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	06/10/2026

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 - Some	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 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 time frames to meet residents' medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 13 residents (Residents #1, #2, and #3) reviewed for care plans. 1. The facility failed to develop a care plan to address Resident #1 had wandering behaviors.2. The facility failed to develop a care plan to address Resident #2 had a diagnosis of other stimulant abuse.3. The facility failed to develop a care plan to address Resident #3 had a diagnosis of alcohol dependence. These failures could place residents at risk of not having their needs met and not receiving appropriate care.The findings include: 1. Record review of Resident #1's face sheet, dated 06/09/2026, reflected an [AGE] year-old male who was initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses to include dementia (decline in cognitive functions [memory, reasoning, and thinking]) which interferes with daily life) and cognitive communication deficit. Record review of Resident #1's admission MDS assessment, dated 04/28/2026, reflected Resident #1 had a BIMS score of 12 out of 15, indicating moderate cognitive impairment. It further revealed the resident did not exhibit wandering behavior. Record review of Resident #1's care plan, undated, did not reflect Resident #1's wandering behavior. Record review of Resident #1's electronic medical record reflected Resident #1's Elopement Evaluation, dated 04/21/2026, reflected he was not a risk for wandering. Record review of the facility's self-report Investigative Worksheet, dated 05/24/2026, reflected Resident #1 entered another resident's room without permission. No negative effects occurred. During an interview on 06/09/2026 at 02:55 PM, CNA B revealed Resident #1 would go into other residents' rooms while looking for his friend in the facility. She revealed it should be on his Kardex (system that is populated by a resident's care plan for reference for resident care for CNAs) for staff to know how to care for our residents. It was important to keep him from going into other residents' rooms to protect him and other residents. During an interview on 06/10/2026 at 09:13 AM, RN F revealed Resident #1 wandered into other residents' rooms and had to redirect him many times. She revealed if a resident was not expecting Resident #1, there was no reason for him to wander into other residents' rooms. She further revealed Resident #1's wandering behaviors should be on his care plan. It would be important to be on his care plan because it was a part of his character and he did it all the time and everyone needed to know to redirect him so nothing inappropriate could happen or something upsetting could happen like a male wandering into a female's room. RN F could not recall when he started wandering but at least for the month of May, he wandered a lot. During an interview on 06/10/2026 at 10:38 AM, RN E revealed Resident #1 was not his resident but he knew Resident #1 wandered around the facility looking for his friend and this should be care planned because it was not appropriate for him to wander into residents' rooms. He could not recall when his wandering behavior started. During an (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455754	A. Building B. Wing	06/10/2026

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 - Some	interview on 06/10/26 at 01:19 PM, the DON revealed Resident #1 forgot where his room was located sometimes and may be in someone else's room in a different hallway. She revealed she had to investigate if this was Resident #1's behavior. She further revealed if he wandered it should be care planned because it was a safety concern. During an interview on 06/10/2026 at 01:56 PM, Resident #1 revealed he got confused frequently and had poor memory. He revealed he walked around the facility, into different hallways, looking for another resident (his friend) because he sometimes forgot where his friend's room was located and where his room was located. 2. Record review of Resident #2's face sheet, dated 06/09/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had a diagnosis to include other stimulant abuse (the harmful recreational use of substances that speed up the central nervous system). Record review of Resident #2's admission MDS assessment, dated 05/07/2026, reflected Resident #2 had a BIMS score of 08 out of 15, indicating moderate cognitive impairment. Record review of Resident #2's care plan, undated, did not reflect Resident #2's diagnosis of alcohol dependence. 3. Record review of Resident #3's face sheet, dated 06/09/2026, reflected an [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #3 had a diagnosis to include alcohol dependence Record review of Resident #3's quarterly MDS assessment, dated 03/26/2026, reflected Resident #3 had a BIMS score of 13 out of 15, indicating intact cognition. Record review of Resident #3's care plan, undated, did not reflect Resident #3's diagnosis of alcohol dependence. During an interview on 06/09/2026 at 01:30 PM, CNA A revealed she took care of Resident #3 and it would be helpful to know if her residents had a history of substance use so she could be prepared when caring for her residents. During an interview on 06/09/2026 at 03:11 PM, CNA C revealed Resident #3 was one of her residents and it would be important to know if he had a history of substance use to be proactive in his resident care. She revealed Resident #1 wandered into people's rooms and staff knew to be firm with him in redirecting him. She revealed it would be important to put this in his Kardex for new nursing staff to know how to provide resident care for Resident #1. She could not recall how long he had been wandering in the facility. During an interview on 06/10/2026 at 12:40 PM, Restorative Aide D revealed it was important to know Resident #2's and Resident #3's history of substance use like Resident #2's stimulant abuse diagnosis so the nursing staff were all aware to prevent anything negative happening to these residents. She revealed Resident #1's care plan should include that he wandered because this was his behavior and staff knew to redirect him from other residents' rooms and his memory was getting worse. She was not aware of how long he had been wandering. During an interview on 06/10/2026 at 02:03 PM, the Operations Manager revealed on 05/24/2026 Resident #1 was in another resident's room and that resident did not want him in there. She revealed there were no injuries during this incident . She revealed the nursing staff knew to redirect Resident #1 when he was not walking to his room. She further revealed she was not sure if it was in the care plan, but she had not personally seen him go into another resident's room, so she did not know if it needed to be in his care plan. During an interview on 06/10/26 at 02:38 PM, MDS nurse G revealed a history of stimulant abuse for Resident #2 was not care planned because it was historical information and not a current issue and it was not something the facility had to address. She confirmed Resident #3 had a diagnosis of alcohol dependence. She revealed if they were hospitalized for dependency recently, then staff would care plan the diagnosis because the facility would monitor them, however, if they had been clean for years, then the facility would not have to document it. MDS nurse G reviewed Resident #1's electronic medical record and revealed he was not a wander risk per his 04/21/26 elopement assessment. She revealed the standard was to look at the elopement assessment and document the care plan accordingly. She revealed if a resident was wandering then this would be a safety issue and staff would update the care plan. During an interview on 06/10/2026 at 02:53 PM, the DON revealed Resident #3 did not need to have alcohol dependency care planned because it was not active and the facility did not serve alcohol. During an interview on 06/10/2026 at 02:59 PM, MDS nurse H revealed IDT care planned residents' diagnoses upon entry. She revealed when she started (continued on next page)

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	06/10/2026

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 - Some	working at the facility, Resident #3 was already a resident and had his care plan done. She revealed Resident #3 did not have a current issue with drinking and alcohol dependency did not need to be on his care plan. She revealed the facility documented it if it was an active diagnosis or if there were behaviors related to those certain diagnoses. MDS nurse H revealed the incident in the self-report should have been brought up with the IDT meeting and the care plan would have been updated to reflect Resident #1 was a wanderer. During an interview on 06/10/26 at 04:15 PM, the DON revealed she would not put Resident #2's and Resident #3's history of substance use on their care plans because it was not being treated. She further revealed if it was appropriate to care plan these diagnoses it would be to prevent substance use. Record review of the facility's policy Elopement/Unsafe wandering, revised 4/.2025, reflected Wandering is the random or repetitive locomotion and can be either goal directed or non-goal directed. 2. Residents with high risk factors will be identified as At Risk and will have an individualized care plan developed that includes measurable objectives and timeframes. A. Care plan interventions will consider the elements of the evaluation or behavior observations that identified the resident at risk. Record review of the facility's policy Behavioral Health Services, revised 4/.2025, reflected .Behavioral health encompasses a resident's whole emotional and mental well-being, which includes the prevention and treatment of mental and substance use disorders.Substance use disorder (SUD) is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment.For residents with a history of previous or current SUD, attempts will be made to identify use details. May consider use of behavioral contract as part of the care process. Record review of the facility's policy Comprehensive Person-Centered Care Planning, revised 4/.2025, reflected .12. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.