling things that are not there) or delusions (false, fixed beliefs), generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry about various everyday events or situations) and insomnia (a sleep disorder characterized by difficulty falling or staying asleep, resulting in daytime fatigue and impairment). Observation on 08/24/2025 at 09:40 am, Resident #17 was in his room, lying on a low bed with mat on the floor. The room had an odor of stale urine. Resident #17 was reaching out and acted like he was trying to get someone's attention. When asked by the surveyor if he could reach and use his call light he stated no and moved his hand to illustrate pressing a call light button. His call light cord and button were located approximately three feet from the bed wrapped around the left arm rest of his tall (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair. During an interview on 08/26/2025 at 4:40 pm with LVN H who was charge nurse on Resident #17's unit revealed she stated she had checked the resident, and he was dry when they put him to bed at 3:00 pm. She stated she had not noticed his call light was not a call bell as care planned and that it was not within reach since she was on the unit. She stated it was important for him to have a call bell and for it to be within reach in case he needed something. During an interview on 08/27/2025 at 09:36 am with the DON, she stated that Resident #17 should have had a call bell because he chewed on the call light. She did not know why he did not have one, and she stated she would get it fixed immediately. She stated he needed to be able to call staff for assistance and care. 2. Record review of Resident #41's electronic face sheet dated 08/25/2025 reflected she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: muscle wasting and atrophy (decrease in muscle size and mass, which results in reduced muscle strength and function), pain due to internal orthopedic prosthetic devices (can arise from surgical complications, mechanical issues with the implant), diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar (glucose) levels), osteoporosis (a condition that weakens bones, making them more prone to fractures), post viral fatigue syndrome (debilitating state of physical and mental exhaustion that persists for weeks or months after a viral infection has cleared) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning-to such an extent that it interferes with a person's daily life and activities) Record review of Resident #41's quarterly MDS assessment with an ARD of 07/17/2025 reflected she could usually understand and usually be understood. She was not a candidate for a BIMS which indicated she was severely cognitively impaired. She was dependent on staff for ADLs except for eating where she required set up assistance. She was always incontinent of bowel and bladder. An indwelling urinary catheter was not reflected. Record review of Resident #41's comprehensive care plan revised date 12/27/2023 reflected Focus, I have a Self-Care deficit r/t Poor physical functioning, weakness and debility, incontinent of bladder and incontinent of bowel. Resident #41's comprehensive person-centered care plan did not reflect an indwelling urinary catheter. Record review of Resident #41's physician order dated 07/15/2025 reflected Collect urine via PVR, urethral catheterization. If residual greater than 250ml leave urethral catheter in place. Record review of Resident #41's Nursing Progress Note dated 07/15/2025 written by LVN D reflected Urine sample collected and sent in hand with lab personnel. Residual greater than 250 cc. Foley catheter remains in place with balloon inflated with 10 cc NS via syringe. Record review of Resident #41's Documentation Survey Reports dated July and August 2025 reflected from 07/15/2025 to 08/04/2025 when the resident went out to the hospital for a change in condition, she had an indwelling urinary catheter. Record review of Resident #41's hospital notes dated 08/14/2025 prior to her discharge back to the facility reflected ESBL, E. Coli, Chronic indwelling Foley catheter (replaced in ED on 08/04/2025). (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/24/2025 at 10:30 am revealed Resident #41 was on contact isolation and EBP. She had a bin outside of her room which contained PPE. She was lying in bed and had a covered urinary drainage bag hanging on the side of her bed frame. During an interview on 08/27/2025 at 08:06 am, LVN F stated she created, reviewed, and updated care plans. She stated Resident #41 had an indwelling urinary catheter the week of 07/15/2025 and the catheter needed to be part of her plan of care. She stated the care plan reflected the care a resident required, and an inaccurate care plan could result in missed care. During an interview on 08/27/25 at 09:36 am, the DON stated Resident #41's indwelling urinary catheter needed to be part of her plan of care. She stated Resident #41's care could be misinterpreted if the plan did not correctly reflect the resident. During an interview on 08/27/2025 at 3:00 pm, CNA K stated she assisted Resident #41 during the last two weeks of July 2025, and the resident had an indwelling urinary catheter. She stated she provided catheter care for the resident. During an interview on 08/27/2025 at 3:10 pm, CNA L stated she assisted Resident #41 during the last two weeks of July 2025, and she had an indwelling urinary catheter. She stated she provided catheter care for the resident. During an interview on 08/27/2025 at 3:20 pm, the DOCR confirmed that Resident #41's indwelling urinary catheter needed to be part of her comprehensive person-centered care plan. 3. Record review of Resident #119's face sheet, dated 08/27/2025, revealed the resident was 102-years-old female who was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis of arthritis (swelling and tenderness on one of more joints, causing joint pain), chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), muscle wasting and atrophy (loss of skeletal muscle mass), and heart failure (the heart can't pump enough oxygen-rich blood to meet your body's needs). Record review of Resident #119's 5-days Medicare MDS assessment, dated 08/02/2025, revealed the resident's BIMS score was 12 out of 15, which indicated the resident had moderate cognitive impairment, required Substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to chair to bed and sit to stand and was receiving oxygen therapy. Record review of Resident #119's comprehensive care plan, dated 08/05/2025, revealed there was no care plan regarding Resident #119's oxygen therapy. Record review of Resident #119's physician order, dated 08/05/2025, revealed the resident had the order of Oxygen 3-5 liters per minute and nasal cannula as tolerated for chronic obstructive pulmonary disease. Observation on 08/24/2025 at 10:09 a.m. revealed Resident #119 was on the bed with oxygen 4 liters per minutes via nasal cannula. During an interview on 08/27/2025 at 11:07 a.m. with the DOCR stated Resident #119's care plan did not address the resident's oxygen therapy. The care plan should have addressed Resident #119's (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen therapy because the resident was taking oxygen therapy as ordered, and it might not affect resident care because nurses followed the physician orders. Review of the facility policy's and procedure titled Care Plans Revised January 2023 reflected The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan should be prepared, reviewed, and updated in accordance with the RAI guidance on a routine cadence (admission, quarterly, annually and with significant change). Additionally, the care plan should be modified as appropriate and on an as needed basis as per the RAI instructions. Review of the facility policy's and procedure titled Care Plans Revised January 2023 reflected The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan should be prepared, reviewed, and updated in accordance with the RAI guidance on a routine cadence (admission, quarterly, annually and with significant change). Additionally, the care plan should be modified as appropriate and on an as needed basis as per the RAI instructions.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, 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 3 (Resident #18, #150, and #1) of 7 residents reviewed for pharmacy services. 1. The facility failed to re-order on time Resident #18's Janumet 50-500 mg medication for diabetes. 2. The facility failed to re-order on time Resident #150's Carboxymethylcellulose sodium 0.5% eye drops for dry eyes. 3. The facility to ensure Resident #1's insulin Lispro KwikPen for diabetes had open date of [DATE], stored inside the 200-unit C-hall nursing cart was not expired. This failure could place residents at risk of not receiving appropriate therapeutic effects of medication. The findings included: 1. Record review of Resident #18's face sheet, dated [DATE], revealed the resident was a 42-years-old male and admitted to the facility on [DATE] with diagnoses of muscle wasting and atrophy (loss of skeletal muscle mass), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), hypertension (high blood pressures), and heart failure (your heart can't pump enough oxygen-rich blood to meet your body's needs). Record review of Resident #18's admission MDS assessment, dated [DATE], revealed the resident's BIMS was 15 out of 15, which indicated the resident's cognitive was intact, required partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to sit to stand and chair to bed transfer, and had Diabetes Mellitus in section I (Active Diagnoses). Record review of Resident #18's comprehensive care plan, dated [DATE], revealed I [Resident #18] have diabetes and I am at risk for: Complications associated with diabetes: Frequent Infections, Diabetic wounds, Vision Impairment, Hyper/Hypo-Glycemia, Renal Failure, Cognitive/Physical Impairment. For intervention - Administer my medications as recommended by my doctor. Record review of Resident #18's physician order, dated [DATE], revealed the resident had the order of Janumet oral tablet 50-500 mg - Give one tablet by mouth two times a day related to Diabetes Mellitus. Record review of Resident #18's medication administration record from [DATE] to [DATE] revealed the resident was receiving Janumet oral tablet 50-500 mg - Give one tablet by mouth two times a day related to Diabetes Mellitus at 8:00 am and 5:00 pm. Observation on [DATE] at 4:21 p.m., revealed LVNN prepared Resident #18's medications in front of the resident's room. LVNN could not find Resident #18's Janumet from her cart, so LVNN tried to get this medication from the facility emergency medication cart, but there was no Janumet in the facility emergency medication cart. Further observation revealed LVNN reported it to the DON and primary care physician. During an interview on [DATE] at 4:32 p.m., with LVNN stated she did not give Resident #18's Janumet at this time because the medication was not available. LVNN said she reported it to the DON and primary care physician. The DON said she contacted to the facility pharmacy, and the DON would send the facility staff to pick up this medication, and the primary care physician said facility nurse could administer this medication to Resident #18 when the medication became available. LVNN said she was an agency nurse and worked as needed. However, the facility nurses should have re-ordered this medication on time to give this medication as scheduled. During an interview on [DATE] at 6:00 p.m., the DON stated Resident #18 received his Janumet at 6:00 p.m. because the facility staff picked it up from the pharmacy. The facility nurses should have re-ordered this medication on time to give this medication to the resident as scheduled. The facility did not have specific policy regarding re-ordering medications on time, but if nurses did not re-order medications on time, it might cause the resident to not take their medications as ordered. 2. Record review of Resident #150's face sheet, dated [DATE], revealed the resident was a 91-years old male and admitted to the facility on [DATE] with diagnosis of anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, (continued on next page)		

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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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a protein found in red blood cells, to carry oxygen all through the body), glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness), and muscle wasting and atrophy (loss of skeletal muscle mass). Record review of Resident #150's admission MDS assessment was in progress because the resident was admitted to the facility on [DATE]. Record review of Resident #150's baseline care plan, dated [DATE], revealed I [Resident #150] am at risk for vision loss/impairment: for intervention - Medications as ordered. Record review of Resident #150's physician order, dated [DATE], revealed Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium (Ophth) Instill 1 drop in both eyes four times a day for dry eyes. Record review of Resident #150's medication administration record from [DATE] to [DATE] revealed the resident was receiving Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium (Ophth) Instill 1 drop in both eyes four times a day for dry eyes at 8:00 am, 12:00 pm, 5:00 pm, and 8:00 pm. Observation on [DATE] at 4:39 p.m., revealed LVNO did not administer Resident #150's Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % to both his eyes because the medication was not available. Further observation revealed LVNO did not report to the DON and primary care physician. LVNO went to the next resident to give medications. During an interview on [DATE] at 10:34 a.m., LVNO stated she did not administer Resident #150's Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % to both his eyes because the medication was not available and did not report it to the DON and primary care physician because she was busy passing medication to other residents. LVNO said nurses should have re-ordered this medication on time, but she did not know what reasons nurses did not re-order on time. During an interview on [DATE] at 9:43 a.m., the DON said she reported regarding Resident #150's Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % was not available to the primary care physician, and the physician said it was fine to administer this medication when this medication was available. The DON stated the facility nurses should have re-ordered this medication on time before nurses run out of the medication to make sure the resident received this medication as ordered, and Resident #150 did not receive this medication as ordered, so it was a medication error, and the resident might not have therapeutic effect regarding his dry eyes. The facility did not have specific policy regarding re-ordering medications on time. 3. Record review of Resident #1's face sheet, dated [DATE], revealed the resident was 71-years-old female, originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnosis of lack of coordination (uncoordinated movement is due to a muscle control problem), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), Chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), and hypertension (high blood pressures). Record review of Resident #1's quarterly MDS assessment, dated [DATE], revealed the resident's BIMS was 6 out of 15, which indicated the resident had severe cognitive impairment, was dependent (Helper does ALL of the effort) to all activities daily living, and received insulin as ordered. Record review of Resident #1's comprehensive care plan dated [DATE], revealed I [Resident #1] have diabetes and I am at risk for Complications associated with diabetes: For intervention - Administer my medications as recommended by my doctor, monitor labs as indicated. Record review of Resident #1's physician order, dated [DATE], revealed HumaLOG Injection Solution 100UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 150 - 199 = 2; 200 - 249 = 4; 250 - 299 = 6; 300 - 349 = 8; 350 - 999 = 10 For B/S (blood sugar) greater than 400 give 10 units and notify MD (medical doctor), subcutaneously before meals and at bedtime for diabetes. Record review of Resident #1's medication administration record from [DATE] to [DATE] revealed the resident was receiving HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale at 7:00 am, 11:00 am, 4:00 pm, and 8:00 pm. Observation on [DATE] at 2:20 p.m., revealed Resident #1's HumaLOG Injection Solution 100UNIT/ML (Insulin Lispro) Inject Pen in the 200-unit C-hall nursing cart, and it was opened on [DATE]. During an interview on [DATE] at 2:20 p.m., LVNP stated she used Resident #1's HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject Pen around 7:00 am. LVNP said she (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checked the open date was [DATE] and thought it was fine to use this insulin because LVNP said she was confused regarding the date nurses should discard the insulin pen to 28 days after opened it. During an interview on [DATE] at 2:35 p.m., the DON stated the facility nurses had the responsibility to check their carts and should have discarded Resident #1's HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject Pen on [DATE] because it was opened on [DATE] and should have been discarded 28 days after opened it. The facility did not have a specific policy regarding when to discard an insulin pen, but the facility was following professional guidelines. Resident #1 might have not therapeutic effects regarding blood sugars. Record review of professional guidelines of https://www.healthline.com/health/diabetes/what-to-do-with-expired-insulin#expiration-dates, accessed [DATE], revealed Humalog/insulin lispro vials, pens, cartridges - expiration from the first use - 28 days.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure: 1. Dietary Aide B failed to wear beard restraints while working in the kitchen.2. Dietary Aide A did not properly wear hair restraints in a way that covered all their hair.3. The facility failed to store wet dishes to allow for air-drying.4. The facility failed to ensure all prepared items in the walk-in refrigerator were labeled and dated with the use by date. These failures could place residents at risk for food borne illness.The findings included:Observation of the facility's kitchen on 08/24/2025 at 8:26 AM revealed a tray with lettuce, sliced tomato, sliced onion and cheese unlabeled, an open bag of lettuce unlabeled, and three drink dispensers with liquids unlabeled being stored in the walk in refrigerator. Observation of the facility's kitchen on 08/24/2025 at 11:59 AM revealed Dietary Aide A standing at the steam table not wearing facial hair restraint over his facial hair and Dietary Aide B wearing hair restraint in a way that did not cover all the hair on his head. Observation of the facility's kitchen on 08/25/2025 at 11:10 AM revealed Dietary Aide A not wearing facial hair restraint over his facial hair while in the kitchen. 9 trays of wet bowls (approximately 12 bowls on each tray) and 3 trays of wet mugs (approximately 15 mugs on each tray) being stored in a way that did not allow air flow was also observed in the kitchen. An interview with [NAME] C on 08/26/2025 at 1:42 PM revealed she worked at the facility about 8 months. [NAME] C stated all prepared items should be labeled before storing in the refrigerator. [NAME] C stated it was the responsibility of all staff to label items before storing items in the refrigerator. [NAME] C stated hairnets and facial hair restraints were to be worn to cover all hair while in the kitchen. [NAME] C stated it was the responsibility of all staff to ensure their hair nets and facial hair restraints covered all hair. [NAME] C stated dishes should be stored dry or in a way to allow air flow to dry. [NAME] C stated it was the responsibility of the dishwasher to ensure dishes were dried correctly. [NAME] C stated these failures could cause food to be contaminated and could have caused residents to become sick. [NAME] C stated she received training on food storage and labeling, hair restraints and washing and drying dishes from the dietary manager when she started working at the facility. An interview with Dietary Aide B on 08/26/2025 at 1:48 PM revealed he worked at the facility about 4 months. Dietary Aide B stated he was a dishwasher and did not handle food. Dietary Aide B stated all items stored in the walk-in refrigerator were to be labeled with the date opened and used by date. Dietary Aide B stated if he observed items unlabeled, he would report it to the cook or the dietary manager. Dietary Aide B stated it was the responsibility of all staff storing items in the walk-in refrigerator to label items before storing items. Dietary Aide B stated by not labeling food being stored it could cause spoiled foods to be served to residents causing them to get sick. Dietary Aide B stated hair nets were to be worn by all staff while they were in the kitchen. Dietary Aide stated on the date his hair was observed not in the hairnet he had tried to put it all up but because his hair was long it was difficult to get it all in the hairnet. Dietary Aide B stated hairnets prevented hair from falling into food and contaminating foods. Dietary Aide B stated contaminated foods could cause the residents to get sick. Dietary Aide B stated it was the responsibility of all staff to ensure hair restraints were worn correctly. Dietary Aide B stated dishes should be stored so that there is air flow to allow them to dry. Dietary Aide B stated bacteria could grow on dishes if not dried properly and could cause the residents to become ill. Dietary Aide B stated it was the responsibility of all staff to ensure dishes air dry. Dietary Aide B stated he received training on received training on food storage and labeling, hair restraints and washing and drying dishes from the dietary manager when he started working at the facility. Interview with Dietary Aide A on 08/26/2025 at 2:15 PM revealed he had worked for the facility about 9 months. Dietary Aide A stated prepared items stored in the walk-in refrigerator should be labeled before they were stored. Dietary Aide A stated it was the responsibility of everyone in the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchen to ensure prepared items stored in the walk in were labeled. Dietary Aide A stated by not labeling items, spoiled items could have been served to residents causing them to get sick. Dietary Aide A stated hair restraints were to be worn by everyone while in the kitchen. Dietary Aide A hair restraints were to be worn to prevent hair from contaminating food. Dietary Aide A stated contaminated food could cause illness in the residents. Dietary Aide A stated it was the responsibility of all staff to ensure hair restraints were worn correctly. Dietary Aide A stated dishes should be stored in a way to allow air flow drying. Dietary Aide A stated bacteria could grow on dishes if not dried properly and could cause the residents to become ill. Dietary Aide A stated it was the responsibility of all staff to ensure dishes air dry. Dietary Aide A stated he received training on received training on food storage and labeling, hair restraints and washing and drying dishes from the dietary manager when he started working at the facility. Interview with the Dietary Manager on 08/26/2025 at 2:21 PM revealed prepared items being stored in the walk-in refrigerator were to be labeled and dated. The Dietary Manager stated it was the responsibility of all staff to label and date items before storing them. The Dietary Manager stated by not labeling items stored could result in spoiled items being served to residents causing illness. The Dietary Manager stated hair restraints were to be worn by everyone that entered the kitchen. Dietary Manager stated hair restraints prevent hair from falling into food and contaminating it. The Dietary manager stated contaminated foods had he potential to cause illness in the residents. Dietary Manager stated it was the responsibility of all staff to ensure hair restraint were worn correctly. The Dietary Manager stated dishes were to be stored to allow them to air dry. The Dietary Manager stated the wet dishes could cause bacteria to grow and could cause illness in the residents. The Dietary Manager stated it was the responsibility of all staff to ensure dishes were stored properly. The Dietary Manager stated he provides training to all new staff on labeling items being stored, wearing hairnet/facial hair restraints, and storing dishes when staff start working in the kitchen. Record review of facility policy named Food Storage dated October 1, 2018, revealed 2. Refrigeratorsd. Date, label and tightly seal all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage. Record review of facility policy named Policy: Mechanical Cleaning and Sanitizing of Utensils and Portable Equipment dated October 1, 2018, revealed 9. Air dry all equipment and utensils after sanitizing. Record review of facility policy named Employee Sanitation dated October 1, 2018, revealed 3. Employee Cleanliness Requirements b. Hairnets, headbands, caps, beard coverings or other effective hair restraints must be worn to keep hair from food and food-contact surfaces Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.(B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying;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. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 states 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.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 5 residents (Residents #9, Resident #17 and Resident #105) reviewed for infection control. 1. The facility failed to ensure to utilize proper PPE for direct care of a resident with EBP precautions in place while performing Resident #9's suppository administration. 2. CNA E and CNA J did not clean Resident #17's anal area and rectum and left on his soiled socks when they performed incontinent care.3. LVN-Q measured Resident #105's blood pressure without cleaning the blood pressure cuff. These deficient practices could place residents at-risk for infection due to improper care practices. The findings were: 1. Record review of Resident #9's face sheet, dated 08/25/2025, revealed Resident #9 was admitted on [DATE] with diagnoses which included: infection following a procedure, other surgical site, subsequent encounter, and pressure ulcer of sacral region stage 4. Record review of Resident #9's Quarterly MDS assessment, dated 07/15/2025, revealed the resident's BIMS score 15 indicating intact cognition. The Quarterly MDS assessment further revealed Resident #9 had an ulcer unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar and that was present upon admission/entry. Record review of Resident #9's care plan, last review completed date 07/30/2025, revealed Resident #9 had a focus of At risk for infection or recurrent/chronic infection r/t compromised medical condition: and intervention/tasks Enhanced Barrier Precautions practice as clinically indicated. Record review of Resident #9's physician order summary, dated 08/25/2025, read, EBP (Enhanced Barrier Precautions): Practice EBP as indicated every shift with a start date of 04/08/2025. During observation and interview on 08/24/2025 at 9:30 a.m. it was observed Resident #9's room door had EBP sign on the outside of her room door. Resident #9 was observed lying in her bed and Resident #9 stated she had a wound to her buttock. Resident #9 stated staff did not wear a gown when performing her care. Observation on 08/25/2025 at 2:03 p.m. revealed after knocking on Resident #9's door and opening slightly LVN D standing to the opposite side of the bed elevating Resident #9's left leg and while not wearing a gown. LVN D stated she was performing patient care in which this surveyor closed the door. During an interview on 08/25/2025 at 2:08 p.m. LVN D informed surveyor she was placing a suppository due to Resident #9 had one ordered and then LVN D looked at the signage on the door for EBP. LVN D stated she should have been wearing a gown aside from just her gloves when performing care for Resident #9. LVN D again stated she had used gloves when providing care. LVN D then pushed the room door slightly open to check for the supplies with supplies noted to be by the door as one would enter the room. LVN D stated she should have been wearing gloves and a gown when caring for Resident #9. LVN D stated this was for infection control and to prevent transmissions. LVN D further stated by not wearing the proper PPE it could cause cross contamination to other residents. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/26/2025 at 11:50 a.m. the DNS stated LVN D should have worn a gown while administering the suppository to Resident #9 because she was on EBP to protect the patient and the employee from cross contamination. During an interview on 08/27/2025 at 1:37 p.m. the Administrator stated LVN D should have been wearing a gown while performing the care of Resident #9. The Administrator stated it was to protect and stop spreading infection, and for infection control. The Administrator stated by not wearing the proper PPE it could have spread anything contagious and potentially harm other residents. Record review of facility's Infection Prevention and Control policy, revised date April 2024, read, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of a quality assurance and performance improvement program. The elements of the infection prevention and control program consist of coordination/oversight, guidance/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. Categories: Types of Isolation Precautions: Transmission-based isolation precautions have been adopted by our community to guide team members to have appropriate isolation techniques when necessary. In addition to isolation practices, Enhanced Barrier Precautions (EBP) maybe implemented as an infection control intervention designed to reduce transmission of resistant organisms. The use of PPE such as gown and glove use during high contact resident care activities. EBP may be indicated as recommendation by the CDC (when Contact Precautions do not otherwise apply) for residents. EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Use of eye protection may be necessary when splash or spray may occur but is not necessary in other situations. Resident/Patients with the following clinical indication should be under EBP: Significant Wounds such as chronic wounds, ulcers, open PUI or complicated/non-healing surgical incisions or wounds, and/or open wounds requiring a dressing. EBP should be utilized during high-contact resident care activities . 2. Record review of Resident #17's electronic face sheet dated 08/24/2025 reflected he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: myopathy (muscle disease which results in spasms, stiffness and cramps), acute respiratory failure with hypoxia (life-threatening condition characterized by insufficient oxygen in the blood), epilepsy (neurological condition characterized by recurrent seizures), suicidal ideations (thoughts or feelings about self-harm) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #17's quarterly MDS assessment with an ARD of 06/23/2025 reflected he could usually be understood and could usually understand others. He scored a six out of fifteen on his BIMS which indicated he was severely cognitively impaired. He was dependent on his ADL care except for eating where he required set up assistance. He was always incontinent of bowel and bladder. Record review of Resident #17's comprehensive care plan with an initiated date of 06/27/25 reflected Focus, I am at risk for depression: Chronic poor health, Focus, I am at risk for psychosocial or emotional distress, Goal, I will not experience any distress or discomfort that will affect my functional well-being, I have incontinence, revised on 08/04/25, Interventions, check and change on rounds as needed, Record review of Resident #17's Psychiatric Subsequent Assessment dated 08/01/2025 reflected he (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was treated for major depressive disorder, recurrent, severe with psychotic symptoms (a form of severe depression that includes symptoms of psychosis, a break from reality, such as hallucinations (seeing, hearing, or feeling things that are not there) or delusions (false, fixed beliefs), generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry about various everyday events or situations) and insomnia (a sleep disorder characterized by difficulty falling or staying asleep, resulting in daytime fatigue and impairment). Observation on 08/26/2025 at 4:00 pm of CNA J and CNA E performed incontinent care for Resident #17 revealed he was lying in bed and his pants, and the back of his shirt was wet with urine. The bed sheet he was lying on had a large ring of wet urine which extended to his curled-up legs and anti-skid socks he wore on his feet. CNA E cleaned her hands and put on gloves. CNA E went into his shower room to clean his chair he was sitting on and found a pair of pants covered with feces lying over the shower chair. As CNA E proceeded with CNA J to do a complete bed change. CNA E took off her soiled gloves, sanitized hands and put on clean gloves, she then removed Resident #17's-soaked pants, degloved, washed hands and put clean gloves on. She then had the dirty linen removed, bed sanitized, and applied clean bedding rolled under to complete the bed change. While cleaning and changing the resident's brief, CNA E cleaned the resident's penis, scrotum and wiped the top of his legs which had contact with the resident's soiled pants. CNA J assisted to roll Resident #17 onto his right side and pulled the clean linen through. CNA J wiped the buttocks of Resident #17, and the resident was turned back toward CNA E. They proceeded to change Resident #17's wet shirt and clean any exposed areas of skin. Resident #17 was turned back toward CNA E and the clean brief was slid through. As CNA J was about to pull through the clean brief, the surveyor requested they clean Resident 17's buttocks and anus area. Resident #17 had feces around his anal and rectal area. CNA E and CNA J neglected to remove Resident #17's nonskid socks which were lying on the urine-soaked area of the sheet which were now lying on the clean sheet. During an interview on 08/26/2025 at 4:30 pm CNA E said she was frustrated and she did not remember to take off Resident #17's socks which were lying on the wet sheet. She knew she checked Resident #17's buttocks but did not spread them and clean his rectum and anus. She stated not cleaning the resident, changing his socks and having soiled clothing in his room could cause cross contamination and infection. During an interview on 08/26/2025 at 4:40 pm LVN H who was charge nurse for Resident #17's unit revealed she stated she checked the resident, and he was dry when they put him to bed at 3:00 pm. She stated she had not entered the resident's bathroom during the day and did not see the soiled pants. She stated leaving soiled linen in the room could result in cross contamination and infection. During an interview on 08/26/2025 at 4:45 pm CNA G, stated she did rounds but did not check Resident #17 and took the previous CNA's word that she just changed and did rounds on the residents. During an interview on 08/27/2025 at 09:36 am, the DON, stated that Resident #17 should have been checked to see if he was wet or soiled. She stated Resident # 17 should not have had soiled clothing left in his room, and CNA E and J needed to ensure his anal and rectal area was cleaned as part of incontinent care. She said leaving him in soiled socks could result in infection by cross contamination. Record review of CNA E's Peri Care Audit Tool dated 07/30/2025 reflected Male, buttocks, using incontinent wipe, wash sides, then middle reflected she met the competency skill. Record review of CNA J's Peri Care Audit Tool dated 07/20/2025 reflected Male, buttocks, using (continued on next page)		

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinent wipe, wash sides, then middle reflected she met the competency skill. Record review of the facility policy and procedure titled Infection Prevention and Control revised April 2024 reflected The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program, includes all staff to include direct and indirect care functions. 3. Record review of Resident #105's face sheet, dated 08/27/2025, revealed the resident was 72-years-old female, originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnosis of cerebral ischemia (condition that occurs when there is not enough blood flow to the brain), muscle wasting and atrophy (loss of skeletal muscle mass), hypertension (high blood pressures), muscle weakness, and pleura effusion (collection of fluid around your lungs). Record review of Resident #105's quarterly MDS assessment, dated 08/07/2025, revealed the resident's BIMS was 15 out of 15, which indicated the resident's cognitive was intact and required Supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) to sit to stand and toilet transfer. Record review of Resident #105's comprehensive care plan, dated 07/12/2025, revealed I [Resident #105] am at risk for significant infections and/or recurrent infections r/t compromised medical condition. For intervention - Provide education to team members, resident and/or visitors regarding infection prevention practices as indicated. Observation on 08/26/2025 at 8:28 a.m., revealed LVNQ came out from Resident #105's next door with a blood pressure cuff and said she completed measuring blood pressure and giving all medications to this resident and went to Resident #105 to give medications. Further observation on 08/26/2025 at 8:29 a.m., revealed LVNQ entered to Resident #105's room and measured the resident's blood pressure without cleaning the blood pressure cuff. During an interview on 08/26/2025 at 8:42 a.m., LVNQ said she measured Resident #105's blood pressure without cleaning the blood pressure cuff. LVNQ stated she should have cleaned the blood pressure cuff before using it on Resident #105 to prevent possible infection. During an interview on 08/27/2025 at 9:43 a.m., the DON stated LVNQ should have cleaned the blood pressure cuff before using it on Resident #105 to prevent possible infection, she said there was no specific policy for cleaning a blood pressure cuff. Record review of the facility policy and procedure titled Infection Prevention and Control revised April 2024 reflected The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program, includes all staff to include direct and indirect care functions.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for two (Resident #17 and Resident #108) of 32 residents observed for dignity and respect. 1. CNA E and J left Resident #17's anti-slip socks which were lying on a urine-soaked sheet on his feet after incontinent care. 2. LVN, I did not knock on Resident #108's door prior to entering his room to administer G-tube medications. These deficient practices could affect residents who require assistance with ADL's and could result in loss of dignity and decreased self-esteem. The findings included: 1. Record review of Resident #17's electronic face sheet dated 08/24/2025 reflected he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: myopathy (muscle disease which results in spasms, stiffness and cramps), acute respiratory failure with hypoxia (life-threatening condition characterized by insufficient oxygen in the blood), epilepsy (neurological condition characterized by recurrent seizures), suicidal ideations (thoughts or feelings about self-harm) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #17's quarterly MDS assessment with an ARD of 06/23/2025 reflected he could usually be understood and could usually understand others. He scored a 06 of 15 on his BIMS which indicated his cognition was severely impaired. He was dependent on his ADL care except for eating where he required set up assistance. He was always incontinent of bowel and bladder. Record review of Resident #17's comprehensive care plan with an initiated date of 06/27/25 reflected Focus, I am at risk for depression: Chronic poor health, Focus, I am at risk for psychosocial or emotional distress, Goal, I will not experience any distress or discomfort that will affect my functional well-being, I have incontinence, revised on 08/04/25, Interventions, check and change on rounds as needed, Record review of Resident #17's Psychiatric Subsequent Assessment dated 08/01/2025 reflected he was treated for major depressive disorder, recurrent, severe with psychotic symptoms (a form of severe depression that includes symptoms of psychosis, a break from reality, such as hallucinations (seeing, hearing, or feeling things that are not there) or delusions (false, fixed beliefs), generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry about various everyday events or situations) and insomnia (a sleep disorder characterized by difficulty falling or staying asleep, resulting in daytime fatigue and impairment). Observation on 08/26/2025 at 4:00 pm of CNA J and CNA E performing incontinent care for Resident #17 revealed he was lying in bed and his pants, and the back of his shirt were wet with urine. The bed sheet he was lying on had a large ring of wet urine which extended to his curled-up legs and anti-skid socks he wore on his feet. At the completion of the peri-care for Resident #17, CNA E and CNA J appeared to be finished with the peri care and pulled a clean brief up onto the resident and did not remove Resident #17's socks. During an interview on 08/26/2025 at 4:30 pm with CNA E who admitted she was frustrated revealed she did not remember to take off Resident #17's socks which were lying on the wet sheet. She stated it could affect his rights to dignity and to have a clean sanitary area. She stated he could become more depressed or have a loss of self-esteem. During an interview on 08/26/2025 at 4:35 pm with CNA J, she stated she and CNA E forgot to change Resident #17's socks and would change his bed linen again. She stated being in wet socks could affect his self-esteem and he had a right to dignity. During an interview on 08/26/2025 at 4:40 pm with LVN H who was charge nurse on Resident #17's unit revealed she had checked the resident, and he was dry when they put him to bed at 3:00 pm. During an interview on 08/26/2025 at 4:45 pm with CNA G, she stated she did rounds but did not check Resident #17 and took the previous CNA's word that she had just changed and did rounds on the residents. During an interview on (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/27/2025 at 09:36 am with the DON, she stated that Resident #17 should have been checked to see if he was wet or soiled. She stated leaving his soiled socks on, having a soiled pair of socks on him could result in further depression or lack of self-esteem. 2. Record review of Resident #108's electronic face sheet dated 08/24/2025 reflected he was a [AGE] year-old male, originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: Cerebral Palsy (a lifelong movement disorder caused by non-progressive brain damage that occurs before, during or shortly after birth, affecting muscle coordination and tone), malignant neoplasm of rectum (cancer that develops in the rectum, the lower part of the large intestine), moderate intellectual disabilities (slow in the understanding and use of language, basic reading, writing, and counting skills), gastroparesis (stomach muscles do not work properly) and anxiety (common mental health condition characterized by excessive worry, fear, and nervousness). Record review of Resident #108's admission MDS assessment dated [DATE] reflected he could sometimes understand and sometimes be understood. He scored a 00 out of 15 on his BIMS which indicated his cognition was severely impaired. He was dependent on staff for his ADL care and had enteral feedings. Record review of his comprehensive care plan revised date 08/11/2025 reflected Focus, I have a Self-Care deficit, cognitive impairment, poor physical functioning, weakness and debility, Interventions, assist with ADLs. Observation on 08/26/2025 at 4:30 pm of LVN I, revealed she did not knock on Resident #108's door prior to entering his room to administer G-tube medications. During an interview on 08/26/2025, LVN I stated she was trained to respect residents' privacy and knew she needed to knock on Resident #108's door prior to entry. She stated not knocking showed a lack of respect and right to privacy. During an interview on 08/27/2025 at 09:36 am with the DON, she stated LVN I needed to knock on Resident #108's door prior to entry. She stated not knocking could be disrespectful of his rights to privacy. Record review of the facility policy and procedure titled Respect and Dignity revised January 2023 reflected The community promotes care for residents in a manner and environment that enhances each resident's dignity and respect in full recognition of their individuality. Dignity means that the team members conduct activities that assist the resident to maintain and enhance self-esteem and self-worth, team members knock on room doors and request permission to enter. Record review of the facility policy and procedure titled Routine Resident Care date revised January 2023 reflected 7. Incontinence care should be offered and provided timely in accordance with individual needs.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to provide the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or residents for one resident (Resident #17) of 32 residents observed for accommodation of needs. Resident #17's call light was located approximately 3 feet from the resident and wrapped around his wheelchair arm rest. This deficient practice could affect residents who require assistance with ADL's and could result in loss of getting needs met. The findings included: Record review of Resident #17's electronic face sheet dated 08/24/2025 reflected he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included: myopathy (muscle disease which results in spasms, stiffness and cramps), acute respiratory failure with hypoxia (life-threatening condition characterized by insufficient oxygen in the blood), epilepsy (neurological condition characterized by recurrent seizures), suicidal ideations (thoughts or feelings about self-harm) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #17's quarterly MDS assessment with an ARD of 06/23/2025 reflected he could usually be understood and could usually understand others. He scored a 06 of 15 on his BIMS which indicated his cognition was severely impaired. He was dependent on his ADL care except for eating where he required set up assistance. He was always incontinent of bowel and bladder. Record review of Resident #17's comprehensive care plan with an initiated date of 06/27/25 reflected Focus, I am at risk for depression: Chronic poor health, Focus, I am at risk for psychosocial or emotional distress, Goal, I will not experience any distress or discomfort that will affect my functional well-being, I have been noted to chew on call light-bell to be used, revised on 08/19/2025, I will be able to utilize my bell without noted decline, Focus, I am at risk for falls, revised on 05/05/2025, Interventions, Anticipated and meet needs and keep call bell within reach. Record review of Resident #17's Psychiatric Subsequent Assessment dated 08/01/2025 reflected he was treated for major depressive disorder, recurrent, severe with psychotic symptoms (a form of severe depression that includes symptoms of psychosis, a break from reality, such as hallucinations (seeing, hearing, or feeling things that are not there) or delusions (false, fixed beliefs), generalized anxiety disorder (a chronic mental health condition characterized by excessive, persistent, and uncontrollable worry about various everyday events or situations) and insomnia (a sleep disorder characterized by difficulty falling or staying asleep, resulting in daytime fatigue and impairment). Observation on 08/24/2025 at 09:40 am, Resident #17 was in his room, lying on a low bed with mat on the floor. The room had an odor of stale urine. Resident #17 was reaching out and acted like he was trying to get someone's attention. When asked by the surveyor if he could reach and use his call light he stated no and moved his hand to illustrate pressing a call light button. His call light cord and button were located approximately three feet from the bed wrapped around the left arm rest of his tall wheelchair. During an interview on 08/26/2025 at 4:40 pm with LVN H who was charge nurse on Resident #17's unit revealed she had checked the resident, and he was dry when they put him to bed at 3:00 pm. She stated she had not noticed his call light was not a call bell as care planned and that it was not within reach since she was on the unit. She stated it was important for him to have a call bell and for it to be within reach in case he needed something. During an interview on 08/27/2025 at 09:36 am with the DON, she stated that Resident #17 should have had a call bell because he chewed on the call light. She did not know why he did not have one, and she stated she would get it fixed immediately. She stated he needed to be able to call staff for assistance and care. Record review of the Code of Federal Regulations, Title 42 as of 08/28/2025 reflected Resident Rights, the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Record review of the facility's policy (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and procedure titled Routine Resident Care, revised date January 2023 reflected 8. Resident call lights should be answered timely and resident requests are addressed. Specific types of call lights, i.e., call light pads, etc. should be added to the resident care plan of care based upon residents' abilities and limitations.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; a resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one resident (#41) out of .three residents reviewed for indwelling urinary catheters. The facility failed to have a diagnosis or physicians order for August 2025 for Resident #41's indwelling urinary catheter. This deficient practice affects residents with indwelling urinary catheters and could result in an inconsistency of care. The findings included: Record review of Resident #41's electronic face sheet dated 08/25/2025 reflected she was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: muscle wasting and atrophy (decrease in muscle size and mass, which results in reduced muscle strength and function), pain due to internal orthopedic prosthetic devices (can arise from surgical complications, mechanical issues with the implant), diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar (glucose) levels), osteoporosis (a condition that weakens bones, making them more prone to fractures), post viral fatigue syndrome (debilitating state of physical and mental exhaustion that persists for weeks or months after a viral infection has cleared) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning-to such an extent that it interferes with a person's daily life and activities). Record review of Resident #41's quarterly MDS assessment with an ARD of 07/17/2025 reflected she could usually understand and usually be understood. She was not a candidate for a BIMS which indicated she was severely cognitively impaired. She was dependent on staff for ADLs except for eating where she required set up assistance. She was always incontinent of bowel and bladder. An indwelling urinary catheter was not reflected. Record review of Resident #41's comprehensive care plan revised date 12/27/2023 reflected Focus, I have a Self-Care deficit r/t Poor physical functioning, weakness and debility, incontinent of bladder and incontinent of bowel. Resident #41's comprehensive person-centered care plan did not reflect an indwelling urinary catheter. Observation on 08/24/2025 at 10:30 am revealed Resident #41 was on contact isolation and EBP. She had a bin outside of her room which contained PPE. She was lying in bed and had a covered urinary drainage bag hanging on the side of her bed frame. Observation on 08/25/2025 at 04:20 pm revealed CNA K and CNA L performed catheter care for Resident #41, CNA K wiped from front to back, cleaned the tip of the catheter and from front out down the tubing. Resident #41's perineal area was cleaned. Aseptic technique was used by both CNA's. Record review of Resident #41's physician order dated 07/15/2025 reflected Collect urine via PVR, urethral catheterization. If residual greater than 250ml leave urethral catheter in place. Record review of Resident #41's Nursing Progress Note dated 07/15/2025 written by LVN D reflected Urine sample collected and sent in hand with lab personnel. Residual greater than 250 cc. Foley catheter remains in place with balloon inflated with 10 cc NS via syringe. Record review of Resident #41's Documentation Survey Reports dated July and August 2025 reflected from 07/15/2025 to 08/04/2025 when the resident went out to the hospital for a change in condition, she had an indwelling urinary catheter. Record review of Resident #41's hospital notes dated 08/14/2025 prior to her discharge back to the facility reflected ESBL, E. Coli, Chronic indwelling Foley catheter (replaced in ED on 08/04/2025). Record review of Resident #41's EMR reflected she had a urinary catheter placed on 07/15/2025 for a change in condition, decreased output, and poor intake. Her physician orders nor diagnoses were updated. She was sent to the hospital on [DATE] with an indwelling urinary catheter (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which was replaced in the ED. She returned to the facility on [DATE] with an indwelling urinary catheter. She had no active orders, nor diagnosis for the catheter at the time of survey. During an interview on 08/27/25 at 09:36 am, the DON stated Resident #41's had an indwelling urinary catheter related to urinary retention and confirmed the diagnosis, nor the catheter, to include orders for catheter care were in her physician orders for August 2025. She stated Resident #41 was on Hospice. She stated not having the orders or a diagnosis did not meet professional standards for having an indwelling urinary catheter and could affect care and result in urinary tract infections or complications. Record review of the facility policy and procedure titled Incontinence and Catheterization Assessment and Evaluation revised January 2023 reflected: Residents who enter the community without an indwelling catheter are not catheterized unless the resident's clinical condition makes catheterization necessary. The community will assess at risk for urinary catheterization and will provide ongoing assessment for the resident who currently has a catheter. This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions. Recognize and assess factors affecting the resident's urinary function and identified the medical justification for the use of an indwelling urinary catheter. Define and implement pertinent interventions consistent with resident conditions, goals and recognized standards of practice to try and minimize complications from and indwelling urinary catheter.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care was provided such care, consistent with professional standards of practice and the comprehensive person-centered care plan for one (Resident #174) of six Residents who were reviewed for respiratory care. Resident #174's tubing and mask which were attached to a nebulizer for the resident's breathing treatment were not covered in a plastic bag when not in use. This deficient practice could place residents at risk of respiratory distress, infections, pneumonia and an overall decline in their physical condition. The findings were: Record review of Resident #174's face sheet, dated 08/27/2025, revealed the resident was 70-years-old male who was admitted to the facility on [DATE] with diagnosis of lack of coordination (uncoordinated movement is due to a muscle control problem), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), and acute respiratory failure (difficulty of breathing). Record review of Resident #174's admission MDS revealed the MDS assessment was in progress because the resident was admitted to the facility on [DATE]. Record review of Resident #174's baseline care plan, dated 08/16/2025, revealed the resident had the care for shortness of breath and providing breathing treatment as ordered. Record review of Resident #174's physician order, dated 08/16/2025, revealed Levalbuterol Inhalation Nebulization Solution 0.31 MG/3ML (Levalbuterol HCl) 1 application inhale orally via nebulizer four times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Observation on 08/24/2025 at 10:32 a.m., revealed Resident #174 was on the bed and sleeping in his room, the was tubing and mask attached to the nebulizer on the nightstand, and the tubing and mask was not covered in a plastic bag. During an interview on 08/24/2025 at 10:39 a.m., LVNM stated Resident #174's tubing and mask which was attached to a nebulizer for the resident's breathing treatment was not covered in a plastic bag when the facility did not use the tubing and mask, and the tubing and mask should have been covered in a plastic bag when they were not used to prevent possible infection. During an interview on 08/27/2025 at 2:49 p.m., the DON said Resident #174's tubing and mask should have been covered in a plastic bag when they were not used to prevent possible infection. Record review of the facility policy, titled Respiratory Tubing/Equipment Management, dated 03/12/2018, revealed To maintain properly functioning equipment and decrease the potential for the spread of infection by maintain clean equipment and tubing bottles and masks.		

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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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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7.41% based on 2 errors out of 27 opportunities, which involved one (Residents #150) of seven residents reviewed for medication errors. a. LVNO did not administer Resident #150's Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % to both his eyes for dry eyes because the medication was not available on 08/25/2025 at 4:39 p.m. b. LVNO administered Resident #150's Timolol maleate 0.5 % eye drop for glaucoma on 08/25/2025 at 4:39 p.m., but the order and schedule was Administer Timolol maleate 0.5 % eye drop for glaucoma every 12 hours to Resident #150 at 8:00 am and 8:00 pm. These failures could place residents at risk of not receiving the intended therapeutic benefits of their medications or not receiving them as prescribed, per physician orders. Findings include: Record review of Resident #150's face sheet, dated 08/27/2025, revealed the resident was a 91-years old male and admitted to the facility on [DATE] with diagnosis of anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), glaucoma (an eye condition that damages the optic nerve. This damage can lead to vision loss or blindness), and muscle wasting and atrophy (loss of skeletal muscle mass). Record review of Resident #150's admission MDS assessment was in progress because the resident was admitted to the facility on [DATE]. Record review of Resident #150's baseline care plan, dated 08/10/2025, revealed I [Resident #150] am risk for vision loss/impairment: for intervention - Medications as ordered. Record review of Resident #150's physician order, dated 08/15/2025, revealed Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium (Ophth) Instill 1 drop in both eyes four times a day for dry eyes. Further record review of the resident's physician order, dated 08/11/2025, revealed Timolol Maleate Gel Forming Solution 0.5 % Instill 1 drop in both eyes two times a day for eye pressure (glaucoma). Record review of Resident #150's medication administration record from 08/01/2025 to 08/31/2025 revealed the resident was receiving Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium (Ophth) Instill 1 drop in both eyes four times a day for dry eyes at 8:00 am, 12:00 pm, and 8:00 pm. Further record review of the medication administration record revealed the resident was receiving Timolol Maleate Gel Forming Solution 0.5 % Instill 1 drop in both eyes two times a day for eye pressure (glaucoma) every 12 hours at 8:00 am and 8:00 pm. Observation of medication pass on 08/25/2025 at 4:39 p.m., revealed LVNO did not administer Resident #150's Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % to both his eyes because the medication was not available, and LVNO did not report it to the DON and primary care physician. Further observation revealed LVNO administered one drop of Timolol Maleate Gel Forming Solution 0.5 % to both eyes on 08/25/2025 at 4:39 p.m. During an interview on 08/26/2025 at 10:34 a.m., LVNO stated she did not administer Resident #150's Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % to both his eyes because the medication was not available, and she did not report it to the DON and primary care physician because she was busy passing medication to other residents. LVNO said the nurses should have re-ordered this medication on time, but she did not know what reasons the nurses did not re-order on time. Further interview with LVNO said she administered one drop of Timolol Maleate Gel Forming Solution 0.5 % to both eyes on 08/25/2025 at 4:39 p.m., LVNO said she was a little bit confused regarding the time, and that was why she administered it at 4:39 pm, instead of 8:00 pm, and the nurse said it was medication error because LVNO should have administered this medication one hour before or one hour after, which indicated 7:00 pm or 9:00 pm. During an interview on 08/27/2025 at 9:43 a.m., the DON said she reported regarding Resident #150's Carboxymethylcellulose Sodium Ophthalmic Solution 0.5 % was not available to the primary care physician, and the physician said it was fine to administer this medication when this medication was available. The DON stated the facility nurses should have (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	re-ordered this medication on time to make sure the resident received this mediation as ordered, she said this was a medication error. The DON said LVNO should have administered Resident #150's Timolol Maleate Gel Forming Solution 0.5 % one hour before or one hour after, which indicated 7:00 pm or 9:00 pm and that was a medication error. The DON said Resident #150 might not have therapeutic effects due to these errors, but the physician said there was no adverse effect to the resident. Record review of the facility policy, titled Medication Administration, revised 01/2024, 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 scheduled for the community.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 (treatment cart) of 5 nursing carts and 1 resident (Resident #34) of 32 residents reviewed for storage, in that: 1. The facility failed to ensure the treatment cart was locked when left unattended. 2. The facility failed to notice and remove a jar of medicated chest rub from Resident #34's nightstand. This failure could place residents at risk of misappropriation of medications and not receiving therapeutic benefits of medications. The findings were: 1. During an observation on 08/25/2025 at 10:50 a.m., revealed the treatment cart was found unlocked and unattended on the 300-unit B-hallway. This surveyor was able to open all drawers revealing multiple medications and ointments, scissors, and bottles of medications. During an interview on 08/25/2025 at 10:52 a.m., the wound care nurse stated the treatment cart was unlocked and unattended on the 300-unit B-hallway. The wound care nurse stated she did not realize she left the cart unlocked. The wound care nurse stated it was important the treatment cart was locked at all times due to resident, visitor, and staff safety. The wound care nurse stated by the treatment cart being unlocked, anyone could get into the cart and take medications or scissors from the cart. During an interview on 08/27/2025 at 9:43 a.m., the DON stated the treatment cart should not have been unlocked as it would not be safe for residents and visitors. The DON stated if the treatment cart was not locked someone other than the nurse, like a resident with dementia, could open the cart, take out the medications and take them. The DON said the wound care nurse was responsible for overseeing this and monitored if or not the cart was locked sometimes. 2. Record review of Resident #34's electronic face sheet dated 08/25/2025 reflected she was an [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: muscle wasting and atrophy (progressive loss or weakening of muscle tissue, characterized by a reduction in muscle size and mass), chronic obstructive pulmonary disease (group of lung diseases that cause airflow obstruction and breathing difficulties), pain (physical suffering or discomfort caused by illness or injury), and major depressive disorder (mood disorder that causes a persistent feeling of sadness or loss of interest and can interfere in daily activities). Record review of Resident #34's annual MDS assessment with an ARD of 07/25/2025 reflected she could understand and be understood. She scored 13 of 15 on her BIMS which indicated her cognition was intact. She required minimal assistance with ADLs. She had an active diagnosis of pain. She had received, was offered, or declined PRN pain medication within the previous five days. Review of section N0415 High-Risk Drug Classes: Use and Indication reflected she was not taking an opioid medication. Record review of Resident #34's comprehensive care plan revised 04/17/2023 reflected Focus, I am at risk for experiencing discomfort or pain r/t: Hx of fractures, co-morbid medical conditions and joint discomfort, Interventions/Tasks, administer my medications to relieve my pain as recommended by my doctor. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #34's Active Orders As of: 08/25/2025 reflected no order for medicated chest rub, or for the resident to self-medicate. Observation on 08/24/2025 at 09:40 am revealed Resident #34 was sitting up in her bed the jar of medicated chest rub was sitting on her nightstand. Observation on 08/25/2025 at 2:00 pm of Resident #34 revealed she was talking with a psychotherapist and the medicated chest rub was on her nightstand. Record review of the label on the jar of medicated chest rub reflected ingredients: Camphor 4.8%, Eucalyptus Oil 1.2% and Menthol 2.6 %, the same ingredients in Vicks VapoRub. Safety warning for external use only. DO NOT USE by mouth, in nostrils or wounds or damaged skin. You should not use on lips because active ingredients like menthol and camphor can be drying, irritating, and toxic if ingested or absorbed through mucous membranes and can cause adverse reactions. During an interview on 08/24/2025 at 10:46 am, Resident #34 stated she used the medicated chest rub on her lips at night, and she had it for a while, and could not remember when or how she acquired the rub. During an interview on 08/26/2025 at 4:45 pm with LVN H, who was the charge nurse on the hall for Resident #34, she stated she had not seen the jar of medicated chest rub in the resident's room. She stated she would have removed it because if the resident used it inappropriately, it could cause her harm. During an interview] on 08/27/25 at 09:36 am, the DON stated she would talk to Resident #34 and remove the jar of medicated chest rub immediately. She stated she was unaware the resident had the medication, and she could have ordered it online or had someone bring it in. She stated even though the resident was cognizant having medicinal ointments or creams at bedside could be harmful for her if used inappropriately. Record review of the facility's policy, titled Medication cart use and storage, revised 01/2023, revealed The medication cart and its storage bins should be kept closed, secured and/or in the line of sight when not in use.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews and record reviews, the facility failed to post the following information on a daily basis for one of one facility. The facility failed to post daily staffing and census requirements for 5 days. This deficient practice affects, residents, visitors and staff and could result in a misconception of staff availability for care. The findings included: Observation on 08/24/2025 at 08:50 am, daily staffing dated 08/19/2025 was posted in a hard plastic display frame on the first nurses station counter. Interview on 08/27/2025 at 09:36 am, the DON stated the person who normally posted the staffing was out and it was missed from August 19, 2025, up to August 24, 2025. She stated the importance of having the nursing staff posted was to show how many staff were available in case of emergency and for needed care. Record review of the facility policy and procedure titled Nursing Services revised January 2023 reflected The community maintains and posts continuous time schedules showing the number and classification of nursing personnel, including relief personnel, who are scheduled or who worked in each unit during each tour of duty. The time schedules will be maintained for the period specified by community policy or for at least two years following the last day in the schedule.		

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to transmit encoded, accurate, and complete MDS data to the CMS System for 1 of 2 residents (Resident #70) reviewed for MDS transmission. Resident #70's discharge MDS assessment was not transmitted within 14 days of completion. This deficient practice placed residents at risk of not having assessments submitted in a timely manner as required. The findings were: Review of Resident #70's face sheet, dated 08/27/2025, revealed an admission date of 04/09/2025 with diagnoses that included: alcohol dependence with withdrawal, unspecified, cyst of kidney, alcoholic hepatitis without ascites, other specified anemias, fatty (change of) liver, not elsewhere classified, acute metabolic acidosis, anxiety disorder, unspecified, acute and chronic respiratory failure with hypoxia. Review of Resident #70's Discharge MDS Assessment, dated 05/02/2025, revealed the assessment had not been transmitted to CMS. During an interview on 08/27/2025 at 10:00 a.m. the NAS stated she was not responsible for transmitting anything. The NAS further stated typically they had an RN who would come sign the MDS for completion and the RN would be the person who would transmit the MDS. The NAS stated she believed it was within 14 days once the MDS was signed and completed that it must be transmitted to CMS, but she was not sure. The NAS reviewed the Discharge MDS assessment for Resident #70 and revealed MDS SS signed and completed the Discharge MDS assessment 05/02/2025. The NAS further stated the Discharge MDS Assessment for Resident #70 had been sent on 08/25/2025, but she was not the one to send the completed MDS to CMS. During an interview on 08/27/2025 at 10:26 a.m. the DOCR stated the facility had 14 days from the ARD to complete the MDS. The DOCR further stated once the MDS was completed they had 14 days to transmit the MDS. The DOCR stated Resident #70's Discharge MDS assessment was late in being transmitted and further stated she was not sure why it was submitted/transmitted late. The DOCR stated the MDS coordinators (NAS) were responsible for the completion of the MDS assessments and ensuring the submission was done timely. The DOCR further stated typically the MDS SS was the RN who would sign the MDS completion for the community and transmit it. During an interview on 08/27/2025 at 10:50 a.m. MDS SS stated she believed she completed Resident #70's Discharge MDS Assessment on Monday morning which was 08/25/2025. The MDS SS stated the Discharge MDS Assessment would be opened as soon as someone discharged and had 14 days to complete the MDS. The MDS SS stated once the MDS assessment was completed it was added to the next batch to be transmitted to CMS, and it was transmitted through PCC. The MDS SS stated she believed they had 30 days once an MDS was completed to transmit but she was not sure. The MDS SS stated Resident #70 Discharge MDS Assessment got missed and she was asked to complete the MDS. The MDS SS stated they completed it as soon as they realized it. The MDS SS stated she did not feel there would have been a negative outcome because people were not going to look the MDS to care for the resident. During an interview on 08/27/2025 at 12:07 p.m. the DNS stated the NAS was responsible for the completion of the MDS assessments. The DNS further stated a possible negative effect could be it might have delayed the payment of services that were provided. During an interview on 08/27/2025 at 1:41 p.m. the Administrator stated the NAS was responsible for the completion and the transmission of the MDS Assessments. The Administrator stated not transmitting the MDS assessments could have caused an issue with the completion of the assessment and continuity of the care and further stated not transmitting the MDS assessments timely could cause an issue with billing. Record review of facility's policy titled Comprehensive Assessments, revised date March 2023, read The community conducts frequent and different types of assessments, depending on the resident's condition and need. Transmitting Data: Within seven days after completion of a resident's assessment, the community will transmit to the state information for each resident contained in the MDS. Monthly Transmittal Requirements: The community electronically transmits, at least monthly, encoded, accurate, complete MDS data to the state for all assessments conducted during the previous month.		