STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455754	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Rehabilitation and Healthcare Center	603 Corinne St San Antonio, TX 78218

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interview and record review the facility failed to ensure all alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities, in accordance with State law through established procedures for 1 of 6 residents (Resident#2) reviewed for abuse and neglect. 1. The facility failed to report to the state survey agency an allegation of abuse reported by a family member of Resident #2. 2. The facility failed to report to the state survey agency an allegation of abuse when Resident #3 allegedly hit Resident #2. This failure could place residents at risk of allegations of abuse not being reported. Findings include: 1. Record review of Resident #2's, undated, face sheet revealed Resident #2 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor or stroke), Dementia (a general term for impaired ability to remember, think or make decisions), Legal Blindness and Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). Record review of Resident #2's MDS Assessment, dated 02/24/2025, revealed Resident #2 had a BIMS score of 7, which indicated severe cognitive impairment. Section E - Behaviors revealed Resident #2 exhibited a wandering behavior on a total of 1 to 3 days during the 7-day assessment period. Section GG - Functional Abilities revealed Resident #2 used a walker and a wheelchair for mobility and required partial assistance from staff to walk up to 50 feet and dependent on staff for wheelchair mobility. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's comprehensive care plan revealed a care plan, dated 12/17/2024, which stated Resident #2 was at risk for impaired cognitive function related to an impaired thought process, AMS, Encephalopathy and Dementia. An additional care plan, date initiated 12/20/2024, revealed Resident #2 was an elopement risk and wandered aimlessly. Record review of Resident #2's psychiatry initial evaluation, dated 01/20/2025, revealed Resident #2 had a history of AMS with auditory and visual hallucinations (hearing sounds or seeing shapes, objects or people who aren't there). The evaluation revealed Resident #2 was oriented to person, had impaired short-term memory and limited insight and judgment. During an interview with Resident #2's Family Member A, on 03/12/2025 at 4:00 p.m., Family Member A said Resident #2 told Family Member B a man had hurt her and twisted her when Family Member B visited Resident #2 one day last week. Family Member A stated they called the facility Administrator on 03/10/2025 and asked about Resident #2's allegation. Family Member A stated the Administrator told Family Member A the allegation was investigated and closed and if anyone hurt her, there would be an x-ray technician who recently administered an x-ray for Resident #2 because no one else was capable of hurting her. During an interview with Resident #2's Family Member B, 03/12/2025 at 4:18 p.m., Family Member B stated they were visiting Resident #2 at the facility on 03/04/2025 and Resident #2 told her some guy twisted her up and hurt her neck all the way down to her knees. Family Member B said Resident #2 would not give her a description of the man. Family Member B stated they notified the Administrator, and the Administrator came into Resident #2's room and asked Resident #2 what happened, and Resident #2 told the Administrator some man twisted her up and her neck and her body. Family Member B stated the Administrator asked Resident #2 several other questions and Resident #2 would not answer the questions, so Family Member B stepped out of the room to give the resident privacy while talking to the Administrator. Family Member B stated the Administrator was in the room approximately 5 minutes and then came out of the room and told Family Member B he was going to investigate it, to call him anytime they wanted an update and provided Family Member B a business card. Family Member B stated Family Member A called the Administrator on Monday, 03/10/2025 and was told the investigation was closed and it had to have been an x-ray technician when she had an x-ray recently. Family Member B stated Resident #2 did not have any bruises or discoloration and did not appear fearful or in distress during the visit. Family Member B stated Resident #2 had Dementia and was legally blind and hallucinated in the past. During an interview with Resident #2 on 03/13/2025 at 2:42 p.m., Resident #2 stated a man twirled me around in my chair and made my whole body hurt. Resident #2 could not give a description of when this occurred, who the man was or any other details of this alleged incident. Resident #2 stated she felt safe at the facility and facility staff were very good to me here. During an interview with the Social Worker on 03/17/2025 at 10:07 a.m., the Social Worker stated she was not aware of Resident #2 making any allegations of abuse the week of 03/04/2025 and stated Resident #2 had a severe memory deficit. The Social Worker stated the Administrator was the Abuse Prevention Coordinator and when an investigation was conducted into allegations of abuse or neglect, the Administrator would instruct her to conduct interviews with facility residents to validate there were no further allegations or concerns from other facility residents. The Social Worker stated she was not asked to conduct resident surveys around the time of the allegation on 03/04/2025. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 03/17/2025 at 10:24 a.m., the Administrator stated he was the Abuse Prevention Coordinator and when he received an allegation of abuse, he would start an investigation and report it to the state in a timely manner. The Administrator stated he would ask the Social Worker to do safe surveys with the residents, have a skin assessment completed on the resident, follow up with the families and formulate the best outcome he could from the information gathered in the investigation. The Administrator said all types of allegations of abuse should be investigated which included mental, physical and sexual abuse. The Administrator stated he was notified by Resident #2's family member on 03/04/2025 that Resident #2 stated a male had turned her too hard and the Administrator stated he did not know the family member and when he asked Resident #2 about it, she did not say anything happened to her. The Administrator stated he told the family member he would start an investigation. The Administrator stated he asked Resident #2's nurse if she was aware of any complaints from Resident #2 and the nurse said no. The Administrator stated no other resident or staff interviews were conducted, no skin assessment was completed, no abuse and neglect training or education was provided and he concluded that no facility staff could have harmed her because Resident #2 did not have any male staff providing patient care to her. The Administrator stated Resident #2 had a recent, possible chest x-ray, and he concluded it must have been the male x-ray technician. The Administrator stated he did not reach out to the x-ray vendor or the x-ray technician to conduct an interview. The Administrator stated he did not report the allegation to the state agency. The Administrator stated it was important that allegations of abuse and neglect were investigated and reported to ensure there was no abuse and neglect taking place and to keep the resident safe from abuse and neglect. 2. Record review of Resident #3's, undated, face sheet revealed Resident #3 was an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included Dementia (a general term for impaired ability to remember, think or make decisions), Paranoid Schizophrenia (a disorder characterized by strong, unfounded beliefs of persecution, auditory hallucinations and delusions), Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome) and Delusional Disorders (a disorder characterized by irrational, unshakeable beliefs that are untrue). Record review of Resident #3's quarterly MDS assessment, dated 01/10/2025, revealed Resident #3 had a short term and long-term memory problem Section E - Behavior revealed Resident #3 displayed episodes of verbal behavioral symptoms directed toward others on 4 to 6 days during the 7-day assessment period. Section GG - Functional Abilities revealed Resident #3 used a wheelchair for mobility. Record review of Resident #3's comprehensive care plan revealed a care plan, date initiated 03/14/2021, revealed Resident #3 had a history of trauma related to being a [NAME] from the Vietnam war and suffered from post-traumatic stress disorder (mental health condition that develops in some people who have experienced or witness a traumatic event) symptoms related to this event. Resident has a care plan, date initiated 11/09/2017, which revealed Resident #3 was at risk for impaired cognitive function or thought process related to Dementia. An additional care plan, date initiated 09/16/2019, revealed Resident #3 had multiple behaviors which included writing and placing scriptures and drawings all over the room, smearing food and drinks on chairs, and refused staff and housekeeping in his room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Rehabilitation and Healthcare Center	603 Corinne St San Antonio, TX 78218

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN G on 03/13/2025 at 10:03 a.m., LVN G stated Resident #2 was moved to B hall on 03/12/2025 due to Resident #3 hitting Resident #2 with a stick. LVN G stated another charge nurse told her Resident #2 wandered into Resident #3's room and Resident #3 hit her with a stick so Resident #2 was moved to a different hall. LVN G stated Resident #2 never made any allegations of abuse to LVN G when providing care. During an interview with LVN C on 03/13/2025 at 10:49 a.m., LVN C stated she was at the nurse's station with RN B on 03/12/2025 around mid-morning and heard a commotion and [Resident #3] yelling 'she is in my room". LVN C stated she and RN C ran down to the room and observed Resident #2 standing beside Resident #3's bed and they escorted her out of Resident #3's room. LVN C stated Resident #2 told LVN C Resident #2 was lying in Resident #3's bed and thought it was her room and Resident #3 hit her on the legs when she was in his bed. LVN C stated Resident #2 was taken to the nurse's station and RN B assessed Resident #2's legs. LVN C stated the Administrator was coming up to the nurse's station when they were assisting Resident #2 to the station. LVN C stated she did not tell the Administrator Resident #2 reported Resident #3 hit her on the legs, but LVN C stated she heard the Administrator talking to Resident #2 and overheard Resident #2 tell the Administrator Resident #3 hit her. LVN C stated Resident #2 was moved to another hallway after the incident. During an interview with Resident #3 on 03/13/2025 at 11:30 a.m., Resident #3 stated when he got into his room before lunch on 03/12/2025, he observed Resident #2 lying in his bed with the covers pulled up over her. Resident #3 stated he told her to get out of his bed and then pulled out a wood stick from his wheelchair that appeared to be approximately 12 inches long. Resident #3 stated, I took my stick and hit her on the legs like this and told her to get up. Resident #3 demonstrated a tapping motion with the stick-on top of his bed covers. Resident #3 stated staff members came in the room and removed Resident #2 from his room. During an interview with RN B on 03/13/2025 at 2:07 p.m., RN B stated another nurse was running down the hall toward Resident #3's room when she heard yelling, so RN B followed her to the room. RN B stated a therapist was already in the room and Resident #3 was shouting and Resident #2 was standing beside Resident #3's bed. RN B stated she and the other staff members assisted Resident #2 out of the room, placed her in the wheelchair in her room, and brought her to the nurse's station. RN B stated Resident #2 made a lot of different comments like I think he is on America's Most Wanted but RN B stated she did not recall Resident #2 stating Resident #3 hit her. RN B stated she assessed Resident #2's legs because we always assess when there is a conflict or something like that, but she never said he hit her. RN B stated she told the Administrator there was an altercation of shouting by Resident #3 when Resident #2 went into his room and Resident #2 was redirected. RN B stated Resident #2 stayed close to the nurse's station until Resident #2 was moved to a different hall to prevent her from potentially wandering into his room again. During an interview with Resident #2 on 03/13/2025 at 2:42 p.m., Resident #2 stated a man hit her with some hard plastic thing on her legs and stated, I told him to stop, or he is going to break my legs. Resident #2 stated when she started hollering, staff came in and took her away from the man. Resident #2 was unable to recall when the incident occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the PTA on 03/13/2025 at 3:28 p.m., the PTA stated she was in another resident room on 03/12/2025 and heard Resident #3 and Resident #2 yelling. The PTA stated Resident #3 was in the doorway to his room and Resident #2 was lying in Resident #3's bed and yelled this is my house. The PTA stated Resident #2 was yelling it was her room and Resident #3 was yelling it was his room and they were going back and forth. The PTA stated two nurses entered the room and the PTA and the nurses assisted Resident #2 out of the room. The PTA stated Resident #2 was saying he doesn't pay a penny here and then stated, he hit me, did you see him hit me. The PTA stated she did not see Resident #3 hit Resident #2 and Resident #3 was in the doorway to the room when she observed him and Resident #2 was in the bed. During an interview with the Social Worker on 03/17/2025 at 10:07 a.m., the Social Worker stated she was unaware of Resident #2 making any allegations of abuse. The Social Worker stated she was present when the Administrator spoke to Resident #2 about the incident with Resident #3 on 03/12/2025 and she did not recall Resident #2 say she was hit by Resident #3. The Social Worker stated the Administrator asked her to complete resident safe surveys with other residents on 03/12/2025 and she completed the assessments and turned them into the Administrator. The Social Worker also stated Resident #2 was moved to a different hallway. During an interview with the PTA on 03/17/2025 at 11:10 a.m., the PTA stated she notified the Administrator Resident #2 was yelling, he was hitting me, he was hitting me on my legs. The PTA stated she notified the DOR who instructed her to go to the Administrator and notify him of the allegation. The PTA stated she wrote a statement and turned it into the Administrator and could not recall if she included Resident #2's allegation in her statement but Resident #2's allegation would have been an important fact to include in the statement. During an interview with the ADON on 03/17/2025 at 12:50 p.m., the ADON stated he completed a skin assessment on Resident #2 on 03/12/2025 due to Resident #2 making an allegation that Resident #3 hit her. The ADON stated his understanding was a therapist was present the whole time and did not observe a physical altercation but since it was an allegation, he completed a skin assessment. The ADON stated Resident #2 did not have any bruising or redness on her legs which indicated Resident #2 was injured. The ADON stated the completion of a skin assessment was a requirement for investigations into abuse and neglect allegations. During an interview with the Administrator on 03/17/2025 at 10:24 a.m., the Administrator stated he was aware of an incident on 03/12/2025 when Resident #2 went into Resident #3's room and got into his bed. The Administrator stated he was notified that a nurse and therapist got Resident #2 out of the room and Resident #2 did not say she was abused. The Administrator stated Resident #2 has Dementia and said, 'something about paying off a house and her grandkids and some other things but she did not mention abuse. The Administrator stated he spoke to Resident #2 and Resident #2 did not tell him Resident #3 hit her on the legs. The Administrator stated a therapist told him she heard Resident #3 yelling at Resident #2 to get out of his room and she went in the room and removed Resident #2. The Administrator stated he interviewed Resident #3 and Resident #3 said he yelled at Resident #2 to get out of the room and Resident #3 did not believe Resident #2 was crazy or blind. The Administrator stated he also spoke with RN B who told him the same information as the PTA and did not say Resident #2 alleged Resident #3 hit her. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's, undated, policy titled, Policy/Procedure-Nursing Administration documented the following: Under the section titled, Reporting/Response, the policy stated, all alleged violations will be reported via phone or email to the state licensing agency. Record review of the facility's in-service document, dated 02/18/2025, revealed the in-service topic was abuse and listed the objectives of the in-service as Abuse Coordinator, . If abuse is observed the resident should be moved to safety immediately and abuse should be reported. The document was signed by 119 employees.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interview and record review the facility failed to have evidence that all alleged violations were thoroughly investigated for 1 of 6 residents (Resident #2) reviewed for abuse. The facility failed to thoroughly investigate an allegation of abuse involving Resident #2. This failure could place residents at risk of allegations of abuse causing mental, physical or emotional harm. The findings include: Record review of Resident #2's, undated, face sheet revealed Resident #2 was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included Encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor or stroke), Dementia (a general term for impaired ability to remember, think or make decisions), Legal Blindness and Anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). Record review of Resident #2's MDS Assessment, dated 02/24/2025, revealed Resident #2 had a BIMS score of 7, which indicated severe cognitive impairment. Section E - Behaviors revealed Resident #2 exhibited a wandering behavior on a total of 1 to 3 days during the 7-day assessment period. Section GG - Functional Abilities revealed Resident #2 used a walker and a wheelchair for mobility and required partial assistance from staff to walk up to 50 feet and was dependent on staff for wheelchair mobility. Record review of Resident #2's comprehensive care plan revealed a care plan, dated 12/17/2024, which stated Resident #2 was at risk for impaired cognitive function related to an impaired thought process, AMS, Encephalopathy, and Dementia. An additional care plan, date initiated 12/20/2024, revealed Resident #2 was an elopement risk and wandered aimlessly. Record review of Resident #2's psychiatry initial evaluation, dated 01/20/2025, revealed Resident #2 had a history of AMS with auditory and visual hallucinations (hearing sounds or seeing shapes, objects or people who aren't there). The evaluation revealed Resident #2 was oriented to person, had impaired short-term memory and limited insight and judgment. During an interview with Resident #2's Family Member A, 03/12/2025 at 4:00 p.m., Family Member A said Resident #2 told Family Member B that a man had hurt her and twisted her when Family Member B was visiting Resident #2 one day last week. Family Member A stated they called the facility Administrator on 03/10/2025 and asked about Resident #2's allegation. Family Member A stated the Administrator told Family Member A the allegation had been investigated and closed and if anyone had hurt her, it had to have been an x-ray technician who had recently administered an x-ray for Resident #2 because no one else was capable of hurting her. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #2's Family Member B, 03/12/2025 at 4:18 p.m.,. Family Member B stated they notified the Administrator that Resident #2 reported to her on 03/04/2025 that a man had hurt her. Family Member B stated the Administrator came into the room and asked Resident #2 what happened, and she told the Administrator that some man twisted her up and her neck and her body. Family Member B stated the Administrator said he was going to investigate it, to call him anytime they wanted an update and provided Family Member B a business card. Family Member B stated Family Member A called the Administrator on Monday, 03/10/2025, and was told the investigation was closed and it had to have been an x-ray technician when she had an x-ray recently. Family Member B stated Resident #2 did not have any bruises or discoloration and did not appear fearful or in distress during the visit. Family Member B stated Resident #2 has Dementia and is legally blind and has hallucinated in the past. During an interview with Resident #2, 03/13/2025 at 2:42 p.m., Resident #2 stated that a man twirled me around in my chair and made my whole body hurt. Resident #2 could not give a description of when this occurred, who man was or any other details of this alleged incident. Resident #2 stated she felt safe at the facility and facility staff were very good to me here. During an interview with the Social Worker, 03/17/2025 at 10:07 a.m., the Social Worker stated she was not aware of Resident #2 making any allegations of abuse the week of 03/04/2025 and stated Resident #2 had a severe memory deficit. The Social Worker stated the Administrator was the Abuse Prevention Coordinator and when an investigation was conducted into allegations of abuse or neglect, the Administrator would instruct her to conduct interviews with facility residents to validate there were no further allegations or concerns from other facility residents. The Social Worker stated she had not been asked to conduct resident surveys around the time of the allegation on 03/04/2025. During an interview with the Administrator, 03/17/2025 at 10:24 a.m., the Administrator stated he was the Abuse Prevention Coordinator and when he received an allegation of abuse, he would start an investigation and report it to the state in a timely manner. The Administrator stated he would ask the Social Worker to do safe surveys with the residents, have a skin assessment completed on the resident, follow up with the families and formulate the best outcome he could from the information gathered in the investigation. The Administrator said all types of allegations of abuse should be investigated including mental, physical and sexual abuse. The Administrator stated he was notified by Resident #2's family member on 03/04/2025 that Resident #2 had stated a male had turned her too hard and stated the Administrator stated he did not know the family member and when he asked Resident #2 about it, she did not say anything happened to her. The Administrator stated he told the family member he would start an investigation. The Administrator stated he asked Resident #2's nurse if she was aware of any complaints from Resident #2 and the nurse said no. The Administrator stated no other resident or staff interviews were conducted, no skin assessment was completed, no abuse and neglect training or education was provided and stated he concluded that no facility staff could have harmed her because Resident #2 did not have any male staff providing patient care to her. The Administrator stated Resident #2 had a recent, possible chest x-ray, and stated he concluded it must have been the male x-ray technician. The Administrator stated he did not reach out to the x-ray vendor or the x-ray technician to conduct an interview. The Administrator stated it was important that allegations of abuse and neglect were investigated and reported to ensure there was no abuse and neglect taking place and to keep the resident safe from abuse and neglect. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 03/17/2025 at 1:15 p.m., the Administrator stated he ruled out the other 17 males listed on the facility roster which included members of dietary, therapy, nurses and housekeeping because they did not provide direct care to Resident #2. Record review of Resident #2's x-ray report provided by the Administrator for review, 03/17/2025 at 1:25 p.m. , revealed a cervical spine x ray completed on 02/13/2025. Record review of the facility's, undated, policy titled, Policy/Procedure-Nursing Administration Section: Resident Rights Subject: Abuse Prevention, Under the section titled, Investigation, revealed, all identified events are reported to the Administrator/Designee immediately and will be thoroughly investigated and goes on to say when an incident or allegation of resident abuse or injury of an unknown source is identified, the Administrator/Designee will initiate an investigation. A licensed nurse shall immediately examine the resident upon receiving reports of alleged physical or sexual abuse. The findings of the examination shall be recorded in the resident's medical record. The investigation shall consist of 1. An interview with the person (s) reporting the incident; 2. An interview with the resident (s); 3. interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; 4. A review of the resident's medical record; 5/ an interview with staff members (on all shifts) having contact with the resident (s) during the period of the alleged incident; 6. Interviews with other residents to whom the accused employee provides care or services; 7. An interview with staff members (on all shifts) having contact with the accused employee; and 8. A review of all circumstances surrounding the incident.