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	04/24/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one 1 of one 1 kitchen reviewed for food safety requirements. The facility failed to ensure: Dishes were kept clean and dry. Food in the walk-in refrigerator was fresh and dated. Food in the walk-in freezer was dated and stored properly. Storage bins and serving utensils were clean. These failures could place residents at risk for the spread of infections, food contamination, food-borne illnesses, and diminished quality of life. Findings included: 1. Observation of the kitchen on 4/22/26, beginning at 10:35 am, revealed a rack next to the handwashing sink. The rack contained trays with dishes stacked on top of the trays. Further observation revealed that when the DM washed her hands, water splashed on a tray with dessert bowls stacked on top of it and pooled on the tray. Further observation of revealed dessert bowls on a tray next to the handwashing sink that were stacked on top of each other. Two bowls were removed from the top of the stack by the investigator; those bowls were moist and had food particles on the inside bottom of the bowls. On the rack above the dessert bowls, there were saucers stacked on top of each other. Three saucers were removed from the top of the stack, and they had food particles on the bottom. On the rack on top of the saucers were cups stacked on top of each other. There was a brown substance on the rim of three cups on top of the stack. The DM confirmed the dishes observed were not dry and had food particles on them. 2. Observation of the walk-in refrigerator on 4/22/26 at 10:44 a.m., revealed a bag of celery that was brown in color, a small plastic bin with tomatoes, and another small plastic bin with red bell peppers that were not dated. 3. Observation of the walk-in freezer on 4/22/26 at 10:47 a.m. revealed breadsticks in a plastic bag that were not dated. Further observation revealed an open bag of frozen carrots that were open and not dated. 4. Observation and interview in the kitchen on 4/22/26 at 12:08 p.m., revealed two bins on a shelf with serving utensils inside, one of the bins had a ladle with food particles on it, the bottom of the bins also had food particles, visibly dirty, and sticky. The DM said the utensils in the bin were supposed to be clean and the bins were not supposed to be like that. During an interview on 4/22/26 at 1:18 p.m., the DM said she was responsible for ensuring that all foods were stored properly and labeled with the opened date, adding she must have missed a few items. The DM said that she did not believe having open and undated items could negatively affect the residents because before the food was served, she ensured that it was edible. The DM said it was important to ensure food items were dated so that prepared food was not served to residents after 3 days. And unprepared, unopened items after 6 days of being stored on the shelves. The DM further stated it was important frozen food items were dated so they were not used after 1 year of being stored in the freezer, adding it was important to ensure the packages were not left open while in the freezer to avoid freezer burn. The DM said it was not a good idea to have the shelf next to the hand-washing sink because water splashes on the tray with the clean dishes. The DM said the dishes should not be stacked on top of each other to dry because the condensation will still be there, he said this was important because the dishes could start growing mold. The DM further stated this could make the residents sick or upset their stomachs. The DM said dirty utensils and dishes could cause cross contamination and make the (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents sick. The DM said everybody was responsible for ensuring the utensils and the bins were kept clean. Record review of the facility policy, titled Food Safety Requirements, dated 4/8/2026, revealed: .Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms.e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food.3. Facility staff shall inspect all food, food products, and beverages for safe transport and quality upon delivery/receipt and ensure timely and proper storage.Practices to maintain safe refrigerated storage include.Labeling, dating, and monitoring refrigerated food.Keeping foods covered or in tight containers.6. All equipment used in the handling of food shall be cleaned and sanitized, and handled in a manner to prevent contamination. Record review of the facility's policy, titled Date Marking for Food Safety, dated 4/8/2026, revealed: .2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.

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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 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 observations, interviews, and record reviews, 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 2 of 2 residents (Resident #3 and Resident #5) reviewed for infection control. The facility failed to ensure: CNA A performed hand hygiene according to facility policy and followed infection control procedures while providing care for Resident #5 on 4/14/26.CNA B followed EBP and infection control procedures while providing care for Resident #3 on 4/14/26. This deficient practice could affect all residents who receive care, placing them at risk of infection. Findings included: 1. Record review of Resident #5's admission Record, dated 4/14/26, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Need for assistance with personal care. Record review of Resident #5's Care Plan, dated 3/7/25, revealed the resident had impaired physical functioning related to mobility impairment and self-care impairment. Observation of peri-care for Resident #5, on 4/14/26 at 11:20 a.m., revealed CNA A washed his hands prior to providing care for 5 seconds. Further observation revealed CNA A removed his gloves and sanitized his hands for 2 seconds after cleaning Resident #5's genital area. Further observation revealed CNA A cleaned the resident's buttocks, disposed of trash and dirty linen, replaced the resident's pillows, blankets, positioned the bed, and handed the remote to the Resident #5 without changing his gloves or performing hand hygiene. During an interview on 4/14/26 at 11:31 a.m., Resident #5 said he was not sure about infection control but knew that staff washed their hands. During an interview on 4/14/26 at 1:10 p.m., CNA A said when he washed his hands, he usually sang the birthday song, which was about 10 seconds. CNA A further stated he did not know how long it was recommended to wash hands for. CNA A said when using hand sanitizer hands should be rubbed together until they were dry, about 5 seconds. CNA A said he was not aware that he only washed his hands for 5 seconds. CNA A said the sanitizer dried real fast. CNA A further stated he had not realized that he did not remove his gloves or perform hand hygiene after cleaning Resident #5's buttocks. CNA A further stated it was important to perform hand hygiene as recommended to avoid cross contamination because whatever bacteria that was on his hands could be transferred to the resident. During an interview on 4/20/26 at 4:31 p.m., the DON said the expectation was for staff to wash their hands for at least 20 seconds, to help prevent the spread of infections. The DON further stated this was important because not doing so could potentially cause infection. The DON said it was ultimately her responsibility to ensure staff performed hand hygiene as recommended, as the infection preventionist. 2. Record review of Resident #3's admission Record, dated 4/14/26, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: ESRD (kidneys can longer function due to permanent damage), Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar) , dependence on renal dialysis (treatment for kidney failure), need for assistance with personal care. Record review of Resident #3's Care Plan, dated 4/2/26, revealed the resident was incontinent of bowel and bladder, self-care deficit related to mobility impairment and self-care impairment, and was on enhanced barrier precautions related to permcath (a device placed under the skin to provide vascular access). Record review of Resident #3's Order Summary, dated 4/14/26, revealed an order for enhanced barrier precautions related to permcath, dated 3/1/26. Observation of peri-care for Resident #3 on 4/14/26, beginning at 1:33 pm, revealed CNA B did not donn PPE prior to entering the resident's room. Further observation revealed there was not an EBP sign outside the resident's door, there was PPE outside the resident's room. Further observation revealed CNA B, after cleaning feces, retrieved a clean washcloth to dry the resident's buttocks, retrieved barrier cream from the resident's side table and applied some to the resident's buttocks, held the resident's hands to assist her with turning on her left side, fastened the resident's brief, and removed the pillow from behind the resident's head without removing the dirty (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves or performing hand hygiene. During an interview on 4/14/26 at 2:00 p.m., Resident #3 said she could not say that staff followed infection control practices all the times. Resident #3 further stated that somebody wore a gown once the previous week but that was the only time. During an interview on 4/14/26 at 1:45 p.m., CNA B said she did not take her gloves off until she was done with everything. CNA B further stated that she put gloves on when she went into a resident's room and took them off when she left the room. CNA B said she did not know what the expectations were but knew that she could not go from room to room with gloves on and could not from resident to resident with the same gloves on. CNA B said that Resident #3 was not on EBP. During an interview on 4/20/26 at 4:31 p.m., the DON said the expectation for staff to change their gloves when they were going from a dirty area to a clean area. The DON further stated staff should assume their gloves were dirty when proving care and not touch other items in the room, such as pillows, remotes, or linen to avoid cross contamination. The DON said that Resident #3 was on EBP. The DON said Resident #3 had an order in place for EBP, but the sign was not on the door. The DON said staff were expected to follow EBP for any high contact resident care activities for residents with wounds and indwelling devices to help prevent the spread of Multi-drug-resistant organisms. Record review of the facility's policy titled Hand Hygiene, dated 4/11/2025, revealed: .4. Hand hygiene technique when using an alcohol-based hand rub.b. Rub hands together, covering all surfaces of hands and fingers until hands feel dry. c. This should take about 20 seconds. 5. Hand hygiene technique when using soap and water.Run hands together vigorously for at least 20 seconds. Record review of the facility's policy titled Perineal Care dated 5/2/2025, revealed: .Apply other personal protective equipment as appropriate.a. Cleanse buttocks and anus.Change gloves and continue with perineal care.