STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455510	A. Building B. Wing	02/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Hills Rehabilitation and Care Center	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #1) of 3 residents reviewed for assessments. Resident #1's admission MDS assessment, dated 02/03/2026, identified the resident did not have pressure ulcer. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #1's face sheet, dated 02/22/2026, revealed the resident was a 65-years-old female and admitted to the facility on [DATE] with diagnosis of pressure ulcer of sacral region (wound that from as a direct result of pressure over a bony prominence to the buttock area). Record review of Resident #1's admission MDS, dated [DATE], revealed the resident's BIMS score was 11 out of 15, which indicated the resident had moderate cognitive impairment, and in Section M (Skin conditions), it was coded that Resident #1 did not have one or more unhealed pressure ulcers/injuries. Record review of Resident #1's comprehensive care plan, dated 01/30/2026, revealed [Resident #1] had deep tissue injury to right and left heel. For intervention - provide pressure reduction/relieving mattress, skin care, treatment, and turning and repositioning schedule per assessment. Further record review of the care plan revealed there was no care plan regarding Resident #1's pressure ulcers to right and left buttock. Record review of Resident #1's wound care assessment, visit dated 02/02/2026, revealed Resident #1 had stage 2 pressure ulcer of left and right buttock area. Record review of Resident #1's physician order, dated 02/04/2026, revealed the resident had the order of Wound Care - Left and Right buttock State 2 - Apply triad with collagen particles daily one time a day for wound care treatment. Observation and interview on 02/21/2026 at 4:30 p.m. revealed Resident #1 was on the bed and sleeping in her room at the acute hospital. Resident #1's family member was at the bedside and said that the resident was sleeping, and he did not want to bother the resident to see the wounds. Interview on 02/21/2026 at 5:00 p.m. the hospital nurse said Resident #1 had stage 2 pressure ulcers to her left and right buttock areas. Interview on 02/22/2026 at 2:37 p.m. the facility wound care LVN-A stated when Resident #1 was admitted to the facility, the resident had an unhealed stage 2 pressure ulcers to her left and right buttock area, and the nurse provided wound care as ordered. Interview on 02/22/2026 at 3:15 p.m. the DON stated Resident #1's admission MDS dated [DATE] was inaccurate regarding pressure ulcers because the resident had an unhealed stage 2 pressure ulcers to her left and right buttock area. In the Section M (Skin conditions), the question of Does this resident have one or more unhealed pressure ulcers/injuries? should have been coded as Yes. DON said the facility MDS nurse did not work on 02/22/2026 because it was Sunday, and DON had responsibility for overseeing MDS accuracy and did not know the reason for the inaccurate MDS assessment. DON said inaccurate MDS assessment might affect inappropriate care to the resident. Record review of the facility policy, titled Documentation in Medical Record, revised 06/06/2025, revealed Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's (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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(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 - Few	progress through complete, accurate, and timely documentation.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that were identified in the comprehensive assessment, and described services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #1) of 3 residents reviewed for care plans. The facility failed to ensure Resident #1's care plan reflected her unhealed stage pressure ulcer to her left and right buttock area. This failure could place residents at risk for not receiving proper care and services.The findings included: Record review of Resident #1's face sheet, dated 02/22/2026, revealed the resident was a 65-years-old female and admitted to the facility on [DATE] with diagnosis of pressure ulcer of sacral region (wound that from as a direct result of pressure over a bony prominence to the buttock area). Record review of Resident #1's admission MDS, dated [DATE], revealed the resident's BIMS score was 11 out of 15, which indicated the resident had moderate cognitive impairment, and in Section M (Skin conditions), it was coded that Resident #1 did not have one or more unhealed pressure ulcers/injuries. Record review of Resident #1's comprehensive care plan, dated 01/30/2026, revealed [Resident #1] had deep tissue injury to right and left heel. For intervention - provide pressure reduction/relieving mattress, skin care, treatment, and turning and repositioning schedule per assessment. Further record review of the care plan revealed there was no care plan regarding Resident #1's pressure ulcers to right and left buttock. Record review of Resident #1's wound care assessment, visit dated 02/02/2026, revealed Resident #1 had stage 2 pressure ulcer of left and right buttock area. Record review of Resident #1's physician order, dated 02/04/2026, revealed the resident had the order of Wound Care - Left and Right buttock State 2 - Apply triad with collagen particles daily one time a day for wound care treatment. Observation and interview on 02/21/2026 at 4:30 p.m. revealed Resident #1 was on the bed and sleeping in her room at the acute hospital. Resident #1's family member was at the bedside and said that the resident was sleeping, and he did not want to bother the resident to see the wounds. Interview on 02/21/2026 at 5:00 p.m. the hospital nurse said Resident #1 had stage 2 pressure ulcers to her left and right buttock areas. Interview on 02/22/2026 at 2:37 p.m. the facility wound care LVN-A stated when Resident #1 was admitted to the facility, the resident had an unhealed stage 2 pressure ulcers to her left and right buttock area, and the nurse provided wound care as ordered. Interview on 02/22/2026 at 3:15 p.m. with DON stated Resident #1 received wound care as ordered, but there was no care plan for specifically stage 2 pressure ulcer to the resident's left and right buttock area because of inaccurate MDS assessment. The facility should have developed Resident #1's care plan regarding the resident's stage 2 pressure ulcer to her left and right buttock area, and no care plan might affect inappropriate care to the resident. Record review of the facility policy, titled Comprehensive Care Plans, revised 06/02/2025, revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #1) out of 3 residents reviewed for medical records. Facility nurses did not document their initials on Resident #1's treatment administration record after giving wound care to the resident on 02/01/2026, 02/07/2026, and 02/08/2026. This failure could place residents at risk for missed treatment and medications which could result in decline in healing and well-being.Findings included: Record review of Resident #1's face sheet, dated 02/22/2026, revealed the resident was a 65-years-old female and admitted to the facility on [DATE] with diagnosis of pressure ulcer of sacral region (wound that from as a direct result of pressure over a bony prominence to the buttock area). Record review of Resident #1's admission MDS, dated [DATE], revealed the resident's BIMS score was 11 out of 15, which indicated the resident had moderate cognitive impairment, and in Section M (Skin conditions), it was coded that Resident #1 did not have one or more unhealed pressure ulcers/injuries. Record review of Resident #1's comprehensive care plan, dated 01/30/2026, revealed [Resident #1] had deep tissue injury to right and left heel. For intervention - provide pressure reduction/relieving mattress, skin care, treatment, and turning and repositioning schedule per assessment. Further record review of the care plan revealed there was no care plan regarding Resident #1's pressure ulcers to right and left buttock. Record review of Resident #1's wound care assessment, visit dated 02/02/2026, revealed Resident #1 had stage 2 pressure ulcer of left and right buttock area. Record review of Resident #1's physician order, dated 02/04/2026, revealed the resident had the order of Wound Care - Left and Right buttock State 2 - Apply triad with collagen particles daily one time a day for wound care treatment. Observation and interview on 02/21/2026 at 4:30 p.m. revealed Resident #1 was on the bed and sleeping in her room at the acute hospital. Resident #1's family member was at the bedside and said that the resident was sleeping, and he did not want to bother the resident to see the wounds. Interview on 02/21/2026 at 5:00 p.m. the hospital nurse said Resident #1 had stage 2 pressure ulcers to her left and right buttock areas. Interview on 02/22/2026 at 2:37 p.m. the facility wound care LVN-A stated when Resident #1 was admitted to the facility, the resident had an unhealed stage 2 pressure ulcers to her left and right buttock area, and the nurse provided wound care as ordered. Record review of Resident #1's treatment administration record (TAR) from 02/01/2026 to 02/28/2026 revealed the resident was receiving Wound Care - Left and Right buttock State 2 - Apply triad with collagen particles daily one time a day for wound care treatment. The TAR was not initialed on the following dates: 02/01/2026, 02/07/2026, and 02/08/2026. Interview on 02/21/2026 at 2:12 p.m. with LVN-B stated she worked on 02/01/2026 and provided wound care of applying triad with collagen particles to Resident #1's stage 2 pressure ulcer of left and right buttock area but forgot document on the treatment administration record. LVN-B said not documenting might affect inappropriate care to the resident. Interview on 02/21/2026 at 2:00 p.m. with LVN-A stated she worked on 02/07/2026 and provided wound care of applying triad with collagen particles to Resident #1's stage 2 pressure ulcer of left and right buttock area but forgot document on the treatment administration record because the nurse just applied triad cream with collagen particles once a day and leave open to air as ordered without changing dressing, so LVN-A said she forgot documenting and not documenting might affect inappropriate care to the resident. Interview on 02/21/2026 at 2:05 p.m. with RN-C said she worked on 02/08/2026 and provided wound care of applying triad with collagen particles to Resident #1's stage 2 pressure ulcer of left and right buttock area but forgot document on the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment administration record because she thought that just applying cream with collagen particles was not wound care. Interview on 02/22/2026 at 3:15 p.m. the DON stated the facility nurses might think that just applying cream with collagen particles to Resident #1 was not wound care because they did not have to change dressing, but it was wound care. She stated the nurses should have documented on Resident #1's treatment administration record after applying triad with collagen particles to the stage 2 pressure ulcer of left and right buttock. DON stated inaccurate documenting might affect care to the resident due to lack of communication among health care professionals. Record review of the facility policy, titled Documentation in Medical Record, revised 06/06/2025, revealed 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3. Documentation may be performed manually or as per the facility's specific electronic medical record software program.