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	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Hills Rehabilitation and Care Center	8020 Blanco Rd San Antonio, TX 78216

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in clinical complications) for 2 of 8 residents (Residents #1 and #2) reviewed for resident rights. The facility failed to notify Resident #1 and Resident #2's physician when they each drank 1 [NAME] on 04/17/26. This failure could place residents at risk of not receiving adequate and timely intervention and a decline in condition. The findings included:Record review of Resident #1's admission record, dated 05/19/26, reflected Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses to include cognitive communication deficit. It further revealed he was his own responsible party (RP). Record review of Resident #1's quarterly MDS assessment, dated 03/31/26, reflected Resident #1 had a BIMS score of 09 out of 15, indicating moderate cognitive impairment. Record review of Resident #1's Order Summary Report, dated 05/19/2026, reflected .Call [hospice company] with any questions or concerns, dated 07/07/2025, May participate in activities as tolerated, dated 07/07/2025, and The physician acknowledges the benefit vs risks for the use of medications listed with a Black Box Warning (highlights serious risks of medications, ensuring both healthcare providers and patients are aware of severe potential side effects), dated 07/07/2025. Record review of Resident #2's admission record, dated 05/19/26, reflected Resident #2 was a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include need for assistance with personal care. It further revealed she was her own RP. Record review of Resident #2's quarterly MDS assessment, dated 05/09/26, reflected Resident #2 had a BIMS score of 13 out of 15, indicating intact cognition. Record review of Resident #1's and Resident #2's electronic medical record reflected no change in condition occurred on 04/17/26 and that no contact was made to the physician. Record review of the facility's April 2026 activities calendar reflected a fiesta event that took place at the facility on Friday 04/17/26. During an interview on 05/19/2026 at 04:08 PM, the Activities Director revealed there was a fiesta event in April 2026 that served alcohol to only a select few residents that the DOR oversaw. During an interview on 05/19/2026 at 04:48 PM, the DOR revealed at the fiesta event in April 2026 the activities director told him that he oversaw handing out alcoholic drinks. He revealed he used his discretion in allowing residents to have alcoholic drinks, for example if a resident was a fall risk he knew not to allow them to drink alcohol. He revealed the vendor said only a little bit of alcohol was in the margaritas, but the DOR had watered down the drinks even more. The DOR was unaware of the exact amount of alcohol that was in the drinks. He revealed Residents #1 and #2 were the only residents who were served alcohol that did not have a doctor's order to drink alcohol. During an interview on 05/20/2026 at 07:08 AM, the DON revealed there was alcohol given to certain residents at the facility's fiesta event in April 2026. She revealed they were not aware that alcohol was going to be served at the fiesta event and if they knew alcohol was going to be served to residents at this event, she would have gotten doctor's orders for select residents to drink alcoholic drinks. She revealed Residents #1 and #2 were the only residents who drank an alcoholic drink that (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not have doctor's orders to drink alcohol. She was not aware of any other residents that drank alcohol other than another resident who had standing doctor's orders to have alcohol. She further revealed that they did not contact these residents' doctors after they drank alcoholic drinks because these residents did not exhibit a change in condition. During an interview on 05/20/2026 at 09:15 AM, Resident #1's [hospice company revealed they were not contacted when Resident #1 attended an event at the facility where he consumed alcohol and they should have been contacted. They revealed that Resident #1 had been educated on his disease process and medications and risks associated with that. They revealed Resident #1 was alert and oriented and able to make his own decisions. They revealed they would not recommend that he drink alcohol, but he had a right to make his own decisions. Their focus with hospice was to improve his quality of life, which would include making his own decisions. They further revealed that if Resident #1 experienced a change in condition after drinking alcohol, then they would expect to be contacted. During an interview on 05/20/2026 at 09:31AM, Resident #2's [physician's group] revealed they were not contacted when Resident #2 consumed alcohol at a facility event. They revealed they would have put a doctor's order in for Resident #2 to have an alcoholic drink. After they reviewed Resident #2's medical record, they revealed it was okay that Resident #2 had an alcoholic drink. Record review of the facility's policy, revised 05/13/2025, Notification of Changes, reflected The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstance requiring notification include: 3. Circumstances that require a need to alter treatment.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 1 of 1 facility reviewed for RN coverage. The facility failed to have the services of an RN on 04/11/2026, 04/12/2026, and 05/10/2026. This failure placed the residents at risk for altered physical, mental, and psychological well-being due to decisions that would have required an RN to make in the management of the residents' healthcare needs and in managing and monitoring the direct care staff. The findings included:Record review of the facility's resident roster, dated 05/18/2026, revealed a census of 54 residents. Record review of the facility's Time detail from April 2026 to May 2026 reflected the facility did not have an RN working for a total of 8 hours on [NAME] 11th, 12th and May 10th of 2026. During an interview on 05/20/2026 at 10:08 AM, the DON revealed there were days when 8 hours of RN staffing hours were missing. She revealed it was important to have RN staff because it's a regulation and it was a regulation because RNs provided a supervisory role to LVN and CNAs. She further revealed they were in the process of hiring more RNs. During an interview on 05/20/2026 at 11:45AM, the ADM revealed it was important to have an RN work 8 hours per day because the additional training that an RN received was important to bring to the facility. He further revealed they were in the process of hiring more RNs and his goal was to have an RN available 24/7 for resident care. Record review of facility's policy Nursing Services-Registered Nurse (RN), revised 02/2026, reflected . 1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day. 7 days per week. (The requirement for 8 consecutive hours of RN services can be met by any RN or multiples of RNs. The hours worked by the DON would be considered applicable towards the requirement.) .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 3 of 8 residents (Residents #3, 4, and 5)) reviewed for pharmacy services. The facility failed to check Resident #3's and Resident #4's blood sugars to administer their respective insulins per doctor's orders on 05/10/26 at 6:30 AM.The facility failed to ensure Resident #5 had Methadone HCl available to her on 05/09/26 at 07:00 PM, 05/10/26 at 07:00 AM, and 05/10/26 at 07:00 PM. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. Findings included: Record review of Resident #3's admission record, dated 05/18/26, reflected Resident #3 was a [AGE] year-old male initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include type 2 diabetes (a chronic metabolic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). Record review of Resident #3's quarterly MDS assessment, dated 03/07/26, reflected Resident #3 had a BIMS score of 15 out of 15, indicating intact cognition. Record review of Resident #3's care plan, last review completed 03/17/26, reflected a focus of At risk for hypo-hyperglycemia (low-high blood sugar level), altered skin integrity, neuropathy r/t [Diabetes], initiated 04/18/26, with intervention Medications/blood sugar check as ordered by physician and as needed, initiated 04/18/26. Record review of Resident #3's Order Summary Report, dated 05/20/26, reflected Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale (blood sugar scale): if [blood sugars] 70-149=0; 150-199=4; 200-249=6; 250-299=8; 300-349=10, subcutaneously before meals and at bedtime for Diabetes GIVE 12 UNITS IF BLOOD SUGAR IS GREATER THAN 349, with start date 03/01/25. Record review of Resident #3's Medication Administration Record, dated 05/18/26, reflected Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 70-149=0; 150-199=4; 200-249=6; 250-299=8; 300-349=10, subcutaneously before meals and at bedtime for Diabetes GIVE 12 UNITS IF BLOOD SUGAR IS GREATER THAN 349 had a chart code of 19=Other-See Progress Note and no blood sugar was documented by LVN A for 05/10/26 at 06:30 AM. Record review of Resident #3's progress note, dated 05/10/26 at 12:12 PM and documented by LVN A, reflected Insulin Lispro Injection Solution 100 UNIT/ML . NO NURSE ASSIGNED TO HALL.Record review of Resident #3's electronic medical record reflected no change in condition occurred on 05/10/26. Record review of Resident #4's admission record, dated 05/19/26, reflected Resident #4 was a [AGE] year-old female initially admitted on [DATE] and re-admitted on [DATE] with diagnoses to include type 2 diabetes (a chronic metabolic condition where your body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). Record review of Resident #4's quarterly MDS assessment, dated 03/20/26, reflected Resident #4 had a BIMS score of 15 out of 15, indicating intact cognition. Record review of Resident #4's care plan, last review completed 03/10/26, reflected a focus of At risk for hypo-hyperglycemia (low-high blood sugar level), altered skin integrity, neuropathy r/t [Diabetes], initiated 04/20/26, with intervention Medications/blood sugar check as ordered by physician and as needed, initiated 04/20/26. Record review of Resident #4's Order Summary Report, dated 05/20/26, reflected Insulin Aspart-szjj Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Aspart-szjj) Inject as per sliding scale: if 150-199=2 UNITS; 200-249=4 UNITS; 250-299=6 UNITS; 300-349=8 UNITS; 350-399=10 UNITS >400 CALL md, subcutaneously before meals and at bedtime for diabetes, with start date 03/31/26. Record review of Resident #4's Medication Administration Record, dated 05/19/26, reflected Insulin Aspart-szjj Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Aspart-szjj) Inject as per sliding scale: if 150-199=2 UNITS; 200-249=4 UNITS; 250-299=6 UNITS; 300-349=8 UNITS; 350-399=10 UNITS >400 CALL md, subcutaneously before meals and at bedtime for (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetes had a chart code of 19=Other-See Progress Note and no blood sugar was documented by LVN A for 05/10/26 at 06:30 AM. Record review of Resident #4's progress note, dated 05/10/26 at 12:11 PM and documented by LVN A, reflected Insulin Aspart-szjj Subcutaneous Solution Pen-Injector 100 UNIT/ML . NO NURSE ASSIGNED TO HALL. During an interview on 05/18/2026 at 03:01PM, Resident #3 revealed he did not get medication in a timely manner but he would let the nursing staff know about needing his medication when they were not on time. He did not reveal a time when he was not given his insulin. During an interview on 05/19/2026 at 09:40 AM, Resident #4 revealed medication was administered in a timely manner to include getting her blood sugar check and receiving insulin. During an interview on 05/19/26 at 02:42 PM, LVN A revealed she wrote a progress note about no nurse being assigned to a hallway because she was not made aware that this hallway needed nurse coverage to administer insulin. She revealed she was monitoring Resident #3 and Resident #4 and they had no change in condition from not checking their blood sugar or giving them insulin had they needed it. Record review of Resident #5's admission record, dated 05/18/26, reflected Resident #5 was a [AGE] year-old female admitted on [DATE] with diagnoses to include osteoarthritis (degeneration of joint cartilage and the underlying bone) of the hip, other muscle spasm (sudden, involuntary contraction of a muscle, muscle weakness, and other abnormalities of gait (manner of moving on foot) and mobility. Record review of Resident #5's quarterly MDS assessment, dated 03/12/26, reflected Resident #5 had a BIMS score of 15 out of 15, indicating intact cognition. Record review of Resident #5's care plan, last review completed 03/17/26, reflected a focus of Potential adverse side effects from opioid medication use, initiated 04/20/26, with intervention Administer medications as ordered by physician, initiated 04/20/26. Record review of Resident #5's Order Summary Report, dated 05/18/26, reflected Methadone HCl Oral Table 5 MG. Give 1 tablet by mouth two times a day for Pain, with start date 03/05/26. Record review of Resident #5's Medication Administration Record, dated 05/19/26, reflected Methadone HCl Oral Tablet 5 MG. Give 1 tablet by mouth two times a day for Pain had a chart code of: 19=Other-See Progress Note by RN B for 05/09/26 at 07:00 PM, 19=Other-See Progress Note by LVN A for 05/10/26 at 07:00 AM, and 19=Other-See Progress Note by LVN C for 05/10/26 at 07:00 PM. Record review of Resident #5's progress note, dated 05/09/26 at 08:16 PM and documented by RN B, reflected Methadone HCl Oral Tablet 5 MG. on order. Record review of Resident #5's progress note, dated 05/10/26 at 11:22 AM and documented by LVN A, reflected Methadone HCl Oral Tablet 5 MG. PENDING DELIVERY FROM PHARMACY. Record review of Resident #5's progress note, dated 05/10/26 at 08:55 PM and documented by LVN C, reflected Methadone HCl Oral Tablet 5 MG. Awaiting delivery of med. During an interview on 05/19/2026 at 02:36 PM, Resident #5 revealed she did not have her pain medications for 4 to 5 days last week. She revealed these medications were narcotics and the facility blamed the pharmacy for not sending medications or not having her medications. She revealed her pain was okay and she was fine but upset that the facility did not have her medication During an interview on 05/19/26 at 02:42 PM, LVN A revealed Resident #5 had no methadone last week. She revealed the doctor and pertinent parties were aware that the facility was just waiting for the medication to arrive because it had to have a triplicate (3 copy prescription form). She further revealed she monitored Resident #5 during this time and her pain was manageable. She said there was no uncontrolled pain otherwise she would have called the doctor. During a combined interview on 05/20/2026 at 05:05AM, RN B revealed Resident #5 did not have her pain medications for an unknown amount of time and was unsure if this was due to the facility or the doctor. RN B ensured that she monitored Resident #5's pain during this time. She revealed Resident #5 was not in pain and the resident was more annoyed than anything. LVN C revealed she did not recall when Resident #5 did not have Methadone. During an interview on 05/20/26 at 07:08 AM, the DON revealed there was a doctor's order for Resident #3 and Resident #4 to have their blood sugars checked by a [blood glucose monitoring tool] to monitor chronic illness and make sure their blood sugars were within normal limits and residents did not have adverse effects. She revealed Resident #4 and Resident #3 did not have a change in condition due to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this missed Accu-check. She further revealed LVN A had misunderstood her assignment and did not check these residents' blood sugar levels to see if they needed insulin. She revealed this was corrected by explaining the nurse's duties that needed to be followed. The DON revealed Resident #5 did not have 3 doses of Methadone from 05/09/26 to 05/10/26. She revealed the facility should be proactively ordering refills. She revealed the pharmacy needed 3 to 4 days' notice to refill medications in a timely manner. She further revealed narcotics needed a triplicate which required a doctor signing a physical form. Record review of facility's policy Medication Administration, dated 05/09/25, reflected Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.