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	03/19/2026

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 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 included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, for 1 of 2 residents (Resident #1) reviewed for a care plan. The facility failed to develop and implement a care plan for Resident #1's physician prescribed right knee immobilizer. This failure could place residents at risk of not having care instructions for orthopedic appliances. The findings include:A record review of Resident #1's admission record dated 3/18/2026, revealed an admission date of 2/2/2026 with a diagnosis of aftercare for orthopedic encounter. A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was an [AGE] year-old female admitted for long term care with ADL supports with a fragile right knee capable of dislocation and supported with an immobilizer. Resident #1 was assessed with a BIMS score of 13 out of a possible of 15 which indicated no cognitive impairment. A record review of Resident #1's physician's orders dated 2/18/2026 revealed the physician prescribed for Resident #1 to have a right knee immobilizer to restrict movement for Resident #1's right knee. A record review of Resident #1's care plan dated 3/18/2026 revealed no focus, no goals, and no interventions for Resident #1's right knee immobilizer. A record review of Resident #1's nursing progress notes revealed LVN A documented on 2/2/2026 at 1:09 PM that Resident #1 had a right knee immobilizer, .Resident has an immobilizer to right knee. No concerns at this time. During an observation and interview on 3/18/2026 at 10:10 AM revealed Resident #1 was in her room in bed watching television. Resident #1 stated she had a bad right knee which gave out on her and she fell in her home sometime in the fall of 2025. Resident #1 stated she had been admitted to the nursing home to help her regain ability to stand however her right knee began to swell and the physician transferred her to the hospital where an orthopedic surgeon had reset her knee and gave her a knee brace so her knee would not dislocate. Resident #1 stated the staff would sometimes give her a bed bath and other times would wrap her right knee in plastic and move her to a shower bed for bathing. Resident #1 stated no staff had removed her brace to check her skin, no staff had removed her brace, no staff had washed her brace. Resident #1 stated she did not believe the staff knew how to care for her brace and thus was reluctant to allow them to remove or check the brace. Resident #1 stated she had become concerned for the brace and her skin and swelling because the brace began to develop a foul smell. Resident #1 stated on 3/10/2026 her Representative brought a knee brace from her home and replaced the dirty smelly brace with the brace from home which she currently wore . During an interview on 3/18/2026 At 5:14 PM CNA B stated she was the CNA for Resident #1 and recalled Resident #1 had a right knee immobilizer. CNA B stated she had no instructions on her CNA care plan which could guide CNAs on how to provide ADL for Resident #1's brace. CNA B stated she used common sense and did not remove Resident #1's brace and if she would bathe Resident #1 she would wrap the brace so as not to get it wet. During an interview on 3/19/2026 at 10:09 AM with Dr. C and Dr. C's Assistant, Medical Assistant D, Dr. C (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

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 03/19/2026
NAME OF PROVIDER OR SUPPLIER: Northeast Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 603 Corinne St San Antonio, TX 78218	

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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	stated regarding Resident #1's knee immobilizer, he expected for the immobilizer to be removed periodically for skin breakdown prevention; However during those times the knee should not have weight on the joint and be kept flat extended during hygiene care. Dr C stated the periodic removal of the brace for hygiene and skin assessments could help prevent skin breakdown. Dr C. stated no one from the facility had called to ask for order clarifications. During an interview on 3/19/2026 at 10:55 AM Physician's Assistant E who works under Dr. F stated that her expectation would be when a resident is admitted with an orthotic device such as a knee immobilizer that there should be a report to the physician to request an order for the knee immobilizer and the daily care on how to apply the knee brace and when and how to remove the knee immobilizer. PA E stated the potential negative outcome for failing to have orders and instructions for daily care could be skin breakdown and possible dislocation of the knee joint. PA E stated Resident #1 was non-weight bearing indefinitely and was to have the knee brace on indefinitely but with opportunities to remove the knee brace and assess her skin for possible breakdown, as well as for staff to provide daily hygiene skin care for areas around the knee brace immobilizer. During an interview on 3/18/2026 at 5:25 PM the DON stated LVN A had admitted Resident #1 on 2/2/2026 and had a progress note which stated Resident #1 had right knee immobilizer. The DON stated she reviewed Resident #1's records and recognized Resident #1 had no orders or care plan interventions for the knee immobilizer. The DON stated she expected the ADON to have reviewed the right knee immobilizer order and to have called the physician and requested care instruction orders for the right knee immobilizer. The DON stated she expected the ADON to update Resident #1's care plan. The DON was asked if there was any potential negative outcome for not having an order or a care plan for Resident #1's right knee immobilizer and the DON replied, the brace was being monitored. A record review of the facility's undated Care Plan policy revealed, It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person centered care plan for each resident that includes measurable objectives and time frames to meet a residents' medical, nursing, mental, and psychosocial, needs that are identified in the comprehensive assessment. The interdisciplinary team will also develop and implement a baseline care plan for each resident within 48 hours of admission that includes minimum health care information necessary to properly care for each resident and instructions needed to provide effective and person-centered care the meat professional standards of quality care.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers for 1 of 2 residents (Resident #1) reviewed for monitoring of applied knee immobilizers. The facility failed to develop and implement supports and monitoring systems for Resident #1's need for a right knee immobilizer, and the resident developed skin breakdown underneath the knee immobilizer. This failure could place residents at risk for injuries from unmonitored orthotic devices. The findings include:A record review of Resident #1's admission record dated 3/18/2026, revealed an admission date of 2/2/2026 with a diagnosis of aftercare for orthopedic encounter. A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was an [AGE] year-old female admitted for long term care with ADL supports with a fragile right knee capable of dislocation and supported with an immobilizer. Resident #1 was assessed with a BIMS score of 13 out of a possible of 15 which indicated no cognitive impairment. Resident #1 was assessed with her pressure ulcer located on her right heel and no other skin breakdown. A record review of Resident #1's physician's orders dated 2/18/2026 through 3/19/2026 revealed no orders for Resident #1's right knee immobilizer specifying any care instructions for the knee immobilizer, no orders for monitoring the knee immobilizer for appropriate fit, no orders for monitoring the skin under and around the knee immobilizer. A single order was given on 2/18/2026, 16 days after Resident #1 was admitted with the knee immobilizer, which called for a right knee immobilizer applied to restrict movement for Resident #1's right knee. No orders were revealed for the new skin breakdown assessment on 3/5/2026. A record review of Resident #1's March 2026 medication administration records revealed no evidence for any monitoring of Resident #1's right knee immobilizer; no evidence of wound care to the newly identified wounds on 3/5/3036 until 3/14/2026. A record review of Resident #1's care plan dated 3/18/2026 revealed no focus, no goals, and no interventions for Resident #1's right knee immobilizer. A record review of Resident #1's nursing progress notes revealed LVN A documented on 2/2/2026 at 1:09 PM that Resident #1 had a right knee immobilizer, .Resident has an immobilizer to right knee. No concerns at this time. A record review of Resident #1's weekly skin assessments revealed LVN G had assessed Resident #1 on:- 2/12/2026 as not having a brace when Resident had a right knee brace and no assessment of her skin under the immobilizer and had a right heel pressure ulcer.- 2/19/2026 as not having a brace when Resident had a right knee brace and no assessment of her skin under the immobilizer and had a right heel pressure ulcer.- 2/26/2026 as not having a brace when Resident had a right knee brace and no assessment of her skin under the immobilizer and had a right heel pressure ulcer. A record review of Resident #1's skin assessments revealed on 3/5/2026 LVN G assessed Resident #1 with 2 new skin breakdown areas on her right thigh one measuring 5cm x 2 cm and the other measured 6cm x 2 cm and LVN G described them as Excoriation sic[the act of abrading, scratching, or wearing off the skin, resulting in raw, irritated, or damaged] from neoprene of brace rubbing at edge of brace. During an observation and interview on 3/18/2026 at 10:10 AM revealed Resident #1 was in her room in bed watching television. Resident #1 stated she had a bad right knee which gave out on her and she fell in her home sometime in the fall of 2025. Resident #1 stated she had been admitted to the nursing home to help her regain ability to stand however her right knee began to swell and the physician transferred her to the hospital where an orthopedic surgeon had reset her knee and gave her a knee brace so her knee would not dislocate. Resident #1 stated the staff would sometimes give her a bed bath and other times would wrap her right knee in plastic and move her to a shower bed for bathing. Resident #1 stated no staff had removed her brace to check her skin, no staff had removed her brace, no staff had washed her brace. Resident #1 stated she did not believe the staff knew how to care for her brace and thus was reluctant to allow them to remove or check the brace. Resident #1 stated she had (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 0686 Level of Harm - Actual harm Residents Affected - Few	become concerned for the brace and her skin and swelling because the brace began to develop a foul smell. Resident #1 stated on 3/10/2026 her Representative brought a knee brace from her home and replaced the dirty smelly brace with the brace from home which wore currently. Resident #1 stated she had developed some wounds to her right thigh under the brace which she could not see but knew because she was receiving wound care from the nurse and doctor. An observation of any possible wounds under Resident #1's knee immobilizer was not made at the time of the interview. During an interview on 3/18/2026 At 5:14 PM CNA B stated she was the CNA for Resident #1 and recalled Resident #1 had a right knee immobilizer. CNA B stated she had no instructions on her CNA care plan which could guide CNAs on how to provide ADL for Resident #1's brace. CNA B stated she used common sense and did not remove Resident #1's brace and if she would bathe Resident #1 she would wrap the brace so as not to get it wet. During an interview on 3/19/2026 at 10:09 AM with Dr. C and Dr. C's Assistant, Medical Assistant D. Dr. C stated regarding Resident #1's knee immobilizer, he expected for the immobilizer to be removed periodically for monitoring skin breakdown prevention; However, during those times the knee should not have weight on the joint and be kept flat extended during hygiene care. Dr C stated the periodic removal of the brace for hygiene and skin assessments could help prevent skin breakdown. Dr C. stated no one from the facility had called to ask for order clarifications. During an interview on 3/19/2026 at 10:55 AM Physician's Assistant E who works under Dr. F stated that her expectation would be when a resident is admitted with an orthotic device such as a knee immobilizer that there should be a report to the physician to request an order for the knee immobilizer and the daily care on how to apply the knee brace and when and how to remove the knee immobilizer. PA E stated the potential negative outcome for failing to have orders and instructions for daily care could be skin breakdown and possible dislocation of the knee joint. PA E stated Resident #1 was non-weight bearing indefinitely and was to have the knee brace on indefinitely but with opportunities to remove the knee brace and assess her skin for possible breakdown, as well as for staff to provide daily hygiene skin care for areas around the knee brace immobilizer. During an Interview on 3/19/2026 at 1:03 PM NP H stated she assessed Resident #1 on 3/9/2026 by removing the right knee immobilizer and assessed Resident #1 with stable skin breakdown on her right thigh most likely from the edges of the right knee immobilizer. NP H stated she had also seen a 2cm circular area of a potentially resolved deep tissue injury underneath the thigh and would follow for resolution. NP H stated she believed the injury was in the process of healing. NP H stated she was concerned for the brace being ill fitted and possibly being applied too tightly and resident could benefit from a larger brace. NP H stated when she assessed Resident #1 again on 3/16/2026 she had on a clean better fitting brace which she learned was supplied and applied by Resident #1's Representative. During an interview on 3/19/2026 at 1:50 PM treatment nurse LVN G stated he began as a treatment nurse on or about 2/2/2026, and when he first assessed Resident #1 he recognized that she was wearing a right-knee brace. LVN G stated he had reviewed Resident #1 weekly for skin assessments and had not removed Resident #1's knee brace because she would not let him, and on 3/5/2026 he had become concerned for the skin underneath the brace and he gained consent from Resident #1 to gently peel back the brace from the edges and that was when he could see the skin breakdown from the edges of the brace and he described the 2 areas as Excoriation from the brace. LVN G stated the brace had developed a smell and Resident #1 continued to not let him remove the entire brace. LVN G stated he documented the findings and reviewed the findings with the IDT team the next day. LVN G stated the plan was for wound care NP H to assess Resident #1 the following Monday 3/9/2026. LVN G stated NP H rounded weekly on Mondays. During a joint interview on 3/19/2026 at 5:25 PM with the Administrator and the DON, the DON stated LVN A had admitted Resident #1 on 2/2/2026 and had a progress note which stated Resident #1 had right knee immobilizer. The DON stated she reviewed Resident #1's records and recognized Resident #1 had no orders or care plan interventions for the knee immobilizer. The DON stated she expected the ADON to have reviewed the right knee immobilizer order and to have called the physician and requested care (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	instruction orders for the right knee immobilizer. The DON stated she expected the ADON to update Resident #1's care plan. The DON was asked if there was any potential negative outcome for not having an order or a care plan for Resident #1's right knee immobilizer and the DON replied, the brace was being monitored. A policy for caring and or monitoring orthotic devices was requested and not provided. The Administrator stated the facility followed HHSC guidelines.

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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 observation, interview, and record review, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 of 2 residents (Resident #1) reviewed for accurate records. Resident #1's medical records contained skin assessments which documented Resident #1 had no knee immobilizer. This failure could place residents at risk for inaccurate medical records. The findings include:A record review of Resident #1's admission record dated 3/18/2026, revealed an admission date of 2/2/2026 with a diagnosis of aftercare for orthopedic encounter. A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was an [AGE] year-old female admitted for long term care with ADL supports with a fragile right knee capable of dislocation and supported with an immobilizer. Resident #1 was assessed with a BIMS score of 13 out of a possible of 15 which indicated no cognitive impairment. A record review of Resident #1's physician's orders dated 2/18/2026 revealed the physician prescribed for Resident #1 to have a right knee immobilizer to restrict movement for Resident #1's right knee. A record review of Resident #1's nursing progress notes revealed LVN A documented on 2/2/2026 at 1:09 PM that Resident #1 had a right knee immobilizer, .Resident has an immobilizer to right knee. No concerns at this time. A record review of Resident #1's weekly skin assessments revealed LVN G had assessed Resident #1 on:2/12/2026 as not having a brace when Resident had a right knee brace.2/19/2026 as not having a brace when Resident had a right knee brace.2/26/2026 as not having a brace when Resident had a right knee brace. During an observation and interview on 3/18/2026 at 10:10 AM revealed Resident #1 was in her room in bed watching television. Resident #1 stated she had a bad right knee which gave out on her and she fell in her home sometime in the fall of 2025. Resident #1 stated she had been admitted to the nursing home to help her regain ability to stand however her right knee began to swell and the physician transferred her to the hospital where an orthopedic surgeon had reset her knee and gave her a knee brace so her knee would not dislocate. During an interview on 3/18/2026 At 5:14 PM CNA B stated she was the CNA for Resident #1 and recalled resident #1 had a right knee immobilizer. During an interview on 3/19/2026 at 1:50 PM treatment nurse LVN G stated as a treatment nurse on or about 2/2/2026, and when he first assessed Resident #1 he recognized that she was wearing a right-knee brace. LVN G stated he had reviewed Resident #1 weekly for skin assessments and was unaware that he had documented on some of those assessments that Resident #1 had no brace. LVN G stated the error was an oversight and could potentially have a negative outcome of an inaccurate record. During an interview with the DON on 3/18/2026 at 5:25 PM the DON stated the expectation was for all staff to have accurate documentation. A record review of the facility's undated Medical Records policy revealed, It is the policy of this facility to ensure every resident has an accurate record.