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	03/06/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 drugs and biologicals were stored in locked compartment within 2 of 2 medication carts (nurse cart in south hall and nurse cart in north hall) observed for medication storage.Nurse cart on south hall was left unlocked and unattended in front of the nurse's station with no staff at the nurse's station. Nurse cart on north hall was left unlocked and unattended in front of a resident's room when nurse went to the nurse's station.This failure could place residents at risk of missing or misuse of drugs by unauthorized personnel.The findings were:Observation of the nurse cart on south hall on 03/06/2026 at 8:28 AM revealed the nurse's cart in front of the nurse's station with drawers facing toward the hallway, unlocked and unattended. No staff were observed at the nurse's station. Interview with RN A on 03/06/2026 at 8:34 AM revealed she was not a regular staff and only worked when the facility needed her to. RN A stated she was passing medications to a resident and forgot to lock the cart when she walked away. RN A stated carts needed to be locked when staff walk away to prevent residents from taking medications that did not belong to them. RN A stated if a resident had taken medications not prescribed for them it could cause illness or negative reaction. RN A stated it was the nurse's responsibility to ensure carts were locked when they leave them. Observation of the nurse cart on north hall on 03/06/2026 at 8:42 AM revealed the nurse's cart in front of a resident room [ROOM NUMBER] with drawers facing toward the doorway, unlocked and unattended. Nurse was observed at the north hall nurse's station, around the corner from the cart. Interview with LPN B on 03/06/2026 at 8:44 AM revealed she worked the 6:00 AM to 2:30 PM shift on north hall regularly. LPN B stated she could see her cart and no residents were around when she walked away. LPN B stated she walked away to grab something from the nurse's station and was only gone for a few seconds. LPN B was asked how leaving the cart unlocked could have affected the residents to which she responded by saying it couldn't affect them since it was within my sight the whole time. LPN B then pushed cart away from surveyor and did not answer any further questions.Interview with DON on 03/06/2026 at 10:09 AM revealed staff who are assigned to either nurse's carts or medication carts were responsible for ensuring they were locked before leaving them unattended. DON stated that both RN A and LPN B were experienced nurses and should not have left their carts unlocked when they walked away. DON stated leaving a cart unlocked placed residents at risk of taking medications not prescribed for them and could cause them to have adverse effects including illness or hospitalization.Record review of the facility policy titled Medication Storage with implemented date 06/15/2025 revealed During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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