

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/12/2025
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the menu was followed in 1 of 1 kitchen. The facility failed to follow the recipe for the main entree to ensure there was enough for residents in the dining room and failed to update a substitution on the posted menu in the dining room. This failure could place resident at risk of frustration and a decreased quality of life. The findings were: During a resident group meeting on 9/11/25 at 10:30 a.m. the residents stated the facility often ran out of the main meal being served and they were stuck with the alternate meal or a sandwich. The residents could not elaborate on exactly when this happened and stated, all the time. The residents stated the alternate was usually chicken tenders. The residents stated they were frustrated and had complained to many people about it but could not state who they had complained to. During an observation on 9/11/25 at 12:00 p.m. residents were seated in the dining room waiting for lunch service. The kitchen was observed through the open-door preparing meals of sloppy joes with French fries and green beans. These meals were checked by a nursing staff member and being loaded into enclosed carts going to the different halls for residents that eat in their rooms. The menu posted on the wall outside the kitchen in the dining room included sloppy joes, herb seasoned red potatoes, and green beans. During an observation on 09/11/2025 at 12:53 p.m. [NAME] EE was observed stating to [NAME] FF he did not know if they would have enough sloppy joe meat. During an interview and observation on 09/11/2025 at 12:57 p.m. the steam table in the kitchen revealed a serving pan that only had approximately 1/4 of pan with sloppy joe mixture and the main dining room had not been served only the room trays had been served. [NAME] FF stated they did not have another pan of Sloppy [NAME] mix in the oven and only had the one pan on the steam table. During an observation and interview on 9/11/25 at 1:00 p.m. the AD took the posted menu on the wall and put a line through herb seasoned red potatoes and wrote in French fries. The AD stated the menu had not been corrected and she was letting all the residents know. During an observation and interview on 9/11/25 at 1:05 p.m. the DM pulled a substitution list from behind the main menu on the wall and observed where French fries were documented as substituted for herb seasoned red potatoes. The DM stated the residents preferred French fries with sloppy joes and he just forgot to update the daily menu posting. During an interview on 9/11/25 at 1:20 p.m. LVN DD stated the facility did not run out of the main (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entr&eacute;e meal very often. LVN DD was unable to state how often it had happened previously. During an interview and observation on 09/11/2025 at 1:27 p.m. the DM was observed separating frozen hamburgers and placing in a pan to cook due to [NAME] FF having run out of the sloppy joe meat for the remaining trays in the dining room. The DM stated he was going to make more sloppy joe meat mixture to finish the meal. The DM stated the cook had only used 10 pounds of meat when the menu/recipe called for 17.5 pounds of meat. Observation on 09/11/2025 at 1:30 p.m. it was observed that 11 residents in the dining room had requested the alternate chicken tender's meal and was reported to the kitchen by the AD while 14 residents were served the main entree after the kitchen had made more. During an interview on 09/11/2025 at 2:02 p.m. [NAME] FF stated he did not believe he made enough sloppy joe meat and further stated the night shift cook sets out the meat for next day's meal. [NAME] FF stated the staff would ask the DM how much they will need to take out for meals. [NAME] FF stated the DM did, however, make more sloppy joe meat by using hamburger patties, grinding up and using sloppy joe sauce. During an interview on 09/11/2025 at 2:37 p.m. the DM stated to make enough sloppy joes the [NAME] FF should have used at least another 5 lbs. of ground meat. The DM stated they did not normally run out of foods. The DM stated he did not usually make the red potatoes with the sloppy joes that the menu calls for because he felt French fries go better with the sloppy joes. The DM stated he forgot to update the menu that was posted in the dining room with the meal change. The DM stated meat is pulled the day before, and the cooks were responsible for pulling their meat the night before for the next day. During an interview on 09/12/2025 at 5:29 p.m. the Administrator stated menu accuracy was important for residents so they are informed, so they can make a choice and to be able to decide what they would like. During an interview on 9/12/25 at 9:15 a.m. CNA C stated she worked in the dining room daily when on duty and about 1 day out of the week the kitchen runs out of the main entree when the male cooks are present but not when other cooks are present. CNA C stated when they run out of the main entr&eacute;e, they usually make something else like sandwiches or another alternative and stated the residents do get upset in the dining room. CNA C stated when the Dietary Manager or one of the ladies supervised, they always make more of the main entree but not when it was just the male cooks. CNA C stated she reported this issue to the Dietary Manager and to the Administrator. CNA C stated she was unsure how it had been addressed with the male cooks. Record review of Week at a glance Menu, with approved date 10/11/2024, read, Thursday 09/11/2025 Lunch: Homestyle Sloppy [NAME] on a Bun, Herb Seasoned Red Potatoes. Record review of Home Style Sloppy [NAME] on a Bun recipe, dated 09/11/2025, read, Servings: 70 Yield 70 sandwiches, 17.5 lb. Ground Beef Browned & crumbled. In an email sent to the Administrator on 09/12/2025 at 9:42 a.m. the policy on food preparation was requested and was not provided by the time of exit.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure dietary staff used facial hair restraints properly during meal preparation. The facility failed ensure proper hand hygiene was performed or changed gloves when touching other items that are not being used for serving or the clean serving area. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 09/11/2025 at 10:50 a.m. [NAME] EE and [NAME] FF were observed not wearing beard restraints or facial hair guards with both cooks having mustache and goatees. The mustache hair being approximately over an inch long and the goatee (chin) hair longer. [NAME] EE preparing the beverage carts with pitchers of beverages. [NAME] FF was preparing the puree prep area to puree the food for the puree diets. During an interview on 09/11/2025 at 10:52 a.m. [NAME] FF stated hair restraints or beard restraints were used to ensure hair did not get in the food. [NAME] FF stated hair restraints and beard restraints were to be worn for sanitary reasons, lessen choke hazards, prevent allergic reactions to what could be on the hair if it fell in the food. [NAME] FF stated they did have them available for the staff with facial hair, and they were kept in the boss office. During an interview and observation on 09/11/2025 at 10:56 a.m. [NAME] EE stated staff should wear beard restraints if they have facial hair. [NAME] EE stated he should wear so the hair did not get in the food and cause contamination of the food. [NAME] EE stated it could cause a resident to choke if the resident were to swallow it. [NAME] EE stated the beard restraints were available. [NAME] EE was observed to continue putting cookies in plastic sandwich bags, while [NAME] FF prepared the pureed meat for the lunch without beard restraints. Observation on 09/11/2025 at 1:19 p.m. [NAME] FF was observed grabbing a box of frozen French fries, shaking the box and then grabbed the bag of frozen fries dumping fries in the fryer basket and placing the basket of fries in the [NAME]. [NAME] FF then returned to preparing plates without having removed gloves or washing his hands. Observation on 09/11/2025 at 1:22 p.m. [NAME] FF was observed leaving the steam table and going to the dish room. [NAME] FF then brought back crate of washed plates and returned to preparing plates without having changed gloves or washing his hands. During an interview on 09/11/2025 at 2:02 p.m. [NAME] FF stated when he left the kitchen to get more plates, he did not change his gloves or wash his hands prior to returning to preparing plates and that he should have washed his hands/changed his gloves. [NAME] FF further stated he should wash his hands whenever he touches anything other than cook ware. [NAME] FF stated when he handled the French fries' box and finished placing fries in the [NAME] he should have washed his hands before returning to preparing plates for residents. [NAME] FF stated it affected the cleanliness of his hands so not to cross contaminate the food he should have washed his hands and changed his gloves. [NAME] FF further stated it could injure someone. [NAME] FF stated he had been trained on hand hygiene and importance of washing his hands. During an interview on 09/11/2025 at 2:37 p.m. the DM stated [NAME] FF should have washed his hands/changed gloves anytime he did something different and touch other items. The DM further stated by doing different duties, staff could pick something on their hands and could spread the bacteria, causing cross contamination. The DM stated beard restraints kept hair from falling in the food like a hair restrain. The DM stated it was not clean either and did not keep the food safe by not wearing them. The DM further stated these restraints were needed to prevent food borne illnesses. The DM stated the beard restraints were available and were available in the kitchen. During an interview on 09/12/2025 at 5:29 p.m. the Administrator stated the staff in the kitchen should wash their hands when leaving the serving area and returning. The Administrator stated could have caused cross contamination of the food. The Administrator further stated it could create bacteria that would (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	affect the health and safety of the resident. The Administrator stated the staff in the kitchen were responsible for following proper protocols and hand hygiene in while working in the kitchen. The Administrator stated with facial hair should wear beard restrains while in the kitchen due to could be a sanitation issue and could be an infection control issue. Review of facility's policy, Food Safety Requirements, dated 02/01/2025, read Policy: It is the policy of [facility name]to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance Guidelines: 7. Staff shall adhere to safe hygiene practices to prevent contamination of foods from hands or physical objects. a. Staff shall wash hands according to facility procedures. d. Dietary staff must wear hair restraints (e.g., hairnets, hat, and/or beard restraint) to prevent hair from contacting food. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-402 Hair Restraints, 2-402.11, Effectiveness., (A) Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-301.14, When to Wash, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTNESILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to provide residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 (Resident #23) of 24 residents reviewed for accommodation of needs. The facility failed to have Resident #23's soft touch call pad within reach for 2-days. The soft touch pad was located on Resident #23's nightstand out of reach. This failure could place residents at risk of not being able to communicate their need for assistance and result in unmet needs. The findings included: Record review of Resident #23's electronic face sheet, dated 09/09/2025, reflected a [AGE] year-old male who admitted on [DATE]. His diagnoses included: spastic diplegic cerebral palsy (form of cerebral palsy (a lifelong group of neurological disorders resulting from brain damage or abnormal brain development that affects a person's ability to control movement, balance, and posture) that affects the legs most severely, causing stiff muscles and scissoring gait, though it can affect the arms), convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders), depression (mood disorder characterized by a persistent feeling of sadness or loss of interest in activities), autistic disorder (a condition related to brain development that affects how people see other and socialize with them, anxiety (a natural emotional response involving feelings of fear, dread, and uneasiness, often triggered by stress), and insomnia (a common sleep disorder characterized by ongoing trouble falling asleep).Record review of Resident #23's quarterly MDS assessment, with an ARD of 08/22/2025, reflected he sometimes understands and would be sometimes understood. He was not a candidate for a BIMS which indicated his cognition was severely impaired. Behaviors were noted as C. Other behavioral symptoms not directed toward others (such as hitting or scratching self or making disruptive sounds), he received enteral feedings and was dependent on care for his ADLs. He was incontinent of bowel and bladder. Record review of Resident #23's comprehensive care plan, dated 06/20/2025, reflected, Focus: has potential for complications r/t cerebral palsy, cognitive impairments, communication deficits. Interventions: assess for adaptive equipment needs to assist with ADLs, assist with ADLs as needed. Focus: at risk for falls/injury r/t cognitive deficits, debility/generalized weakness, poor safety awareness. Interventions: call light within reach, encourage to call for assistance. Observation on 09/09/2025 at 10:30 a.m., of Resident #23 revealed he was lying on a low bed in his room, and his soft touch call pad was located on his night stand out of reach. Observation on 09/10/2025 at 07:00 a.m., of Resident #23 with LVN A revealed he was sitting up in his bed, his soft touch call pad was on his night stand out of reach. During an interview on 09/10/2025 at 07:15 a.m., LVN A stated Resident #23's soft touch pad needed to be within reach, so he could use it to call staff in case he was in trouble. She stated she sat the call light on his nightstand when she gave Resident #23 his G-tube medications and forgot to put it back onto his bed. During an interview on 09/10/2025 at 3:55 p.m., CNA B stated Resident #23's soft touch pad was on the nightstand because Resident #23 would throw the soft touch pad. She stated the resident needed to be able to touch the soft pad and let staff know he needed something. During an interview on 09/12/2025 at 10:40 am, the DON stated Resident #23 needed a soft sensor pad as a call light and staff was responsible to have it within his reach in case he was in trouble and needed help. She stated she was accountable for facility nursing care. Record review of the facility policy and procedure titled Accommodation of Needs (undated) reflected The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident. Record review of the facility policy and procedure titled Call Lights: Accessibility and Timely Response (undated) reflected The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility to allow residents to call for assistance. Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed for the resident to utilize the call system. Staff will ensure the call light is within reach of resident and secured, as needed.		

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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 interviews and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for two residents (Resident #25 and Resident #33) of 8 residents reviewed for MDS assessments. The facility failed to ensure Resident #25's resistive to care was coded on her Quarterly MDS Assessment. The facility failed to ensure Resident #33's nutritional status was coded accurately. These deficient practices could place residents at risk of missed or inappropriate care. The findings included: 1. Record review of Resident #25's face sheet dated 09/12/2025, revealed Resident #25 was admitted [DATE], readmitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (a brain condition that gradually destroys memory and cognitive skills, ultimately interfering with daily tasks), secondary Parkinsonism (conditions that cause movement-related symptoms similar to those seen in Parkinson's disease), unspecified, Schizophrenia (a serious mental health condition that affects how individuals think, feel, and behave), anxiety disorder, and mood disorder due to known physiological condition. Record review of Resident #25's progress notes dated 07/26/2025 that revealed, Despite encouragement and multiple attempts, resident refused incontinence care, bed linen change and medication. Resident #25's progress notes further revealed a progress note dated 07/30/2025 that revealed MD notified of medication refusals. Record review of Resident #25's Quarterly MDS assessment, dated 08/01/2025, revealed a BIMS score of 00 which indicated severely impaired cognition. The Quarterly MDS Assessment further revealed in Section E 0800 (Rejection of Care-Presence & Frequency) coded 0 behavior not exhibited regarding resident rejection of care that was necessary to achieve the resident's goals for health and well-being. The quarterly MDS assessment revealed Resident was not coded 1 indicating behavior of this type occurred 1 to 3 days. Record review of Resident #25's care plan, revision date of 06/27/2025, revealed Resident #25 had a focus of The resident is resistive to care r/t Alzheimer's, schizophrenia. During an interview and observation on 09/12/2025 at 1:13 p.m. the SW stated Resident #25 refused care most of the time. The SW after reviewing Resident #25's progress notes stated the Quarterly MDS assessment was not accurate. The SW stated she had made a mistake. The SW stated she was responsible for the completion of section E of the MDS assessments. The SW stated when she completed a MDS assessment she would review notes and her own personal knowledge of knowing the resident. The SW stated when she completed section E, she would review the resident's documentation for the 7 days prior to the MDS ARD date which was required for completion. The SW again stated she made a mistake in her coding of Resident #25's Quarterly MDS assessment. During an interview on 09/12/2025 at 4:56 p.m. the DON stated the SW was responsible for the completion of section E of the MDS assessments. The DON stated if the MDS assessment was an admission or comprehensive assessment, it would trigger the care plan but since it was a quarterly it would not. The DON further stated Resident #25 refused care daily and it should have been coded on the MDS assessment. 2. Record review of Resident #33's face sheet dated 09/10/2025, revealed Resident #33 was admitted [DATE], readmitted [DATE] with an original admission date of 03/18/2020 with diagnoses that included: senile degeneration of brain, not elsewhere classified, gastro-esophageal reflux disease without esophagitis, and type 2 diabetes mellitus without complications. Record review of Resident #33's physician order summary dated 09/10/2025, revealed an order dated 07/30/2025, Regular diet Regular texture, Thin consistency. Record review of Resident #33's Quarterly MDS assessment, dated 08/27/2025, revealed a BIMS score of 00 which indicated severely impaired cognition. The Quarterly MDS Assessment further revealed in Section K 0520 Nutritional Approaches was coded while a resident had parenteral/IV feeding when resident did not have a feeding tube. Record review of Resident #33's care plan, revision date of 06/10/2025, revealed Resident #33 had a focus of Resident #33 has potential nutritional problem r/t therapeutic diet, risk for malnutrition, DM (diabetes mellitus), impaired cognition and GERD. During an interview on (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/10/2025 at 1:23 p.m. Resident #33's RP stated Resident #33 never had a feeding tube. Resident #33's RP further stated the family told the facility no feeding tubes and a supplement was added to her diet when the resident lost weight. During an interview on 09/12/2025 at 11:18 a.m. the MDS Resource stated she over sees the MDS process for facilities assigned. The MDS Resource stated the coding of Resident #33's Quarterly MDS assessment for the feeding tube was an error. The MDS Resource stated the completion of MDS assessments was usually the responsibility of the MDS coordinator, however the facility had been without a MDS coordinator several months and had one who was only there for a month then was terminated. During an interview on 09/12/2025 at 4:53 p.m. the DON stated the MDS coordinator and the RN reviewing the MDS assessments were responsible for the accuracy of the MDS. The DON stated Resident #33 had not had a tube feeding since she had been working at the facility. During an interview on 09/12/2025 at 5:21 p.m. the Administrator stated the MDS nurse, and the DON were responsible for the MDS assessment accuracy. The Administrator stated the MDS assessment was to be able to have the clinical understanding of the individual. The Administrator stated Resident #25 had behaviors and that would be a miscoding of the MDS assessment to code she had no behaviors. The Administrator stated Resident #33 had not had a feeding tube to the best of his knowledge. The Administrator stated the MDS assessment was used to provide accurate care and services. The Administrator further stated the MDS assessment was used to maintain proper care/services and to provide the correct care/services. The Administrator stated by miscoding the MDS assessment could affect how care was provided or affect the awareness of the staff to the help the resident might have needed. Record review of facility's policy titled Conducting an Accurate Resident Assessment, revised date 5/5/2025, read, Policy: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessments, by staff qualified to assess relevant care areas. Definition: Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status). Record review of the CMS RAI Version MDS 3.0 Manual dated October 2024 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident.		

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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 observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 (Residents #2 and #23) of 16 residents reviewed for comprehensive care plans. 1. The facility failed to ensure Resident #2's care plan included his being a smoker. 2. The facility failed to reflect Resident #23 required a soft touch pad instead of a call light in his care plan. This facility failure could place residents at risk of inappropriate care or increased safety issues. The findings included: 1. Record review of Resident #2's face sheet, dated 09/12/2025, revealed he was admitted on [DATE] with diagnoses which included: essential (primary) hypertension (high blood pressure), malignant neoplasm of colon, and hypotension (low blood pressure), unspecified. Record review of Resident #2's Quarterly MDS assessment, dated 08/07/2025, revealed the resident's BIMS score 15 for intact/borderline cognition. Record review of Resident #2's Social History, dated 08/08/2025, revealed Resident #2 was a Current smoker. Record review of Resident #2's care plan, with a revision date of 09/09/2025, revealed there was not a care plan reflecting Resident #2's smoking. During an interview on 09/12/2025 at 4:45 p.m. the DON stated Resident #2's smoking should have been care planned. The DON stated the SW or the AD whoever did the smoking evaluations would care plan the resident being a smoker. The DON stated by not care planning Resident #2's smoking the staff would not have known if he was a supervised smoker or if he needed a vest. During an interview and observation on 09/12/2025 at 5:09 p.m. the SW stated a resident smoking would be something that was care planned. The SW stated after reviewing Resident #2's care plan she did not see a care plan regarding Resident #2 smoking. The SW stated the purpose of a care plan was, so the staff were aware he was a smoker, what the plan was, and whether he was a safe smoker. During an interview on 09/12/2025 at 5:16 p.m. the Administrator stated the MDS nurse, and the IDT were responsible for the care plans. The Administrator stated care planning smoking was for his safety. Record review of facility's Resident Smoking policy, revision date, 07/25/2022 read, Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Policy Explanation and Compliance Guidelines: 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervision resident while smoking. Supervision will be provided as indicated on each resident's care plan. 2. Record review of Resident #23's electronic face sheet dated 09/09/2025 reflected he was a [AGE] (continued on next page)		

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 09/12/2025
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	year-old male who was admitted to the facility on [DATE]. His diagnoses included: spastic diplegic cerebral palsy (form of cerebral palsy (a lifelong group of neurological disorders resulting from brain damage or abnormal brain development that affects a person's ability to control movement, balance, and posture) that affects the legs most severely, causing stiff muscles and scissoring gait, though it can affect the arms)., convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders), depression (mood disorder characterized by a persistent feeling of sadness or loss of interest in activities), autistic disorder (a condition related to brain development that affects how people see other and socialize with them., anxiety (a natural emotional response involving feelings of fear, dread, and uneasiness, often triggered by stress), and insomnia (a common sleep disorder characterized by ongoing trouble falling asleep). Record review of Resident #23's quarterly MDS assessment with an ARD of 08/22/2025 reflected he sometimes understands and would be sometimes understood. He was not a candidate for a BIMS which indicated his cognition was severely impaired. Behaviors were noted as C. Other behavioral symptoms not directed toward others (such as hitting or scratching self or making disruptive sounds), he received enteral feedings and was dependent on care for his ADLs. He was incontinent of bowel and bladder. Record review of Resident #23's comprehensive care plan dated 06/20/2025 reflected Focus, at risk for falls/injury r/t cognitive deficits, debility/generalized weakness, poor safety awareness, Interventions, call light within reach, encourage to call for assistance. Resident #23 required a soft touch pad, and it was not reflected in his care plan. Observation on 09/09/2025 at 10:30 am of Resident #23 revealed he was lying on a low bed in his room, and his soft touch call pad was located on his night stand out of reach. His fingernails were 1/2 inch in length and appeared jagged. Observation on 09/10/2025 at 07:00 am of Resident #23 with LVN A revealed he was sitting up in his bed, his soft touch call pad was on his night stand out of reach. During an interview on 09/10/2025 at 3:55 pm, CNA B stated Resident #23's soft touch pad was on the nightstand because Resident #23 would throw the soft touch pad. She stated the resident needed to be able to touch the soft pad and let staff know he needed something. During an interview on 09/12/2025 at 10:40 am, the DON stated Resident #23 needed a soft sensor pad as a call light and staff was responsible to have it within his reach in case he was in trouble and needed help. She stated the IDT was responsible for care plans, so if it was a nursing issues, she was responsible. She stated Resident #23's comprehensive care plan needed to reflect the soft touch pad instead of the call light because based on assessment that was the best accommodation for his needs. Record review of the facility policy and procedure titled Care Plans, Comprehensive Person-Centered dated Qtr. 3, 2022 reflected The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (Resident #23) of 24 residents reviewed for grooming. The facility failed to perform nail care for Resident #23 who was observed with long ragged fingernails. This facility failure could place residents at risk of injuries or decreased self-esteem. The findings included: Record review of Resident #23's electronic face sheet dated 09/09/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: spastic diplegic cerebral palsy (form of cerebral palsy (a lifelong group of neurological disorders resulting from brain damage or abnormal brain development that affects a person's ability to control movement, balance, and posture) that affects the legs most severely, causing stiff muscles and scissoring gait, though it can affect the arms)., convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders), depression (mood disorder characterized by a persistent feeling of sadness or loss of interest in activities), autistic disorder (a condition related to brain development that affects how people see other and socialize with them., anxiety (a natural emotional response involving feelings of fear, dread, and uneasiness, often triggered by stress), and insomnia (a common sleep disorder characterized by ongoing trouble falling asleep). Record review of Resident #23's quarterly MDS assessment with an ARD of 08/22/2025 reflected he sometimes understands and would be sometimes understood. He was not a candidate for a BIMS which indicated his cognition was severely impaired. Behaviors were noted as C. Other behavioral symptoms not directed toward others (such as hitting or scratching self or making disruptive sounds), he received enteral feedings and was dependent on care for his ADLs. He was incontinent of bowel and bladder. Record review of Resident #23's comprehensive care plan dated 06/20/2025 reflected Focus, at risk for self-harm r/t poor coping mechanisms, emotional distress secondary to autistic disorder, scratching at self (arms/face). Focus, has potential for complications r/t cerebral palsy, cognitive impairments, communication deficits, Interventions, assess for adaptive equipment needs to assist with ADLs, assist with ADLs as needed. Observation on 09/09/2025 at 10:30 am of Resident #23 revealed he was lying on a low bed in his room, and his fingernails were long and appeared jagged. Observation on 09/10/2025 at 07:00 am of Resident #23 with LVN A revealed he was sitting up in his bed, and his fingernails were long and appeared jagged. During an interview on 09/10/2025 at 07:15 am, LVN A stated it appeared like Resident #23's fingernails needed to be trimmed, however, she stated the nails should be trimmed during his bath on Sundays. She stated she would get them trimmed, and if they were left long and sharp he could scratch himself and get hurt. Record review of Resident #23's Skin Monitoring; Comprehensive CNA Shower Review dated 09/08/2025 reflected CNA B provided his recent bath. No mention of Resident #23's long fingernails was noted. During an interview on 09/10/2025 at 3:55 pm, CNA B stated she noticed Resident #23's fingernails were long, but he would not let the staff trim them. She stated she reported Resident #23s long nails to the nurse. She stated his fingernails needed to be trimmed to cut back on bacteria or he could hurt himself. During an interview on 09/12/2025 at 10:40 am, the DON stated when staff bathed the resident, staff was responsible to trim any ragged or long nails for safety and dignity reasons. She stated nail care was completed weekly or as needed. Record review of the Point of Care Charting dated 09/07/2025 to 09/08/2025 reflected when nail care was provided for Resident #23 reflected No history found. Record review of facility policy and procedure titled Nail Care (undated) reflected The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health., nails should be kept smooth to avoid skin injury, routine nail care, to include trimming and filing, will be provided on a regular schedule such as weekly, nail care will be provided between scheduled occasions as the need arises.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interviews and record review, the facility failed to ensure 1 medication cart (Hallway 4 medication cart) of 4 medication carts was left unlocked and unattended.LVN A did not secure hallway #4's medication cart when she went to provide a resident medication.This facility failure could place residents at risk of misappropriation of drugs or misuse. The findings included: Observation during medication pass on 09/11/2025 at 09:45 am, LVN A left the medication cart insecure when she went into a resident's room to administer his G-tube medications. She closed the door behind her and the medication cart was left unlocked in hallway 4. During an interview on 09/11/2025 at 09:50 am, LVN A stated she should have secured the cart because others would have access to the medications and it could result in misappropriation or misuse leading to harm.During an interview on 09/12/2025 at 10:40 am, the DON stated LVN A needed to secure the medication cart when she left it so others could not have access to medications and other biological substances that could cause harm. She stated she was accountable for facility nursing care. Record review of facility policy and procedure titled Medication Storage revised date 06/15/2025 reflected 1. General guidelines, a. All drugs and biologicals will be stored in locked compartments, b. Only authorized personnel will have access to the keys or locked compartments, c. During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.		

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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 establish and 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 (Residents #69 and #23) of 3 residents reviewed for incontinent care. CNA C failed to change gloves and sanitize hands between soiled and clean items when she performed incontinent care for Resident #69. 2. CNA C failed to wear a gown or change gloves and sanitize hands between soiled and clean items when she performed incontinent care for Resident #23 who was on EBP. This failure could place residents at risk of UTI's or spread of an MDRO. The findings included: 1. Record review of Resident #69's electronic face sheet dated 09/09/2025 reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: cerebral infarction due to embolism of right middle cerebral artery (type of stroke where a blood clot, formed elsewhere in the body and travelled to and blocked the right middle cerebral artery, interrupting blood flow to the right side of the brain), fracture of lower end of left ulna (a break in the ulna bone on the inner side of the left forearm near the wrist), type 2 diabetes mellitus (chronic condition where the body either doesn't produce enough insulin or doesn't use insulin properly, leading to high levels of blood sugar), hemiplegia (paralysis of one side of body), fracture of the lower end of left radius (break in the bone that connects the forearm to the wrist), fracture of right talus r/t motor vehicle accident (break of a critical bone in the ankle that connects the lower leg bones). Record review of Resident #69's admission MDS assessment dated [DATE] reflected her cognitive skills were moderately impaired. She had a staff assessment performed in lieu of a BIMS. She required moderate assistance with her ADLs. She was dependent for dressing and showering. She was frequently incontinent of bowel and bladder. Record review of Resident #69's comprehensive care dated 08/26/2025 reflected Focus, is frequently incontinent of bowel and bladder, Intervention, provide proper peri-care. Observation on 09/12/2025 at 9:02 AM of CNA C performed incontinent care for Resident #69. She washed her hands and put on gloves and proceeded to take off the soiled brief and started to wipe Resident #69's perineal (is the region of the body located between the thighs, encompassing the anus and genitals) area, split the labia (folds of skin that protect the vulva, the external part of the female genitals) and then turned the resident to continue wiping her buttocks and anal area. CNA C, then took the clean brief and placed it onto Resident #69 without removing her soiled gloves, sanitizing hands and putting on clean gloves prior to working with the clean brief and bedding. CNA C then straightened up Resident #69's blankets and bedding and proceeded to take out the dirty brief and wipes she had placed in a plastic bag. During an interview on 09/12/2025 at 09:15 am CNA C revealed she did not know she was supposed to change her gloves between dirty and clean. She performed incontinent care for Resident #69 and did not change her gloves between soiled and clean items. She stated it was important to change her gloves because of cross contamination. She stated she had training on incontinent care and on EBP. 2. Record review of Resident #23's electronic face sheet dated 09/09/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: spastic diplegic cerebral palsy (form of cerebral palsy (a lifelong group of neurological disorders resulting from brain damage or abnormal brain development that affects a person's ability to control movement, balance, and posture) that affects the legs most severely, causing stiff muscles and scissoring gait, though it can affect the arms)., convulsions (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders), depression (mood disorder characterized by a persistent feeling of sadness or loss of interest in activities), autistic disorder (a condition related to brain development that affects how people see other and socialize with them.), anxiety (a natural emotional response involving feelings of fear, dread, and uneasiness, often triggered by stress), and insomnia (a common sleep disorder characterized by (continued on next page)		

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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	ongoing trouble falling asleep). Record review of Resident #23's quarterly MDS assessment with an ARD of 08/22/2025 reflected he sometimes understands and would be sometimes understood. He was not a candidate for a BIMS which indicated his cognition was severely impaired. Behaviors were noted as C. Other behavioral symptoms not directed toward others (such as hitting or scratching self or making disruptive sounds), he received enteral feedings and was dependent on care for his ADLs. He was incontinent of bowel and bladder. Record review of Resident #23's comprehensive care plan revised date of 06/20/2025 reflected Focus, at risk for self-harm r/t poor coping mechanisms, emotional distress secondary to autistic disorder, scratching at self (arms/face). Focus, has potential for complications r/t cerebral palsy, cognitive impairments, communication deficits, Interventions, assess for adaptive equipment needs to assist with ADLs, assist with ADLs as needed, Focus, has potential for complications r/t bladder and bowel incontinence, Interventions, provide proper perineal care., Focus, enhanced barrier precautions r/t G-tube, Interventions, don gown and gloves during high-contact personal care.Observation on 09/12/2025 at 10:10 am, CNA C performed incontinent care for Resident #23. She entered the room with EBP signage on the door, and a bin of PPE outside the room, washed her hands and put clean gloves on. CNA C did not don a gown which was required for a resident on EBP. She then took off Resident #23's soiled brief, wiped his perineum, penis and scrotum from front to back, threw the wipes into trash container lined with a plastic bag. CNA C then turned grabbed a clean brief from the counter top and placed it near Resident #23. She then turned Resident #23, wiped his buttocks and anal area and threw away the wipes. CNA C then placed the clean brief onto Resident #23, straightened up his bed and then proceeded to change her gloves.During an interview on 09/12/2025 at 10:25 am, CNA C stated she was confused about when to change her gloves. She stated she was trained to change her gloves between soiled and clean. She stated she was trained on EBP and did not remember to put a gown on for direct care. She stated cross contamination could occur leading to infection.During an interview on 09/12/2025 at 10:40 am, the DON stated CNA C needed to deglove, sanitize hands and put on clean gloves between soiled items and clean when she performed incontinent care for both Residents #23 and #69. She stated not doing so, could result in UTI's and cross contamination. She stated she was accountable for facility nursing care. She stated EBP signage was on residents' doors and staff had been trained. She stated CNA C needed to wear a gown when she performed incontinent care for Resident #23. Record review of CNA C's Competency Assessment-Perineal Care dated 07/25/2025 reflected Competency Demonstrated-yes for both male and females. Record review of facility policy and procedure titled Perineal Care dated 05/01/2025 reflected It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. 6. Perform hand hygiene and put on gloves. Apply other personal protective equipment as appropriate, cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate washcloth or wipes, thoroughly dry, 10. Reposition resident in supine position. Change gloves and continue with perineal care. Record review of facility policy and procedure titled Enhanced Barrier Precautions dated 04/10/2025 reflected Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and gloves use during high contact resident care activities.		

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their own established smoking policy for 1 of 1 resident reviewed for smoking. (Resident #2) The facility failed to ensure to complete a Resident Safe Smoking Assessment for Resident #2. This failure could place residents at risk for injury or harm. Findings included: Record review of Resident #2's face sheet, dated 09/12/2025, revealed he was admitted on [DATE] with diagnoses which included: essential (primary) hypertension (high blood pressure), malignant neoplasm of colon, and hypotension (low blood pressure), unspecified. Record review of Resident #2's Quarterly MDS assessment, dated 08/07/2025, revealed the resident's BIMS score 15 for intact/borderline cognition. Record review of Resident #2's Social History, dated 08/08/2025, revealed Resident #2 was a Current smoker. Record review of Resident #2's EMR revealed he not been assessed for smoking safety. During an interview on 09/12/2025 at 4:45 p.m. the DON stated activities and social services was responsible for completing the smoking evaluations. The DON stated she was not aware Resident #2 was on the smokers list. The DON stated by not having an assessment it did not let the staff know if Resident #2 was a supervised smoker. During an interview and observation on 09/12/2025 at 5:01 p.m. the SW stated Resident #2 was a smoker. The SW stated she was responsible for completing the smoking assessments with the nurses and the activities director having done them also. The SW stated after review of Resident #2's EMR that he did not have one completed. The SW stated smoking assessments were used to determine the resident's capacity to smoke, whether the resident needed protective equipment or maybe they could not properly dispose of the ashes. During an interview on 09/12/2025 at 5:17 p.m. the Administrator stated the MDS nurse would be responsible for the completion of the smoking assessments and second would be the charge nurse. The Administrator stated the social worker had been responsible in the past, but he would hold the nurse responsible due to clinical concerns there might be involved. The Administrator state it was important to assess for the safety of the resident and others. The Administrator stated by not having been assessed the resident and his mobility it could affect his safety. Record review of facility's Resident Smoking policy, revision date, 07/25/2022 read, Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Policy Explanation and Compliance Guidelines: 6. Residents who smoke will be further assessed, using the resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking or if resident is safe to smoke at all.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility and failed to post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public for 4 of 4 days (9/9/25-9/12/25) for 1 of 1 facility, observed for postings. The survey results were behind the receptionist's desk on a shelf and the sign for the survey results was not viewable from 9/9/25-9/12/25 during the survey period. This failure could place residents, family, and visitors at risk of not knowing the results of the facility survey history. The findings were: In a resident group meeting on 9/11/25 at 10:30 a.m., the residents unanimously stated they were not aware they could read the facility's survey results and stated they had no idea where to find them. The residents stated they were interested in the results and would like to read them. During observations on 9/9/25 at 8:48 a.m., 9/10/25 at 9:34 a.m., and 9/11/25 at 11:00 a.m., revealed the facility survey results and signage indicating the location of the survey results were not located at the entrance or in the small lobby area. During an observation on 9/9/25 at 8:50 a.m., two binders labeled survey results, one black and one white, approximately 6-8 inches wide, were observed approximately 7 feet behind the receptionist desk on a built-in bookshelf about 3 feet high. The survey results were not immediately noticeable unless specifically looking for them. No signage indicating the location of the survey results was observed. In an observation and interview on 9/12/25 at 3:10 p.m. while standing in front of the Administrator's office behind the reception desk and in front of the bookshelf, the survey results binders were still on the shelf behind the receptionist desk and there was a sign next to the survey results binders that read survey results. The sign could not be viewed unless standing directly in front of the survey results behind the receptionist desk. The Administrator stated the residents and families knew the area behind the reception desk leading to the Administrator's office was an open area they could walk through. The Administrator immediately moved the survey binders and the sign to the first shelf at the beginning of the wall in view of anyone entering the front door. The Administrator stated the possible consequences of the survey results not being in the open and accessible could possibly be people would not have knowledge of the facility survey history. In an interview on 9/12/25 at 3:10 p.m. the facility survey results policy was requested from the Administrator and not received prior to exit.		