

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  01/16/2026
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)		
F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for one (1) of seven (7) residents (Resident #1) reviewed for pharmaceutical services. RN A failed to administer Resident #1's cefazoline sodium injection solution (an antibiotic) at the rate confirmed through the pharmacy during administration on 01/15/2026. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: Record review of Resident #1's admission Record, dated 01/16/2026, revealed a [AGE] year-old male admitted on [DATE]. Record review of Resident #1's Diagnosis Report, dated 01/16/2026, revealed diagnoses including bacteremia (the presence of bacteria in the bloodstream), methicillin resistant staphylococcus aureus infection (MRSA, a type of antibiotic-resistant bacterial infection), and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #1's Annual MDS, dated [DATE], reflected Resident #1 had a BIMS score of 0, indicating he was severely cognitively impaired. Record review of Resident #1's admission MDS, dated [DATE], reflected Resident #1 had a BIMS score of 15, indicating he was cognitively intact. His active diagnoses included multidrug-resistant organism (occurs when a microorganism, predominately bacteria, becomes resistant to one or more classes of antimicrobial agents) and septicemia (occurs when bacteria entered the bloodstream from other parts of the body). He was noted to have received an antibiotic during the last seven (7) days or since admission/reentry and had received IV medications while a resident and within the last fourteen (14) days. Record review of Resident #1's Order Audit Report, dated 01/16/2026, reflected order summary ceFAZolin [sic] Sodium Injection Solution Reconstituted 2 GM (Cefazolin Sodium) [sic] use 2 gram intravenously every 8 hours for MSSA to BLEs until 01/20/2026 23:59 [11:50 p.m.], order date 12/16/2025 by MD B. Under Order Supply Summary and Medication/Supply and Directions, CEFAZOLIN 2G/50 ML-DEXTROSE ACTIVATE, MIX AND INFUSE ENTIRE CONTENTS OF ONE BAG INTRAVENOUSLY OVER 30 MINUTES AT A RATE OF 100ML/HR EVERY 8 HOURS UNTIL 12/19/25, noted as date dispensed 01/15/2026 and from Source Pharmacy- [named pharmacy]. Record review of Resident #1's Licensed Nurse MAR, dated 01/01/2026- 01/31/2026 and printed on 01/16/2026, reflected the order ceFAZolin [sic] Sodium Injection Solution Reconstituted 2 GM (Cefazolin Sodium) [sic] use 2 gram intravenously every 8 hours for MSSA to BLEs until 01/20/2026 23:59 [11:50 p.m.]. The order was noted to have been administered by RN A on 01/15/2026 at the 1700 [05:00 p.m.] administration time. During an observation and interview on 01/15/2026 at 05:13 p.m., Resident #1 was observed lying in bed. Resident #1 was observed to have a PICC line on his left upper arm. Resident #1 stated he had not experienced any issues or concerns with his IV medication administrations. During an observation on 01/15/2026 at 06:35 p.m., RN A was observed to administer Resident #1 his Cefazoline Sodium IV medication. RN A was observed to set the rate of</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 455510	If continuation sheet Page 1 of 4

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>administration at 75 mg/hr. The prescription on the IV medication was observed to be printed as Cefazoline 2g/50mL-Dextrose.administer 100mg/hr . During an interview on 01/16/2026 at 01:48 p.m., the DON stated the difference in administering a medication at a rate of 75 versus 100 mg/hr was that the medication would administer at a slower rate. She stated she did not believe the change would impact the resident because the resident would still have received his medication. The DON stated she did not see a negative impact resulting from this change in rate but that she expected the nurses to check the rate. The DON stated the rate was not written into the medication order because the hospital discharge orders do not come with a rate, so the pharmacy would set the rate. The DON stated the rate of administration was printed on the medication IV bag. During an interview on 01/16/2026 at 04:16 p.m., RN A stated Resident #1's medication was to be titrated (a medication given in a solution administered in a continuous volume over a certain amount of time) for one (1) hour. He stated the rate to give the medication was on the prescription. He stated the 100 [mL] on the prescription was for the volume and the rate was 75 [mg/hr]. He stated that was how he read the prescription. During an interview on 01/16/2026 at 04:45 p.m., MD B stated Resident #1 having been given his IV medication at a rate of 75 [mg/hr] versus the prescribed 100 [mg/hr] was fine as it would not have impacted Resident #1 medically. She stated the change would have only resulted in the administration of the medication taking longer. A facility policy regarding medication administration was not requested for review.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, 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 diseases and infections for one (1) of seven (7) residents (Resident #2) reviewed for infection control. The facility failed to ensure Resident #2's foley catheter (a tube inserted into the bladder used to drain urine from the bladder) bag was not touching the floor. This failure could place residents at risk of infection and cross contamination. The findings included: ? Record review of Resident #2's admission Record, dated 01/14/2026, revealed a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #2's Diagnosis Report, dated 01/16/2026, revealed diagnoses including cerebral palsy (a disorder that affects a person's ability to move and maintain balance and posture), profound intellectual disabilities (a limitation in cognitive functioning and adaptive behavior which affects a person's ability to learn, communicate, and perform everyday tasks), and neuromuscular dysfunction of bladder (a condition that occurs when nerve damage affects bladder control leading to urinary incontinence, retention, or loss of sensation regarding bladder fullness). Record review of Resident #2's Annual MDS, dated [DATE], reflected Resident #1 had a BIMS score of 0, indicating he was severely cognitively impaired. Record review of Resident #2's Quarterly MDS, dated [DATE], reflected Resident #2 had a BIMS score of 00, indicating he had severe cognitive impairment. He had range of motion impairment on both sides for upper and lower extremities, used a wheelchair, and was dependent for his self-care and mobility needs. He had an indwelling catheter. Record review of Resident #2's Care Plan, dated last care conference 11/05/2025, reflected Resident #2 had an indwelling catheter related to his neurogenic bladder (a condition that occurs when a problem with the brain, nerves, or spinal cord result in the lack of control of the bladder), date initiated 04/29/2025 and revised on 04/30/2025. Record review of Resident #2's Order Summary Report, dated 01/14/2026 with active orders as of 01/14/2026, reflected the order Catheter. Indwelling Catheter Indication: NEUROMUSCULAR DYSFUNCTION OF BLADDER. The order status was noted as active and the order was dated 10/14/2025. During an observation on 01/14/2026 at 03:24 p.m., Resident #2 was observed in his room in bed. Resident #2's foley bag was observed to be hung vertically with the bottom of the bag touching the floor. During an observation and attempted interview on 01/14/2026 at 03:58 p.m., Resident #2 was observed sleeping in his room. His foley bag was observed touching the floor. CNA C was observed to walk past Resident #2's room. During an interview on 01/14/2026 at 03:59, CNA C revealed she normally worked in the hall Resident #2 lived on. She stated the foley bag was to catch the resident's urine and it should be set up under the bed on the side, it should be vertical, it should have a privacy bag, and it should not be touching the floor. CNA C stated the CNAs and nurses were responsible for ensuring the foley bags did not touch the floor. CNA C stated Resident #2's bag was touching the floor, and it would be considered contaminated. CNA C stated the facility had provided training on where the bag should be located or secured. During an interview on 01/14/2026 at 04:04 p.m., RN D stated the nurse was responsible in ensuring the foley bag did not touch the floor. He stated the foley bag should be lower than the resident, hung on the bed on a section that cannot move, in a position where the resident cannot tug on it, and it should not be touching the floor where it would be at risk for contamination. RN D stated he had received training by the facility on foley bag positioning and staff were expected to do rounds to check foley bags were properly positioned. During an interview on 01/14/2026 at 04:14 p.m., the DON stated the nurses and CNAs were responsible ensuring that the foley bags were appropriately placed or in a basin, so they did not touch the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON stated it would be an infection control concern if the foley bag touched the floor. The DON stated she expected the foley bag to be placed on the metal piece of the bed at the bottom, below the resident's bladder, have a foley cover over the bag, and the bag itself should not touch the floor. The DON stated the facility staff completed foley catheter competencies with placement of the foley catheter bag as part of the competency confirmation. During an interview on 01/16/2026 at 01:48 p.m., the DON stated she did not believe the foley catheter bag touching the floor would have impacted Resident #2 because the bag was enclosed. Record review of facility policy, Catheter Care, dated as implemented and revised 05/02/2025, reflected Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care.</p>