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	08/21/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the resident had the right to be free from abuse for 1 of 11 residents (Resident #3) reviewed for abuse. The facility failed to ensure Resident #3 was free from verbal abuse when LVN-H said to the resident Shut up on 04/04/2025. These failures could place residents at risk of feelings of indignity, irritability, and sadness. The noncompliance was identified as PNC (Past Non-Compliance). The noncompliance began on 04/04/2025 and ended on 04/05/2025. The facility had corrected the noncompliance before the survey began. The findings included: Record review of Resident #3's face sheet, dated 08/21/2025, revealed the resident was [AGE] years old female, originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses of encephalopathy (any brain disease that alters brain function), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), schizoaffective disorder (mental condition that is marked by a mix of schizophrenia - affects a person's ability to think and feel and mood disorder), and depression (lowering of a person's mood). Further record review of the resident's face sheet revealed the resident was discharged [DATE] to the resident's home. Record review of Resident #3's admission MDS, dated [DATE], revealed the resident's BIMS was 14 out of 15, which indicated the resident's cognitive was intact and required partial/moderate assistance (helper does less than half the effort) to sit to stand, chair to bed transfer, and toilet transfer. Record review of the facility's Provider Investigation Report, dated 04/11/2025, revealed Resident #3 reported to CNA supervisor that LVN-H said to the resident, Shut up! Let me talk on 04/04/2025. Further record review of the Provider Investigation Report revealed the facility administrator immediately suspended and fired LVN-H, notified this incident to the resident's medical doctor and responsible party, offer psych service to the resident, and completed in-services regarding abuse to all staff on 04/05/2025. Record review of the facility employee profile of LVN-H revealed the facility terminated LVN-H on 04/10/2025. During an interview on 08/20/2025 at 2:06 p.m. with hospital aide-I acknowledged that hospital aide-I saw and heard LVN-H say to Resident #3, Shut up. Let me talk! at the D-hall of the facility on 04/04/2025 around 7:00 a.m. Hospital aide-I said Resident #3 wanted to report this incident to CNA supervisor, so hospital aide-I helped the resident to meet CNA supervisor. During an interview on 08/20/2025 at 2:23 p.m. with CNA supervisor said Resident #3 was crying and said that LVN-H said to the resident, Shut up! Let me talk. CNA supervisor reported it to the administrator immediately. The surveyor tried to call LVN-H on 08/20/2025 at 2:23 p.m., but LVN-H did not answer the phone. The surveyor left voice message and send text message to LVN-H on 08/20/2025 at 2:35 p.m., but the nurse never called back. During an interview on 08/20/2025 at 2:59 p.m. with the administrator stated once the administrator received the incident from CNA supervisor, he immediately removed LVN-H from resident care, suspended LVN-H, started investigation, and then finally fired LVN-H on 04/10/2025. The administrator said the resident received psych services on 04/07/2025, and the resident did not have any emotional distress due to this incident. The administrator notified this incident to Resident #3's medical doctor and responsible party and completed in-services regarding abuse to all staff on 04/05/2025. During interviews from 08/19/2025 to 08/21/2025 with CNA-A, CNA-B, MDS/LVN-C, CNA-D, CNA-E, ADON-F, ADON-G, LVN-H, hospital aide-I, RN-J, medication aide-K, CNA-L, CNA-M, CNA-N, CNA-O, housekeeper-P, housekeeper-Q, CNA-R, CNA-s, CNA-T, CNA-U, CNA supervisor, maintenance, director of rehab, and wound care nurse stated the completed taking in-services regarding abuse on 04/05/2025. During interviews from 08/19/2025 to 08/21/2025 with Resident #1, #2, #4, #5, #6, #7, #8, #9, #10, and #11 stated they did not see any abuse in the facility. Record review of the facility policy, titled Resident Right - Abuse Prevention, undated, the facility had the policy of It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation and if the suspected perpetrator is an employee: remove employee immediately from the care of any resident and suspend employee during the investigation. The noncompliance was identified as PNC (Past Non-Compliance). The noncompliance began on 04/04/2025 and ended on 04/05/2025. The facility had corrected the noncompliance before the survey began.

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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 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's nursing needs that were identified in the comprehensive assessment for 2 of 3 Residents (Resident #1 and Resident #2 reviewed for mechanical lift transfers. MDS Coordinator, LVN C failed to identify that Resident #1 and Resident #2 were transferred via mechanical lift on their Care Plan. This deficient practice could affect any resident and could result in staff not providing the required services during transfers. The findings were: 1.Review of Resident #1's face sheet, dated 8/21/25, revealed she was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (characterized by shortness of breath, cough and sputum production) with (Acute) Exacerbation (sudden worsening) and Morbid (severe) morbid obesity. Review of Resident #1's quarterly MDS, dated [DATE], revealed her BIMS score was 13 of 15 reflective that she was cognitively intact and she dependent on staff for Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). Review of Resident #1's Care Plan, dated 11/25/24, revealed Resident #1 had a self-performance deficit and she required physical assistance with transferring. Further review did not reveal that staff should transfer Resident #1 using a mechanical lift. Observation on 8/20/25 at 3:05 PM revealed CNA A and CNA B transferring Resident #1 from the wheelchair to the bed. 2. Review of Resident #2's face sheet, dated 8/21/25, revealed he was admitted to the facility on [DATE], with diagnoses including Vascular Parkinsonism (is a condition that's directly related to your vascular system and shares similarities to Parkinson's disease (PD). While vascular Parkinsonism isn't the same condition as PD, some of the symptoms are similar, including difficulty with large and small muscle control) and Vascular Dementia (is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain). Review of Resident #2's quarterly MDS, dated [DATE], revealed his BIMS score was 13 of 15 reflective of moderate cognitive impairment and he dependent on staff for all ADL's including rolling left and right while in bed, sitting to lying while in bed and sitting to standing from bed. Further review revealed there had not been any attempts during the assessment period to transfer Resident #1 from Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) because of his medical condition or safety concerns. Review of Resident #2's Care Plan, dated 2/28/25, revealed he required assistance with ADL's r/t to muscle weakness, muscle wasting and lack of coordinator and the only intervention identified was that he would use mobility bars to aide in bed for easy turning and repositioning while in bed. Further review revealed Resident #2 had a self-performance deficit and the only intervention identified was that he was encouraged to participate to the fullest extent possible with every interaction. Observation on 8/21/25 at 10:00 AM revealed CNA D and CNA E transferring Resident #2 from the wheelchair to the bed. Interview on 8/21/25 at 4:30 PM with MDS Coordinator/LVN C revealed Resident #1's and Resident #2's Care Plan did not identify they required 2 person, staff assistance with transfers via mechanical lift. LVN C stated she understood both Resident #1 and Resident #2 were transferred using a mechanical lift. She stated the Resident's Care Plan should identify the care areas, level of care and staff interventions to ensure Residents received the care and services they needed. LVN C stated otherwise it could contribute to staff not providing the level of care the Resident's needed to ensure their safety. Interview on 8/21/25 at 7:30 PM with the DON revealed Resident #1 and Resident #2 required a 2-person, staff assistance with transfers via mechanical lift. She stated the purpose of the Care Plan was to identify a Resident's care areas, needs, level of care and interventions the facility staff would provide while the Residents remained in the facility. The DON stated failure to identify that Resident #1 and Resident #2 required assistance with transfers via mechanical lift could contribute to an improper transfer and result in potential accidents and or injuries. Review of the facility policy Comprehensive Person-Centered Care Planning, revised on 12.2023, read It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure it provided assistive devices to each resident to prevent avoidable accidents for 1 of 2 Residents (Resident #1) who were observed for mechanical lift transfers. CNA A and CNA B failed to use proper technique when transferring Resident #1 from the wheelchair to the bed on 8/20/25. CNA B walked away from Resident #1 while in mid-air, swinging side to side and while CNA A was attempting to position the mechanical lift under Resident #1's bed. CNA A continued to maneuver the mechanical lift on her own without CNA B's assistance as required according to facility policy. This deficient practice could affect residents who were transferred via mechanical lift, result in avoidable accidents and contribute to serious bodily injuries and possible death. The findiings were: Review of Resident #1's face sheet, dated 8/21/25, revealed she was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (characterized by shortness of breath, cough and sputum production) with (Acute) Exacerbation (sudden worsening) and Morbid (severe) morbid obesity. Review of Resident #1's quarterly MDS, dated [DATE], revealed her BIMS score was 13 of 15 reflective that she was cognitively intact and she dependent on staff for Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). Review of Resident #1's Care Plan, dated 11/25/24, revealed Resident #1 had a self-performance deficit and she required physical assistance with transferring. Further review did not reveal that staff should transfer Resident #1 using a mechanical lift. Observation and interview on 8/20/25 at 3:05 PM revealed CNA A stepping back into the hallway as she was pulling a mechanical lift backwards. Upon approaching the doorway observation revealed Resident #1 was in a sling, mid-air, swinging from side to side. Her legs were shaking. CNA B was standing between bed A and bed B. They were positioned horizontally to each other. Interview with CNA B revealed she had to move wheelchair away from the foot of the bed which she did and then moved bed A towards her. CNA B was not guiding Resident #1 while CNA A continued to operate the mechanical lift. Further observation revealed CNA A using her body weight (using force) as she pushed the mechanical lift sideways gliding the back wheels against the grain and across the floor. The legs were widened/in the opened position. CNA A managed to position the legs of the mechanical lift under the center of the bed, She then lowered Resident #1 onto the bed while CNA B guided Resident #1. Interview with CNA A revealed the back wheels were not rolling like they should be. Further interview revealed both CNA A and CNA B stated they should be working together while operating the mechanical lift. CNA B stated she was not assisting while CNA A was maneuvering the mechanical lift. CNA B stated her role was to guide Resident #1 to prevent any body parts from hitting the mechanical lift. She further stated that guiding Resident #1 also helped to stabilize the mechanical lift while Resident #1 was in the air. CNA A and CNA B both stated Resident #1 would have fallen and been injured had the mechanical lift tilted to the side. Both CNA A and CNA B stated it was not safe for one person to operate the mechanical lift and it placed Resident #1 in danger. Observation and interview at 3:30 PM with Resident #1 revealed she was doing fine. She stated she was not scared when on the mechanical lift. She stated her legs were shaking because her blood sugar dropped. She stated it was always two staff that transferred her when using a mechanical lift. Resident #1 stated the CNA A and CNA B were playing and rushing through care. Interview on 8/20/25 at 3:40 PM with CNA A revealed she had worked at the facility since [DATE]. She stated she was transferring Resident #1 from the wheelchair to the bed while struggling to maneuver the mechanical lift because the room was small and there was not enough space. CNA A stated she did not have an excuse and couldn't say anything that would make sense about why she did what she did. CNA A stated the wheels were not rolling and sometimes that would happen when there was hair build up around the wheels. She stated she did not check the wheels prior to using it which she should have. CNA A stated she used force and was pushing the mechanical lift at an angle because of the lack of space as she was attempting to position the legs underneath the bed. CNA A stated if the mechanical lift became unbalanced it could have tilted sideways, Resident #1 would have fallen and she could have been hurt. CNA A stated Resident #1 was a heavy woman, maybe about 300 pounds. She stated there was no way she could have prevented the mechanical lift from tilting over. She stated it was dangerous, she knew better, and stated she had been in-serviced several times on operating a mechanical lift. CNA A stated she would have been responsible for the fall. Interview on 8/20/25 at 4:07 PM with the DON revealed transferring a resident using a mechanical lift required 2 staff. She stated one staff operated the mechanical lift while the second staff

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records in accordance with accepted professional standards and practices for one (Resident #4) out of seven residents reviewed for documentations. The facility failed to document wound care dressing changes on the Treatment Administration Record (TAR) for Resident #4 on 08/15/2025, 08/16/2025, and 08/17/2025. These failures placed residents at risk for missed treatments and care which could result in the wound deterioration, and development of infection.Findings included: Record review of Resident #4's face sheet, dated 08/21/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnoses of surgical after care following surgery, muscle wasting and atrophy (loss of skeletal muscle mass), depression (lowering of a person's mood), old myocardial infarction (blockage of blood flow to the heart muscle), and muscle weakness. Record review of Resident #4's admission MDS assessment, dated 05/05/2025, revealed the resident's BIMS was 11 out of 15, indicated the resident had moderate cognitive impairment and required partial/moderate assistance (helper does less than half the effort) to sit to stand and chair to bed transfer, and supervision or touching assistance (helper provides verbal cues or touching /steadying and /or contact guard assistance as resident completes activity) to toilet transfer. Record review of Resident #4's comprehensive care plan, dated 05/01/2025, revealed [Resident #4] has a stage 3 pressure ulcer to coccyx - buttock area. For interventions - Administered treatment as ordered and monitor for effectiveness. Record review of Resident #4's physician orders, dated 05/01/2025, revealed the resident had the orders of cleans coccyx - buttock area - with normal saline and apply Triad paste and leave open to air, one time a day for wound care. Record review of Resident #4's treatment administration record, from 08/01/2025 to 08/31/2025, revealed there were empty blanks (no nurses' initials) on 08/15/2025, 08/16/2025, and 08/17/2025 for wound care to Resident #4's coccyx - buttock area - once a day. During an interview on 08/21/2025 at 9:00 a.m. with Resident #4 stated he did not have any pain at this time and received wound cares from nurses. During an interview on 08/19/2025 at 3:59 p.m. with RN-J stated she provided wound care to Resident #4 on 08/15/2025, 08/16/2025, and 08/17/2025 as ordered, but she forgot documenting on Resident #4's treatment administration record because she was very busy at those dates. Further interview with the RN-J stated she should have documented on Resident #4's treatment administration record after providing wound care on 08/15/2025, 08/16/2025, and 08/17/2025. It was RN-J's mistake, and the resident might have improper wound care due to lack of documentations. During an interview on 08/19/2025 at 4:00 p.m. with DON stated RN-J should have documented on Resident #4's treatment administration record after she provided wound care to the resident. It was basic nursing responsibility, and if they did not document correctly, it might cause improper wound care to Resident #4 due to lack of communications. Record review of the facility policy, titled Nursing Documentation, date 10/2024, revealed The following items should be noted in the resident chart - medication and/or treatment administration.