STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675858	A. BUILDING _____ B. WING _____	**06/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE NURSING & REHABILITATION	**5437 EISENHAUER RD SAN ANTONIO, TX 78218**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 1 resident (Resident #3) reviewed quality of care, in that: LVN C did not provide wound treatment for [REDACTED]. The findings were: Record review of Resident #3's face sheet, dated 06/27/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's physician order [REDACTED]. Record review of the wound progress noted by external professionals, dated 06/18/2020, revealed, Resident #3 originally presented with ulcers to bilateral 1st MTH (metatarsal head), dorsal hallux, and dorsal 2nd toes . Continue local wound care to left 2nd toe; cover with [MEDICATION NAME] gauze and dry gauze dressing and secure with tape. Change daily and PRN if soiled. Observation on 06/27/2020 at 10:21 AM with RN B revealed Resident #3's left foot was wrapped with kerlix which was dated 6/25. During an interview with RN B on 06/27/2020 at 10:43 AM, RN B confirmed the dressing on Resident#3's left foot was dated 06/25/2020. During an interview with LVN C on 06/27/2020 at 4:08 PM, LVN C confirmed she forgot to change Resident #3's dressing and apply [MEDICATION NAME] on the 2nd left toe per the resident's physician order [REDACTED]. Record review of the facility's policy titled Basic Standard for Clinical Procedure dated 03/12/2019, revealed, Purpose: Appropriate care is taken to put forth the resident's right to privacy and dignity, as well as the resident's health and safety are protected during the performance of any clinical care or procedure.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement ongoing infection prevention and control for 2 of 2 residents (Residents #1 and #2) reviewed for infection control, in that: Social Worker A did not sanitize the blood pressure cuff, thermometer, and pulse oximeter when using them between Residents #1 and #2. This deficient practice could place residents who have their vitals taken at risk for cross-contamination and/or spread of infection. The findings were: Record review of Resident #1's Admission Record, dated 06/27/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Admission Record, dated 06/27/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on 06/27/2020 at 9:51 AM revealed Social Worker A was taking Resident #1's temperature, blood pressure, and oxygen saturation. Observation on 06/27/2020 at 9:53 AM revealed Social Worker A did not sanitize or disinfect the thermometer, blood pressure cuff, and the pulse-oximeter after exiting Resident #1's room. Further observation revealed Social Worker A then checked Resident #2's temperature, blood pressure, and oxygen saturation without sanitizing or disinfecting the forehead thermometer, blood pressure cuff, and the pulse oximeter before using for Resident #2. During an interview with Social Worker A on 06/27/2020 at 10:15 AM, Social Worker A confirmed she did not disinfect or sanitize the forehead thermometer, blood pressure cuff, and the pulse oximeter when using them between Residents #1 and #2. During an interview with the DON on 06/27/2020 at 5:45 PM, the DON confirmed the Social Worker A should have disinfected the forehead thermometer, blood pressure cuff, and pulse oximeter in between each resident used with the blue top - bleach wipe or alcohol wipe. Record review of the COVID-19 Response for Nursing Facilities, version 3.1 dated 06/02/2020, revealed, Clean and disinfect the facility: . Equipment includes items like blood pressure cuffs, Hoyer lifts and other shared equipment used for resident care - clean and disinfect after each use.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.