

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 1 of 5 residents (Residents #1) reviewed for reporting allegations of abuse and neglect. Administrator failed to report an incident of suspected abuse, from 06/18/2025, to the State Survey agency (HHSC) within the required 2 hours for suspected abuse. This failure could place residents at risk for continued abuse and neglect. The findings were: Record review of Resident #1's face sheet dated 06/24/2025 revealed resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses that included chronic systolic (congestive) heart failure, epilepsy, and chronic obstructive pulmonary disease. Record review of the facility provided Provider Investigation Report dated 06/19/2025 revealed the incident was observed on 06/18/2025, at 10:30 PM., and reported to HHSC on 06/19/2024 at 04:41 PM. CNA B reported to the DON that she observed CNA A kissing Resident #1. Interview with CNA B on 06/25/2025 at 10:54 AM revealed she observed the incident with CNA A and resident #1 on 06/18/2025 around 10:30 PM and called the DON immediately to report the incident. CNA B stated the DON asked her to write a statement while the DON called the administrator for guidance. CNA B stated she received training on abuse/neglect and when to/how to report it in February when the new company bought out the old company. CNA B stated per the training any suspected abuse/ neglect is to be reported to the administrator immediately. Interview with DON on 06/25/2025 at 3:18 PM revealed CNA B called to report an incident between CNA A and resident #1 at 10:15 PM. DON stated she text the administrator at 10:19 PM informing him of the incident. DON stated she was instructed to contact CNA A and place her on suspension immediately pending the investigation. DON stated she text CNA A at 10:28 PM informing her of the suspension pending the investigation. DON stated she received training on abuse/neglect and how to/when to report it upon hire in February. DON stated the facility receives in-services on abuse/neglect frequently in response to incidents at the facility. Interview with the Administrator on 06/26/2025 at 9:51 AM revealed he was the abuse and neglect coordinator and the person responsible to report any suspected abuse/neglect to HHSC within the regulated timeframes. Administrator stated he first learned of the incident between CNA A and resident #1 on 06/18/2025 around 10:30 PM. Administrator stated after ensuring the resident felt safe and free from abuse, they let the resident sleep the rest of the night. Administrator stated he started to investigate the incident the following morning, on 06/19/2025. Administrator stated after conducting his investigation he made the report to HHSC in the afternoon around 4:30 PM. Administrator stated he received abuse and neglect training in February of 2025 when the new company bought out the old company. Administrator stated any suspected abuse/neglect was to be reported to him immediately and he was to report it to HHSC within 2 hours of the facility learning of the incident. Administrator stated failure to report incidents of abuse/neglect to HHSC could place the residents a further risk of abuse or neglect. Record review of CNA A's employee file revealed CNA A was suspended via phone on 06/18/2025 pending an investigation. CNA A was terminated via phone on 06/19/2025. Record review of facility policy named Abuse, Neglect and Exploitation, with a implemented date of 02/01/2025, revealed VII. Reporting/Response A. The facility will have written procedures that include: I. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. , law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p>		