

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Northeast Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect or exploitation were reported no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury to the State Survey Agency for 2 of 4 residents (Residents #1 and #2), reviewed for freedom from abuse, neglect, and exploitation. The facility failed to report to the State Survey Agency (HHSC) an incident that occurred on 12/27/25-12/28/2025 in which Resident #1 received a package delivery intended for Resident #2 that contained multiple baggies of a crystal-like substance suspected to be narcotics. This failure could place residents at risk for neglect and could lead to a diminished quality of life and physical harm. The findings were: Record review of Resident #1's face sheet dated 1/16/2026 revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: legal blindness as defined in USA, type 2 diabetes mellitus and schizophrenia. Record review of Resident #1's Care Plan dated 4/30/2023 revealed he had impaired visual function/blindness with intervention including: assist with ADLs as needed. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 10 which indicated a moderate cognitive impairment. The assessment indicated the resident required moderate assistance with toileting and bathing and was independent of most other ADLs. He was listed as non-ambulatory with the ability to stand unassisted. Record review of Resident #2's face sheet dated 1/16/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: unspecified fracture of shaft of right tibia subsequent encounter for closed fracture with routine healing, major depressive disorder recurrent and edema. Record review of Resident #2's Care Plan dated 10/03/2025 revealed she had a self-care performance deficit which included intervention of monitor for changes in care or declines in function. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated she was cognitively intact. Her functional status was listed as independent with exception of lower body involvement which was listed as moderate. She was non ambulatory. Record review of a facility document, titled Investigative Report dated 12/28/2025 revealed on 12/28/2025 LVNA reported Resident #1 inquired about picking up a delivered package and RN A assisted Resident #1 in retrieving the package. The report stated upon opening the package, it was discovered that the contents appeared to be drugs. Immediately following the discovery, law enforcement was notified and took possession of the suspected drugs. Record review of a local police department Incident report dated 12/27/2025-12/28/2025 revealed police were dispatched to the facility for a narcotics call. A nurse found 4 grams of a crystal-like substance which was confiscated for destruction. It was explained that at some point (visitor) came to the facility and acted as the family member to Resident #2 in order to drop off a package. Resident #1 retrieved the package and attempted to take it to Resident #2 when a staff member intervened and inspected the package to find the substance hidden inside the packaging and called authorities (police). When</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455754	Facility ID: 455754 If continuation sheet Page 1 of 3

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1 and #2 were spoken to, they plead their innocence to the incident claiming they did not know drugs were entering the facility. No further actions were conducted. During an interview on 1/15/2026 at 2:09 p.m. Resident #2 stated on an unknown date she wanted to buy a cross for a friend who was leaving the facility. Resident #2 said she was sick, so she sent Resident #1, who is blind, to go get it but the nurse, RN A thought the package looked suspicious and intercepted the package. Resident #2 stated Resident #1 was blind and could not see. Resident #2 stated they ordered the package from a man who was the friend of another resident (unknown name) that no longer lived at the facility and had not lived there for a while. She stated the friend sent her an unsolicited text message asking if she wanted to buy a homemade cross his mother made. She stated he delivered the package with the cross. She stated it was a beautiful cross, in a nice decorative box. Resident #2 stated the next thing she knew the police were at the facility grilling them. Resident #2 stated she was upset and realized she could have gotten in trouble or been arrested. She stated she blocked the visitor from her phone and had no further contact. She stated she had never been in trouble a day in her life and had never done drugs. Resident #2 stated the man did not charge her for the cross. He said it was a donation for homeless people. She stated she provided the police with his contact information and as much information as she could. She stated the next day, a Monday the Administrator came to her room to talk to her about what happened. She denied using drugs and denied knowing anyone at the facility using drugs. During an observation and interview on 1/15/2026 at 2:28 p.m., Resident #1 was observed maneuvering his wheelchair around objects in his room. He stated he was blind but was able to see light and dark and the edges of shadows only. He denied using drugs or having any knowledge about anyone at the facility using drugs. He stated the cross incident was a misunderstanding. Resident #1 stated it started with a man's (visitor's) who was giving away her homemade crosses to homeless people[SP1]. He stated he paid \$10 dollars for the cross, and the lady was supposed to bring the cross to him. Instead, she sent her family member. Resident #1 stated he asked RN A to help him get the delivery since he was blind. He stated he wanted to make sure he got the cross in the package. Resident #1 stated RN A saw something suspicious with the package, took it and saw drugs. He stated he did not know what type of drugs they were. Resident #1 stated he thought the man delivered the wrong package. He stated the cops came to visit. He stated he told the cops it was a mistake, that he just wanted a cross. He stated he doesn't do stuff like that (drugs) and never did. He stated he believed it was all a misunderstanding. During an interview on 1/15/2026 at 2:51 p.m., RN A stated he was the weekend supervisor on an unknown date in December. He stated around 9-10 p.m., Resident #1 was waiting for a package. He stated Resident #1 asked him to assist with the front door. RN A stated a man said he had a gift for Resident #2. RN A stated the man gave the gift to Resident #1, who in turn gave the man a bag of chips. RN A stated Resident #1 asked him to check the package for the cross. RN A stated he checked the package and saw the cross. He stated under the cross there were approximately 3 dime sized baggies of a white powdery unknown substance. RN A stated he asked Resident #1 about it. He said Resident #1 said he had no idea what it was, that it was supposed to be just a cross. RN A stated he confiscated it and notified the DON and Administrator and told them he was calling the cops. He said both the DON and Administrator gave him the green light. RN A stated he wore gloves when handling the baggies and put them in the DONs office and then waited for the cops. He stated his shift was over before the cops came, so he reported off to RN B. He stated he did believe Resident #1 did not know anything about the drugs. He stated he did not interview or talk to Resident #2. He stated neither resident had any known behaviors. RN A declined knowing any resident or staff member who was using drugs at the facility. Attempted interview on 1/15/2026 at 2:59 pm with RN B.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No return call received prior to exit. During an interview on 1/16/2026 at 9:30 p.m., the DON stated she was called during the middle of the night about the incident with the cross on an unknown date. She stated it was reported by RN A that a person never seen before at the facility had delivered a package with a rosary or a cross with a little baggie. She stated she told him to notify the police. She stated she was unsure if it was ever positively identified as drugs. She stated the front door to the facility was kept locked and only opened by staff. She stated all packages by an unknown source were to be opened in the presence of the resident, that come into the facility. She stated the only exception to that was a package that comes from a reliable source, such as from the USPS, or other delivery service. She stated the staff responded exactly how they were supposed to. She stated the package was reported as being very suspicious looking. The DON stated Resident #1 had requested help from staff to open the package. The DON stated neither Residents #1 nor #2 had a history of leaving the facility on pass and neither resident was on her radar for drug use. The DON stated both residents refused a drug test. She stated they did monitor their cognition and neither showed any alterations. She stated the Administrator completed the investigation for this event. During an interview on 1/16/2026 at 12:29 p.m., the Administrator stated he was notified the night the incident happened by RN A (unknown date). He stated RN A told him he went to pick up a package for Resident #1, opened it and saw a substance. The Administrator stated RN A did not know what the substance was but called the police. The Administrator stated he made sure no residents got any drugs, that they were secured and they were handed over to police. He stated he had not received any updates from the police department about the substance. The Administrator stated he conducted an internal investigation. He stated both residents' stories collaborated the others and his conclusion was there was a mix up with the package which was intended for someone else. He stated he did not have any evidence to the contrary and there was no signs of drug use from either resident. The Administrator stated he did not report the incident to HHSC. He stated he did not report because the facility uses the provider letter for reporting. He stated there was nothing in the provider letter to indicate he needed to report. He stated neither resident ever had any contact with the drugs and there was not a concern for the residents health or safety. Record review of the facility's Abuse Prevention policy, undated, revealed: Reporting/Response: Alleged violations will be reported via phone or email to the State Licensing Agency.</p>		