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	10/17/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, based on the comprehensive assessment of a resident, residents received treatment and care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 13 residents (Resident #7) reviewed for quality of care. The facility failed to ensure Resident #7 received care and services according to professional standards when Resident #7, who was on blood thinners, fell before noon on [DATE] and received orders for monitoring and neuro checks. The last neuro check was completed at 2:45 a.m. on [DATE]. Resident #7 was last seen at 4:30 a.m. on [DATE]. Resident #7 was found unresponsive at approximately 7:20 a.m., with EMS services activated at 7:28 a.m. on [DATE] and she expired. This failure resulted in the identification of an Immediate Jeopardy (IJ) on [DATE] at 4:14 p.m. The IJ template was provided to the facility on [DATE] at 4:24 p.m. While the IJ was removed on [DATE] the facility remained out of compliance with a scope identified at isolated and a severity level of potential for more than minimal harm because the facility needed to monitor the implementation of the plan of removal. This failure could place residents at risk of not receiving care and services needed to meet their needs and could result in a decline in health and/or death. The findings included: Record review of Resident #7's face sheet dated [DATE] revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (stroke affecting the right side), gout (a type of arthritis affecting one or more joints with sudden attacks of severe pain and swelling), and hypertension (high blood pressure). She expired on [DATE] at 7:40 a.m. and was discharged to a funeral home. Record review of Resident #7's quarterly MDS assessment dated [DATE] revealed a BIMSs score of 13 which indicated she was cognitively intact with no symptoms of delirium or behavior symptoms. Her functional status for toileting was listed as substantial/maximal assistance where the helper did more than half of the effort. Her chair/bed-to-chair transfer assistance was listed as partial/moderate assistance where the helper did less than half of the effort. Record review of Resident #7's care plan initiated on [DATE] revealed she was at risk for falls with interventions to be sure her call light was within reach and encourage her to use it to call for assistance as needed. Record review of Resident #7's care plan initiated on [DATE] revealed she had an ADL self-care performance deficit related to generalized weakness with interventions to include: required one-person minimal assistance with transferring. Record review of Resident #7's care plan initiated on [DATE] revealed she had elected Full code Status with interventions to include: initiate full code measures in case of cardiac arrest, to include CPR and AED use. Record review of Resident #7's Order Summary Report for [DATE] revealed the following orders:-aspirin oral tablet chewable 81 mg-give one tablet by mouth one time a day for heart health. (aspirin - an antiplatelet medication which increased bleeding risk). -Clopidogrel Bisulfate (Plavix- antiplatelet medication used to prevent blood clots to reduce risk for heart attack and stroke and increases bleeding risk) oral tablet 75 mg, give one tablet by mouth one time a day for blood thinner with a start date of [DATE]. -Monitor and report to MD immediately any signs and symptoms of unusual bleeding, pale skin, weakness, black/tarry stools, head injury related to fall/trauma with a start date of [DATE]. Record review of Resident #7's progress notes revealed: -[DATE] 12:36 p.m.-Resident on day 1 of 3 fall follow up. Vitals WNL, no visible injuries noted at this time. Resident in wheelchair, call bell in reach. Documented by LVN C. There were no notes on the actual fall or interventions post fall. -[DATE] at 12:42 pm SBAR Summary to Providers: documented below. No orders documented. No interventions documented. The note indicated Resident #7 was an anticoagulant. Documented by LVN C. -[DATE] at 9:21 p.m. Resident #7 was quietly resting in bed during afternoon, she was not trying to get out of bed without assistance, denies pain/discomfort, pain in low position, call light in reach. Will continue to monitor. Documented by LVN D-[DATE] at 7:20 a.m. Change of Condition: Unresponsiveness. Documented by LVN B and ADON I. Record review of a facility fall incident report for Resident #7 dated [DATE]-25 at 12:00 p.m., documented by LVN C revealed the resident was observed on the floor in the restroom in between commode and sink. Resident #7's description of events included: I thought I heard someone say go ahead and stand up, so I was going to get on commode. I bumped my head on toilet and my arms. I don't have no bumps (sic), but my arms were hurting already. Immediate Action Taken: Resident assessed at this time, no visible injuries noted this shift, no bumps to back of head. Call placed to (physician's office) spoke with (RN at physician's office) at this time who stated to follow protocol. (LVN C) advised resident on aspirin 81 mg and had started a new medication

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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 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. (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 0842 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 interviews and record reviews, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 of 13 residents (Resident #7) reviewed for clinical records. The facility failed to document Resident #7's verbal aggression and room change, time or location of fall, monitoring and neuro check orders from physician, or pain and skin/injury assessment on 10/02/2025. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included:Record review of Resident #7's face sheet dated 10/13/2025 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (stroke affecting the right side), gout (a type of arthritis affecting one or more joints with sudden attacks of severe pain and swelling), and hypertension (high blood pressure). Record review of Resident #7's SBAR Communication Form dated 10/02/2025 and completed by LVN C indicated Resident #7 had a fall. LVN C marked not clinically applicable to the change of condition reported to behavior, evaluation, pain evaluation and neurological evaluation. Notification to the physician office RN was documented at 10/02/2025 at 12:00 p.m. with check marks in other with note na (not applicable) x 2. No physician orders or feedback were documented. The time of the fall or location of the fall was not documented and there were no interventions documented on this form. Record review of Resident #7's UDA revealed an incomplete pain assessment had been started by LVN C on 10/02/2025 but the actual assessment was not documented, and the assessment was blank. There were no UDA [SH3] for skin observation or assessments documented in the EMR. Record review of Resident #7's progress notes revealed there was no documentation of the fall expect the SBAR Communication. There were no orders documented, no physician feedback, no interventions and the time and location of the fall was not documented. Record review of Resident #7's Order Summary Report for October 2025 revealed there were no orders for neuro checks or monitoring post fall on 10/02/2025. Record review of Resident #7's EMR including progress notes, assessments, and orders there was no documentation of LVN D's recollection of events of verbal aggression directed toward a roommate and subsequent room change on 10/02/2025. During an interview on 10/13/2025 at 11:08 a.m., LVN C stated a CNA (unknown) told her Resident #7 fell so she went to assess the resident in the bathroom. She stated she did not see any bruises or injuries. She stated she did not see any knots on the head or any bruising. LVN C stated she notified the physician's office of the fall. She stated she reported to the RN at the physician's office Resident #7 had no knots on the head or bruising and that she hit her head, right in the back. She stated she completed the pain assessment and the resident was not having significant pain. She completed the skin and injury assessment and did not see any injuries. She stated she did assess for injuries and for pain. She stated the resident was not having any significant pain. LVN C stated the RN at the physician office told her to follow the facility protocol which included neuro checks. She stated she was not aware of any other interventions other than monitoring and did not have a copy of the protocol. LVN C stated she marked the SBAR in error as not clinically insignificant for the assessments in error and marked the orders as na and other because it referenced the facility policy. She stated she did not enter orders because it was a facility protocol. During an interview on 10/13/2025 at 12:37 p.m., LVN D stated she worked the evening shift from 2 pm-10 pm on 10/02/2025. LVN D stated at approximately 8:30 p.m. Resident #7 had gotten into an argument with her roommate. She stated Resident #7 was being aggressive verbally with her roommate and would not calm down, so she moved her to a different room across the hall. She stated it was verbal aggression and nothing physical had occurred. She stated both roommates were lying in bed, but Resident #7 just wouldn't stop. She wanted to fight with her roommate. LVN D stated they tried getting her to stop, she tried to close the curtain, but she declined to go to sleep and kept pulling the curtain over. LVN D stated she asked the roommate not to engage, but it continued so she decided to make the room change. LVN D stated after the room change Resident #7 was calm. She stated she did not document the verbal aggression and did not document the room change because as soon as the resident was moved to a new room, she was calm. She stated she also did not think about documenting it because it was just two roommates arguing. She stated she should have documented it in the medical record. During an interview on 10/14/2025 at 3:34 p.m., the DON stated she reviewed the SBAR documentation by LVN C. She stated every fall triggered a separate UDA [SH4] that should have