

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 05/20/2026
NAME OF PROVIDER OR SUPPLIER Northeast Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 603 Corinne Drive 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one (1) of one (1) kitchen (Kitchen 1) reviewed for food safety requirements. 1. Food service staff failed to ensure an unidentified nursing staff member wore hair restraints while in the kitchen during meal preparation on 05/17/2026. 2. Food service staff failed to ensure personal foods and beverages were not kept in the kitchen refrigerator and freezer on 05/19/2026. 3. Food service staff failed to ensure a facility contracted chemical supplier representative wore hair restraints while in the kitchen during meal preparation on 05/20/2026. These failures could place residents at risk for the spread of infections, food contaminations, food-borne illnesses, and diminished quality of life. The findings included: 1. During an observation on 05/17/2026 at 12:23 p.m., an unidentified nursing staff member was observed to walk into the facility kitchen through the dining room to kitchen door and walked through the kitchen to obtain a wrapped silverware set from a dietary staff member. The unidentified nursing staff member was not wearing a hair restraint. The dietary staff were in the middle of lunch service with uncovered cooked foods on the service line. The closest dietary staff member gave the wrapped silverware to the nursing staff member and directed the nursing staff member out of the kitchen. The Dietary Supervisor was then observed to block entry into the kitchen from the dining room door and dietary staff were observed to directly address any requests following the observation from the doorway. 2. During observation and interview on 05/19/2026 at 03:05 p.m., a Styrofoam clamshell container was observed in Refrigerator #2. It had a name and was dated 05/19/2026. It did not have an expiration or use-by date. One (1) single-serving plastic beverage and one (1) Styrofoam beverage cup with lid were observed in the reach-in freezer. Neither beverage was labeled with an open or production date, with a use-by date, or with an owner's identifier. The Dietary Supervisor stated the Styrofoam clamshell container was hers. She identified it as leftovers from lunch. She was then observed to remove the clamshell container and the two beverage containers and told the two other dietary staff present that they could not store their drinks in the reach-in and handed each dietary staff member their beverages. During an interview on 05/19/2026 at 03:22 p.m., the Dietary Supervisor confirmed that she observed the unidentified nursing staff member walk into the kitchen during lunch service on 05/17/2026. She stated she believed the CNAs and nurses received education on the requirement for hairnets but did not provide their education. She stated that when that type of situation occurs, the dietary staff were to re-educate the person that they are not supposed to enter the kitchen. She stated the impact of a person coming into the kitchen without a hair restraint was that with the food, hair could get into the food. 3. During an observation on 05/20/2026 at 11:32 a.m., a facility contracted chemical supplier representative was observed to walk into the facility kitchen through the dining room to kitchen door and walked through the kitchen to ask staff for direction to (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the three-compartment sink. He was not wearing a hair restraint. The dietary staff were completing meal service preparation with uncovered foods cooking and cooked on the stove tops and on the service line. [NAME] A was observed to redirect him out of the kitchen, to the hall to kitchen door, and observed to educate him on his requirement to put on a hair restraint. During interview on 05/20/2026 at 11:38 a.m., the Dietary Supervisor stated the hair nets were only available on the hall to kitchen door and not on the door from the dining room. She stated dietary staff would usually close the door to the dining room. She stated the chemical supplier was new, from a new contract, and did not know that he was supposed to come into the kitchen from the hall door. She stated staff were not supposed to put their personal food items in either the freezer or refrigerator because the food in the kitchen refrigerators and freezer was only for residents' food. She stated dietary staff were to store their food items in the employee breakroom refrigerator and store their beverages on her desk. She stated the risk of staff storing their food in the kitchen refrigerator or freezer was that it might cause confusion for other dietary staff, thinking the food item was for a resident and serve a food to a resident that did not match their diet order. She stated employee food might also not be dated or labeled appropriately. During an interview on 05/20/2026 at 12:40 p.m., the DON stated her expectation for nursing staff was for them to go to the kitchen door if they needed to ask for something, but not to go grab something on their own. She stated she expected nursing staff to wear a hair net if entering the kitchen. She stated nursing staff attended huddles, received in-services, and reminders from dietary staff to educate and re-educate them on wearing hair restraints in the kitchen. She stated the impact of a staff member entering the kitchen without a hair restraint was that hair could be found in the food. She stated it was an infection control concern. She stated employee food found in the kitchen refrigerator and freezer could result in cross-contamination. During an interview on 05/20/2026 at 02:46 p.m., the Operations Manager stated facility staff received in-service training to educate them on the importance of wearing hair nets. She stated facility contractors were educated when they are coming in to the facility. She stated the storage of employee food items in the kitchen refrigerator or freezer and persons entering the kitchen without hair restraints was an infection control concern. She stated the entry into the kitchen could result in transferring contamination through not hand washing and hair could be unsanitary. She stated it was everyone's responsibility to ensure they follow kitchen sanitation requirements. Record review of the facility's policy, Section: Departmental, Subject: Dietary Services, dated as revised 05/2007, revealed: Policy: It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. Procedures: .4. Personal Hygiene A. Proper attire for food handlers should include a hair covering (hair nets or caps). Record review of the FDA Food Code 2022, https://www.fda.gov/food/retail-food-protection/fda-food-code, accessed 05/21/2026 revealed: 2-402 Hair restraints 2-402.11 Effectiveness. (A) Except as provided, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. On-premises preparation Prepare and hold cold 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified., refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Commercially processed food Open and hold cold (B) Except as specified., (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for one (1) of two (2) residents (Resident #78) reviewed for clinical records.^^ ^ The facility failed to ensure Resident #78's wound care treatments were accurately documented on her Treatment Administration Records for 14 of 222 scheduled wound care treatments from 12/22/2025 to 05/18/2026.^ 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 #78's Face Sheet, dated 05/18/2026, reflected a [AGE] year-old female. She was initially admitted to the facility on [DATE] and re-admitted on [DATE]. Record review of Resident #78's Medical Diagnosis, undated and accessed 05/18/2026 at 03:16 p.m., revealed a diagnoses of type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel) with diabetic peripheral angiopathy (narrowing of the peripheral arteries due to diabetes that lowers blood supply), atherosclerosis (the gradual buildup of fat and other substances in the arteries, leading to narrowed arteries and reduced blood flow) of native arteries of extremities (arms and legs) with rest pain, right leg, chronic venous hypertension (a condition where high pressure in the leg veins disrupts normal blood flow) [idiopathic (a condition that arises spontaneously or without an identifiable cause)] with ulcer (a lesion or sore on the skin) of left lower extremity, and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #78's Modification of Quarterly MDS, dated [DATE], revealed Resident #78 had a BIMS score of 15, which indicated she was cognitively intact. She had range of motion impairment on both sides of her upper extremities and one side of her lower extremities. She required supervision or touching assistance with rolling left and right in bed, transitioning from sitting to standing, transferring from chair/bed-to chair, and walking 10 feet. She was documented as at risk for developing pressure ulcers/injuries, did not have a pressure ulcer/injury, and had diabetic foot ulcer(s) and surgical wound(s). She received application of dressings to feet (with or without topical medications). Record review of Resident #78's Order Summary Report, dated 05/18/2026, revealed two (2) active wound care orders as of 05/18/2026. Wound care orders noted included:- DFU right 3rd toe-cleanse area with NS/WC, pat dry with gauze, apply Iodosorb [a gel used to clean and promote healing of wet ulcers and wounds] and cover with dry dressing MWF every day shift every Mon, Wed, Fri, noted as active, order date 04/25/2026, start date 04/27/2026, and no end date.- Surgical incision left foot-cleanse with NS/WC, pat dry with gauze, apply skin prep to area and LOTA every day shift every Mon, Wed, Fri, noted as active, order date 04/25/2026, start date 04/27/2026, and no end date. Record review of Resident #78's Treatment Administration Records, dates reviewed 12/01/2025- 05/18/2026, revealed the following: - Treatment Administration Record, dated 12/01/2025- 12/31/2025, revealed one (1) wound or skin care order with two (2) blanks out of five (5) scheduled treatments. 1) The order, cleanse wound to right 2nd digit with n/s and pat dry paint with betadine [an ointment that kills bacteria, prevents infection, and aides in healing] and cover with dressing one time a day every Mon, Wed, Friday for wound care, was dated 12/22/2025 at 07:48 a.m. and discontinued on 03/16/2026 at 05:49 p.m. The Treatment Administration Record had blanks for two (2) of the five (5) scheduled treatments, 12/24/2025 and 12/26/2025. - Treatment Administration Record, dated 01/01/2026- 01/31/2026, revealed three (3) wound or skin care orders with two (2) (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blanks out of twenty-four (24) scheduled treatments. 1) An order, APPLY BETADINE TO right TOE. LOTA every day shift, dated 01/26/2026 at 08:47 a.m. and discontinued on 04/13/2026 at 04:17 p.m. The Treatment Administration Record had a blank for one (1) of five (5) scheduled treatments, 01/29/2026. 2) An order, APPLY BETADINE TO RLE TOE. COVER WITH GAUZE AND KERLIX [a medical grade cotton gauze used to pull moisture from the wound] DAILY. every day shift, dated 01/20/2026 at 01:53 p.m. and discontinued on 01/26/2026 at 08:47 a.m. The Treatment Administration Record had a blank for one (1) of six (6) scheduled treatments, 01/29/2026.- Treatment Administration Record, dated 02/01/2026- 02/28/2026, revealed two (2) wound or skin care orders with six (6) blanks out of forty (40) scheduled treatments. 1) An order, APPLY BETADINE TO right TOE. LOTA every day shift, dated 01/26/2026 at 08:47 a.m. and discontinued on 04/13/2026 at 04:17 p.m. The Treatment Administration Record had blanks for four (4) of twenty-eight (28) scheduled treatments, 02/04/2026, 02/05/2026, 02/20/2026, and 02/26/2026. 2) An order, cleanse wound to right 2nd digit with n/s and pat dry paint with betadine and cover with dressing one time a day every Mon, Wed, Friday for wound care, dated 12/22/2025 at 07:48 a.m. and discontinued 03/16/2026 at 05:49 p.m. The Treatment Administration Record had blanks for two (2) of twelve (12) scheduled treatments, 02/04/2026 and 02/20/2026. - Treatment Administration Record, dated 03/01/2026- 03/31/2026, revealed four (4) wound or skin care orders with four (4) blanks out of fifty-nine (59) scheduled treatments. 1) An order, APPLY BETADINE TO right TOE. LOTA every day shift, dated 01/26/2026 at 08:47 a.m. and discontinued on 04/13/2026 at 04:17 p.m. The Treatment Administration Record had blanks for two (2) of thirty-one (31) scheduled treatments, 03/06/2026 and 03/24/2026. 2) An order, cleanse wound to right 2nd digit with n/s and pat dry paint with betadine and cover with dressing one time a day every Mon, Wed, Friday for wound care, dated 12/22/2025 at 07:48 a.m. and discontinued 03/16/2026 at 05:49 p.m. The Treatment Administration Record had a blank for one (1) of seven (7) scheduled treatments, 03/06/2026. 3) An order, cleanse wound to right 3rd digit DFU with n/s then pat dry paint with betadine. Leave open to air. QD one time a day for wound care, dated 03/16/2026 at 05:49 p.m. and discontinued on 04/13/2026 at 04:19 p.m. The Treatment Administration Record had a blank for one (1) of fifteen (15) scheduled treatments, 03/24/2026. During an interview on 05/17/2026 at 10:33 a.m., Resident #78 stated she had a wound and on one or two occasions staff failed to come to provide the scheduled treatment. She stated the facility has since corrected the issue with a new wound care nurse and she has not experienced any missed treatments in the last month. She stated she expected to be discharged soon but did not want any other residents to have to experience a missed wound care treatment. She stated because she had very sensitive skin and had toes amputated in the past, at the time of the missed treatment she worried about the possibility of having to go through an amputation again. She stated she had no current complaints about her wound care. During an interview on 05/20/2026 at 10:02 a.m., RN D identified herself as the wound care nurse. RN D stated she started in the wound care role in early March 2026 but had been working in the facility since July 2024. She stated Resident #78 had chronic wounds. She stated, when she was first oriented to Resident #78 wound care needs, Resident #78 was noted to have a history of reoccurring pressure ulcers to the foot and had a few amputated toes. She stated the wound care treatments scheduled from December 2025 to early March 2026 would have been completed by ADON C, or another nurse if he was not available. She stated she was told at the time of her change in roles by ADON C that some treatments were not signed off because the nurse had put in the incorrect order. She stated she could not state if the treatments ordered were provided or not during that time. She stated for the blank on 03/24/2026, the order was discontinued on the same day, which was possibly why she did not sign off on the treatment order. She stated she (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was sure that Resident #78 received wound care on 03/24/2026 while at her doctor's office. She stated she recalled ADON C worked on 03/06/2026, as that was his last day, but could not say if the treatment was missed or not documented as administered. She stated it was expected that staff complete orders on time and the administration of the orders are documented timely. She stated Resident #78 had not reported any missing treatment complaints to her. She stated Resident #78 was diabetic and more susceptible for infections due to having poor circulation which could lead to additional amputations. RN D stated missed treatment documentation could affect staff because staff could not state if a treatment was missed or not documented. During an interview on 05/20/2026 at 12:40 p.m., the DON stated she expected staff to sign off on a treatment right after they provide it. She stated during December 2025- March 2026 she had two (2) separate wound care nurses and she was sure Resident #78 was receiving her scheduled wound care because Resident #78 did not have a decline. She stated Resident #78 did not experience a deterioration in her wound. She stated Resident #78's wounds were recurring and because her skin was frail, the staff were careful with her. She stated the staff ran omissions reports to identify any missed treatments administrations and they had identified issues with both prior wound care nurses. She stated following counseling with both wound care nurses; one nurse voluntarily left and the other was dismissed due to poor documentation. She stated the facility changed wound care staffing due to the identified concern. The DON stated she had not received any complaints from Resident #78 or Resident #78's family regarding her wound care since the change in wound care staffing and the wound care nurse practitioner has since said that there have been improvements in Resident #78's wound and wound documentation. The DON stated she expected treatment documentation to be completed in the Treatment Administration Record and that the Treatment Administration Record was the required documentation to show a treatment was provided. She stated the impact of the Treatment Administration Record having a blank was that it could be questioned whether the order was completed or not. During an interview on 05/20/2026 at 02:56 p.m., the Operations Manager stated a blank in the Treatment Administration Record could indicate the treatment was not administered correctly or not administered. She stated the impact of a blank in the Treatment Administration Record was that if staff were not documenting then how could anyone know if the order was administered. Record review of unnamed and undated document, received from Operations Manager on 05/17/2026, revealed a staff listing of eighty-four (84) Nursing staff. ADON C was not listed. Record review of the facility's policy, Section: Documentation, Subject: Charting and Documentation, dated as revised 05/2007 revealed: Policy: The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Is also necessary to include data needed for identification and communication with family and friends. Complete history of resident and present illness is required under current law and regulations at the time of admission. Rules for charting. 5. Continuous nurse's notes are required on all residents as the necessary arises.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 11 (Medication Aide G, CNA H, CNA I, CNA J, CNA K, Dietary Supervisor, Activity Director, Operations Manager, ADON L, RN D, CNA M) of 28 employees reviewed for training requirements. The facility failed to implement and maintain a training program that ensured Medication Aide G, CNA H, CNA I, Dietary Supervisor, ADON L, and Operations Manager received required training within 21 days of hire, per facility's training policy. The facility failed to implement and maintain a training program that ensured CNA J, CNA K, Activity Director, and RN D received required training annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings include: Record review of personnel record for Medication Aide G revealed hire date of 04/08/2026. Review of the training log provided by human resources revealed no evidence that Medication Aide G completed their initial training of HIV, restraint reduction, prevention of falls, or emergency preparedness within 21 days of hire. Record review of personnel record for CNA H revealed hire date of 04/15/2026. Review of the training log provided by human resources revealed no evidence that the CNA H completed their initial training of HIV, restraint reduction, prevention of falls, or emergency preparedness within 21 days of hire. Record review of personnel record for CNA I revealed hire date of 04/08/2026. Review of the training log provided by human resources revealed no evidence that the CNA I completed their initial training of HIV, restraint reduction, prevention of falls, or emergency preparedness within 21 days of hire. Record review of personnel record for Dietary Supervisor revealed hire date of 09/05/2025. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Dietary Supervisor completed their initial training of behavioral health or restraint reduction within 21 days of hire. Record review of personnel record for Operations Manager revealed hire date of 04/24/2026. Review of the training log provided by human resources revealed no evidence that the Operations Manager completed their initial training of effective communications, resident rights, QAPI program, infection control, behavioral health, HIV, restraint reduction, prevention of falls, or emergency preparedness within 21 days of hire. Record review of personnel record for ADON L revealed hire date of 02/18/2026. Review of the training log for the previous 12 months provided by human resources revealed no evidence that ADON L completed behavioral health or restraint reduction training within 21 days of hire. Record review of personnel record for CNA J revealed hire date of 02/21/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the CNA J completed effective communications, QAPI program, ethics, HIV, restraint reduction, prevention of falls, or emergency preparedness training annually. Record review of personnel record for CNA K revealed hire date of 03/10/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the CNA K completed effective communications or emergency preparedness training annually. Record review of personnel record for Activity Director revealed hire date of 11/04/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Activity Director completed effective communications, abuse prevention, infection control, behavioral health, prevention of falls, or emergency preparedness training annually. Record review of personnel record for RN D revealed hire date of 07/25/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the RN D completed dementia management or ethics training annually. Record review of personnel record for CNA M revealed hire date of (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and follow a policy to provide pharmacy services in accordance with State and Federal laws or rules of the Drug Enforcement Administration for 1 of 6 Residents (Resident #118) reviewed for pharmacy services. The facility failed to ensure LVN F documented that she provided the Medication Aide a Dronabinol capsule (a controlled medication prescribed for protein malnutrition and appetite stimulation) on the Controlled Substance Administration Record for May 2026 for Resident #118. This deficient practice could put residents at risk of misappropriation and drug diversion. The findings included: Record review of Resident #118's face sheet dated 5/19/26 reflected a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included cerebral infarction (a type of stroke that occurs when blood flow to part of the brain is blocked causing brain tissue to die due to lack of oxygen), sepsis (a life-threatening condition that happens when the body has an extreme and harmful response to an infection), and aphasia (a condition that affects a person's ability to communicate, such as from a stroke). Record review of Resident #118's care plan with revision date 5/15/26 reflected the resident had a nutritional problem or potential nutritional problem related to risk for malnutrition with interventions that included to administer medications as ordered and was prescribed Dronabinol. Record review of Resident #118's Order Summary Report dated 5/19/26 reflected the following:- Dronabinol oral capsule, 5 mg, give 1 capsule by mouth two times a day for protein malnourishment, and to stimulate appetite with order date 5/13/26 and no end date. Record review of Resident #118's Medication Administration Record dated May 2026 reflected the resident was scheduled to receive Dronabinol 5 mg at 7:00 a.m., and 3:00 p.m. Resident #118's Medication Administration Record reflected the resident was administered the 7:00 a.m. morning dose of Dronabinol medication on 5/19/26 by the Medication Aide and the evening dose scheduled for 3:00 p.m. was pending. Record review of the Controlled Substance Administration Record for Resident #118's Dronabinol 5 mg capsules with received date 5/16/26 reflected there were 21 capsules left in the medication package and 7 out of 28 doses had been dispensed. During an interview and inspection of the Medication Aide cart for half of C unit and all of D and E unit on 5/19/26 at 3:06 p.m. with the Medication Aide revealed a loose Dronabinol capsule found in a medication cup on the top left drawer. The Medication Aide stated the Dronabinol capsule was a controlled medication and had to be refrigerated and locked in a box in the refrigerator in the medication room. The Medication Aide stated she did not have access to the key to the lock box. The Medication Aide stated LVN E signed out the Dronabinol in the Controlled Substance Administration Record and then gave her the capsule around 40 minutes ago because LVN E believed he would be busy at the time when the Medication Aide needed the capsule for Resident #118. The Medication Aide stated that since the medication was supposed to be refrigerated, she should not have left it in the medication cart. The Medication Aide stated she had administered the morning dose to Resident #118 and was planning on administering the second dose but the State Surveyor walked up on her. During record review and interview with LVN E and the Medication Aide on 5/19/26 at 3:24 p.m., LVN E stated the Medication Aide did not have access to the key to the lock box in the refrigerator in the medication room and stated he provided the Medication Aide with Resident #118's Dronabinol capsule. LVN E stated the Dronabinol capsule was a controlled medication and required refrigeration. LVN E stated that the Medication Aide (continued on next page)		

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 05/20/2026
NAME OF PROVIDER OR SUPPLIER Northeast Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 603 Corinne Drive San Antonio, TX 78218	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should not have loose pills in the medication cart, and when the medications are taken out of the package they should be administered immediately. LVN E stated he signed out Resident #118's Dronabinol capsule on the Controlled Substance Administration Record. Record review of the Controlled Substance Administration Record for Resident #118's Dronabinol reflected there were 21 capsules on the record, but 20 capsules were observed in the blister pack. LVN E stated the Dronabinol medication count was off. The Medication Aide stated LVN F provided her with the Dronabinol morning dose and LVN E provided her with the afternoon dose. LVN E stated there needed to be a system in place to keep track of controlled medications locked in the refrigerator because the Controlled Substance Administration Record could be overlooked since it was not kept with the medication. During an interview on 5/19/26 at 3:46 p.m., the DON stated the Dronabinol medication was a controlled medication that was supposed to be locked and refrigerated. The DON stated, at the time the medication is due and pulled from the package, the Controlled Substance Administration Record should be filled in and the count should match. The DON stated, the Dronabinol is a narcotic, and has to be accounted for, which in this case the count was off. If the count is off, that is a drug diversion, and I would have to report to the State. During an interview on 5/19/26 at 4:40 p.m., LVN F stated only the nurses had access to the lock box in the refrigerator in the medication room. LVN F stated she provided the Medication Aide with the morning dose of Resident #118's Dronabinol medication, a controlled medication, and admitted she had forgotten to sign out the medication in the Controlled Substance Administration Record. LVN F stated, it got busy and she forgot to go back and sign the record. LVN F stated that after a medication is taken from the package it should be documented in the record otherwise there could be potential for drug diversion. LVN F stated, if a drug diversion should occur it would mean either the medication was given to the wrong resident or the resident never received the medication. Record review of the facility document titled Pharmacy Services; Administration and Documentation of Controlled Medications, undated, reflected in part, .It is the policy of this facility to Administer and document-controlled medications in compliance with State and Pharmacy regulations. When a controlled substance is poured for administration, the administering staff will. Document on the narcotic count down sheet provided for each individual substance, the date, time, and signature of the staff member pouring and administering medication. Staff member will correctly indicate the amount poured. and will enter the correct number of remaining medications. Staff will count all narcotics at the beginning and end of each shift and will sign the master list attesting to accuracy of the count. Any and all discrepancies will be reported immediately to the Director of Nursing or Administrator.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored properly in the cart for 1 of 6 medication carts (Medication Aide cart for half of C unit and all of D and E unit) reviewed for storage: The facility failed to ensure Resident #118's Dronabinol capsule (a controlled medication prescribed for protein malnutrition and appetite stimulation) was stored appropriately in the medication cart. This failure could place residents at risk of not receiving prescribed medications as ordered and drug diversions. The findings included: Record review of Resident #118's face sheet dated 5/19/26 reflected a [AGE] year old male admitted to the facility on [DATE] with diagnoses that included cerebral infarction (a type of stroke that occurs when blood flow to part of the brain is blocked causing brain tissue to die due to lack of oxygen), sepsis (a life-threatening condition that happens when the body has an extreme and harmful response to an infection), and aphasia (a condition that affects a person's ability to communicate, such as from a stroke). Record review of Resident #118's care plan with revision date 5/15/26 reflected the resident had a nutritional problem or potential nutritional problem related to risk for malnutrition with interventions that included to administer medications as ordered and was prescribed Dronabinol. Record review of Resident #118's Order Summary Report dated 5/19/26 reflected the following:- Dronabinol oral capsule, 5 mg, give 1 capsule by mouth two times a day for protein malnourishment, and to stimulate appetite with order date 5/13/26 and no end date. Record review of Resident #118's Medication Administration Record dated May 2026 reflected the resident was scheduled to receive Dronabinol 5 mg at 7:00 a.m., and 3:00 p.m. Resident #118's Medication Administration Record reflected the resident was administered the 7:00 a.m. morning dose of Dronabinol medication on 5/19/26 by the Medication Aide and the evening dose scheduled for 3:00 p.m. was pending. Record review of the Controlled Substance Administration Record for Resident #118's Dronabinol 5 mg capsules with received date 5/16/26 reflected there were 21 capsules left in the medication package and 7 out of 28 doses had been dispensed. During an interview and inspection of the Medication Aide cart for half of C unit and all of D and E unit on 5/19/26 at 3:06 p.m. with the Medication Aide revealed a loose Dronabinol capsule found in a medication cup on the top left drawer. The Medication Aide stated the Dronabinol capsule was a controlled medication and had to be refrigerated and locked in a box in the refrigerator in the medication room. The Medication Aide stated she did not have access to the key to the lock box. The Medication Aide stated LVN E signed out the Dronabinol in the Controlled Substance Administration Record and then gave her the capsule around 40 minutes ago because LVN E believed he would be busy at the time when the Medication Aide needed the capsule for Resident #118. The Medication Aide stated that since the medication was supposed to be refrigerated, she should not have left it in the medication cart. The Medication Aide stated she had administered the morning dose to Resident #118 and was planning on administering the second dose but the State Surveyor walked up on her. During an interview on 5/19/26 at 3:24 p.m., LVN E stated the Medication Aide did not have access to the lock box in the refrigerator in the medication room and stated he provided the Medication Aide with Resident #118's Dronabinol capsule. LVN E stated the Dronabinol capsule was a controlled medication and required refrigeration. LVN E stated that the Medication Aide should not have loose pills in the medication cart, and when the medications are taken out of the package they should be administered immediately otherwise it could (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause a drug diversion.During an interview on 5/19/26 at 3:46 p.m., the DON stated there should not be any loose pills in the medication cart because it puts patients at risk for error or missed dosage. The DON stated, at the time the medication is due and pulled from the package it should be administered to the residents.Record review of the facility document titled Medication Access and Storage, undated reflected in part, .It is the policy of this facility to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 6 residents (Resident #116 and #10) reviewed for infection control: The facility failed to ensure RN N wore proper PPE while providing indwelling urinary catheter care to Resident #116 who was on EBP status and failed to use appropriate hand hygiene when moving from a clean area to a dirty area when administering medications to Resident #10. These failures could place residents at risk for cross-contamination and infection and could result in illness due to improper care practices. The findings included: 1. Record review of Resident #116's face sheet dated 5/19/26 reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included urinary tract infection and sepsis (a serious medical condition that happens when the body's response to infection causes widespread inflammation and organ dysfunction). Record review of Resident #116's Order Summary Report dated 5/18/26 reflected the following:- Enhanced Barrier Precautions: PPE required for high resident contact care activities. Indication: Implanted IV access, Foley (urinary catheter) every shift with order date 5/17/26 and no end date. Record review of Resident #116's care plan with revision date 5/17/26 reflected the resident had an indwelling urinary catheter related to neurogenic bladder (condition in which the bladder does not function normally because of problems with the nerves that control urination) with interventions that included monitoring indwelling catheter output every shift and use Enhanced Barrier Precautions. During an observation on 5/18/26 at 1:59 p.m., RN N completed administering Resident #116's intravenous medication, removed his gown and gloves, and then returned to the resident's bedside to empty the resident's indwelling urinary catheter bag. Resident #116 had signage on the doorway which indicated the resident was on EBP status. RN N did not put on a gown when he emptied the resident's indwelling urinary catheter bag filled with urine. RN N made two trips to the resident's bathroom after he emptied the indwelling urinary catheter bag into a bedside urinal. During an interview on 5/18/26 at 2:03 p.m., RN N stated he was supposed to put on a gown when emptying Resident #116's indwelling urinary catheter bag because it protected the resident and RN N from passing an organism that could cause an infection. RN N stated, disposable gowns were kept in the middle of the unit in a linen cart. RN N stated the CNA staff usually checked and emptied the resident's indwelling urinary catheter bag but decided to empty the bag and forgot to put on a gown. 2. Record review of Resident #10's face sheet dated 5/19/26 reflected a 61- year-old male admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included pneumonia (an infection of the lungs that causes inflammation and fluid or pus buildup in the air sacs of the lungs), dysphagia/oropharyngeal phase (difficulty swallowing; the stages where food or liquid moves from the mouth through the throat toward the esophagus), severe intellectual disabilities, and gastrostomy status (a medical procedure in which an opening is created through the abdomen directly into the stomach usually to provide nutrition, fluids, or medications; feeding tube). Record review of Resident #10's most recent comprehensive MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills, had a swallowing disorder, and had a feeding tube. Record review of Resident #10's Order Summary Report dated 5/19/26 reflected the following:- Enteral Feed Order every shift may crush/combine medications for administration if not contraindicated and mix with 4 ounces of water, may use slow push to facilitate consumption with order date 4/2/26 and no end date. Record review of Resident 10's comprehensive care plan with (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revision date 1/22/25 reflected the resident required a feeding tube related to dysphagia with interventions that included to use Enhanced Barrier Precautions and mix each medication with water then administer via gastrostomy tube. Observation during the medication pass on 5/19/26 at 8:55 a.m. revealed RN N prepared medications for Resident #10 and placed a pair of gloves on a tray with the resident's medications. RN N put on a disposable gown, put on a disposable glove on his left hand, and with his left hand closed Resident #10's bedroom door to provide privacy. RN N then put on a disposable glove to his right hand. RN N, while he continued to use the same disposable gloves, took the resident's bed remote and placed it on the bed, took an empty cup from the tray and moved to the resident's bathroom and turned on the faucet to fill the empty cup with water. RN N, while in Resident #10's bathroom, pulled on the doorknob to the adjoining room to close the door. RN N then returned to Resident #10's bedside and drew the privacy curtain to provide privacy. RN N then turned off the resident's feeding pump, took a large syringe from the plastic sleeve, and pulled back the resident's hospital gown to expose the gastrostomy tube. RN N checked for residual and then administered Resident #10's medications through the gastrostomy tube. During an interview on 5/19/26 at 9:10 a.m., RN N stated, touching Resident #10's personal items with the disposable gloves was considered cross contamination. RN N stated he was unsure about being able to pull up the sleeves on the disposable gown since there was no sanitizer readily available in the room. RN N stated he should have been able to wash his hands before and after glove changes to prevent cross contamination which could result in the resident getting an infection. During an interview on 5/19/26 at 10:41 a.m., the DON stated, not performing hand hygiene or changing gloves after touching multiple personal items in a resident's room was a potential for cross contamination and considered an infection control issue. The DON stated it was her expectation that the staff should be changing their gloves multiple times during a skill, especially after touching resident items such as curtains, doorknobs and a bed remote. The DON stated, the same applied for residents who were on EBP status, which meant following EBP rules and the use of proper PPE. Record review of the facility document titled Infection Control with revision date 4/2025 reflected in part, .It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. Transmission-Based Precautions are the second tier of basic infection control and used in addition to Standard Precautions for patients who are or may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Procedure. Standard Precautions are infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. They are based on the principle that all blood, body fluids, secretions, and excretions (except sweat) may contain transmissible infectious agents. Standard Precautions include. Proper selection and use of PPE, such as gowns, gloves, facemasks, respirators, and eye protection. Use and type of PPE is based on the predicted staff interaction with residents and the potential for exposure. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Enhanced Barrier Protection (EBP) used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident activities. Indwelling medical devices include, but are not limited to. urinary catheters. Record review of the facility document titled Hand Hygiene, with revision date 4/2025 reflected in part, .It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene, which is one of the most effective measures to prevent the spread of infection. Wash hands with soap and water for the following situations. Before and after direct contact with residents. Before moving from a contaminated body site to a clean body site during resident care; after contact with a resident's intact skin. After contact with objects in the immediate vicinity of the resident.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop policies and procedures to ensure the resident's medical record included documentation that indicated, at minimum that the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization and influenza immunizations and that the resident either received the pneumococcal immunization and influenza immunizations or did not receive the pneumococcal immunization and influenza immunization due to medical contraindication or refusal for 1 of 10 residents (Resident #10) reviewed for immunizations. The facility failed to ensure Resident #10 had record of receiving education or being offered the pneumococcal vaccine and influenza (flu) vaccine. This failure could cause residents to be vulnerable to preventable diseases and illness. The findings were: Record review of Resident #10's face sheet dated 5/20/2026 revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses which included: severe intellectual disabilities, anxiety disorder and epilepsy unspecified, not intractable with status epilepticus (seizure disorder). Record review of Resident #10's annual MDS assessment dated [DATE] revealed a BIMS score of 00 which indicated a severe cognitive impairment and/or responses that could not be understood. The assessment indicated inattention and disorganized thinking behaviors that were continuously present without rejection of care behaviors. Resident #10's functional status was documented as total dependence on staff for all care and movement. Record review of Resident #10's Care Plan dated 11/01/2023 revealed the resident was PASRR positive with interventions which included: notify physician and responsible party of any changes. A plan of care for impaired cognitive function/dementia or impaired thought processes dated 10/24/2023 with interventions that included: needs supervision/assistance with all decision making. Record review of Resident #10's Flu Vaccine Consent dated 4/18/2024 revealed Resident #10's RP consented to the vaccination in writing. Record review of Resident #10's Pneumovax Vaccine Consent dated 4/18/2024 revealed Resident #10's RP consented to the pneumovax vaccine in writing. Record review of Resident #10's Flu vaccine Consent dated 8/07/2024 revealed Resident #10's RP consented to the vaccine by phone consent witnessed by two staff members. Record review of Resident #10's Pneumococcal Consent dated 8/07/2024 revealed Resident #10's RP consented to the vaccine by phone consent witnessed by two staff members. Record review of Resident #10's Pneumococcal Vaccine Consent dated 3/02/2026 Resident #10's RP consented to the vaccine by phone consent witnessed by two staff members including RN N. Record review of Resident #10's Influenza Vaccine Consent dated 3/02/2026 revealed Resident #10's RP consented to the vaccine by phone consent witnessed by two staff members including RN N. Record review of Resident #10's Immunization Record in PCC revealed: Influenza vaccine refused by Resident #10 on 12/26/2025. Education provided was marked no. There was no evidence the flu vaccine had been offered in 2024 after consents were signed. No evidence that the pneumococcal vaccination was offered or why it was not administered since consents signed in 2024. Record review of Resident #1's Progress Notes dated 12/25/2025-12/27/2025 when the immunization record was marked as refused by resident, revealed no notes on attempts at vaccination for influenza or communication with the RP and/or Physician for direction. During an interview on 5/20/2026 at 11:25 a.m., RN N stated Resident #10's RP had consented to both flu and pneumococcal vaccines in March 2026. RN N stated he was the charge nurse who obtained the consents. He stated the charge nurses obtain consents but do not administer the vaccinations. He stated nursing management was responsible for ensuring vaccinations were administered. RN N stated Resident #10 had behaviors (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that were difficult including constantly moving with procedures and refusing cooperation. During an interview on 5/20/2026 at 11:40 am the DON stated the Charge Nurses were responsible for giving vaccinations once the consent was obtained. She stated that applied during flu vaccination season that occurred from October to March of every year. She stated she was not sure of Resident #10's age, but she believed he was under the age threshold of 65 for the pneumococcal vaccine. She stated vaccines were important to protect the residents from illness. During an interview on 5/20/2026 at 11:59 am the Infection Preventionist stated she used to be a facility ADON until February 2026. She stated the Charge Nurses obtain consent but either the Charge Nurses or ADONs administered the vaccinations. She stated the flu vaccine was seasonal during flu season. She stated the pneumococcal vaccine was offered to everyone who enters the facility as a resident regardless of age. She stated residents younger than 65 can also benefit if they are susceptible to respiratory infection. She stated she approached Resident #10 three times on 12/26/2025 when she intended to give the flu vaccine. She stated the resident refused and moved his arms around constantly. She stated she was at greater risk for getting an injection injury by continuing to attempt to administer the vaccine. The Infection Preventionist stated Resident #10 refused most touch. She stated she did not reapproach on any other day; she did not notify the RP or MD of his refusal or for coordination of care and marked the vaccine record as resident refused. She stated she was responsible for tracking vaccinations and doing audits but was new to the position of Infection Preventionist. She stated it was important to vaccinate in order to prevent the spread of diseases and illness. https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html as viewed on 5/20/2025 revealed pneumococcal vaccine was appropriate for people aged 50 years and up and those with compromised immunologic conditions. Record review of the facility policy titled Pneumococcal Immunization Monitoring and Management-Guideline Policy dated 11/23/2016 revealed: 1. All residents who have no medical contraindication to the pneumococcal vaccine will be offered the pneumococcal vaccine upon admission. Record review of the facility policy titled Immunizations-Residents last revised 4/2025 revealed: 1. Residents will be screened at the time of admission to determine vaccine status and eligibility, using current CDC/ACIP Guidelines, to receive the influenza, pneumococcal, and/or COVID-19 vaccine(s). During an interview on 5/20/2026 at 1:26 pm the DON stated the facility did not have a policy for resident refusals.		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility failed to provide mandatory effective communications training for 4 (CNA J, CNA K, Activity Director, Operations Manager) of 28 employees reviewed for training, in that: The facility failed to ensure effective communication training was provided to Operations Manager within 21 days of hire, per facility's training policy. The facility failed to ensure effective communication training was provided to CNA J, CNA K or Activity Director annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. Findings include: Record review of personnel record for Operations Manager revealed hire date of 04/24/2026. Review of the training log provided by human resources revealed no evidence that the Operations Manager completed their initial training of effective communications within 21 days of hire. Record review of personnel record for CNA J revealed hire date of 02/21/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the CNA J completed effective communications training annually. Record review of personnel record for CNA K revealed hire date of 03/10/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the CNA K completed effective communications training annually. Record review of personnel record for Activity Director revealed hire date of 11/04/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Activity Director completed effective communications training annually. Interview with HR O on 05/20/2026 at 2:15 PM revealed newly hired employees were to complete their new hire training within 21 days of hire. HR O stated new employees signed an agreement at orientation that stated they would complete their training and that it was the employee's responsibility to complete training timely. When asked, HR O did not state how staff not completing their training could affect the residents. A group interview with HR P, DON and Operations Manager on 05/20/2026 at 4:51 PM revealed new employees signed a training agreement in orientation agreeing that they would complete training within 21 days of hire. HR P stated, per facility policy, employees were to complete their training within 21 days of hire or they could be suspended or terminated. DON and Operations Manager stated it was the responsibility of the employees to complete their training on time. DON and Operations Manager stated supervisors were responsible to ensure staff completed training within 21 days and annually. When asked, HR P and Operations Manager stated they were new in their positions and were unaware that staff had not completed their training or how it could affect the residents. DON stated residents could be at risk for poor quality of care by staff not completing their training. Record review of the facility's new employee training acknowledgement, not dated, revealed New Hire LMS Training is due within the first 21 days of your start date. A policy addressing annual employee training was requested from the Operations Manager and DON on 05/20/2026 at 2:15 PM and again on 05/20/2026 at 4:51 PM but was not provided prior to exit.		

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 05/20/2026
NAME OF PROVIDER OR SUPPLIER Northeast Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 603 Corinne Drive San Antonio, TX 78218	
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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. Based on interview and record review, the facility failed to provide resident rights training for 1 (Operations Manager) of 28 employees reviewed for training, in that: The facility failed to ensure resident rights training was provided to Operations Manager within 21 days of hire, per facility's training policy. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. Findings include: Record review of personnel record for Operations Manager revealed hire date of 04/24/2026. Review of the training log provided by human resources revealed no evidence that the Operations Manager completed their initial training of resident rights within 21 days of hire. Interview with HR O on 05/20/2026 at 2:15 PM revealed newly hired employees were to complete their new hire training within 21 days of hire. HR O stated new employees signed an agreement at orientation that stated they would complete their training and that it was the employee's responsibility to complete training timely. When asked, HR O did not state how staff not completing their training could affect the residents. A group interview with HR P, DON and Operations Manager on 05/20/2026 at 4:51 PM revealed new employees signed a training agreement in orientation agreeing that they would complete training within 21 days of hire. HR P stated, per facility policy, employees were to complete their training within 21 days of hire or they could be suspended or terminated. DON and Operations Manager stated it was the responsibility of the employees to complete their training on time. DON and Operations Manager stated supervisors were responsible to ensure staff completed training within 21 days and annually. When asked, HR P and Operations Manager stated they were new in their positions and were unaware that staff had not completed their training or how it could affect the residents. DON stated residents could be at risk for poor quality of care by staff not completing their training. Record review of the facility's new employee training acknowledgement, not dated, revealed New Hire LMS Training is due within the first 21 days of your start date. A policy addressing annual employee training was requested from the Operations Manager and DON on 05/20/2026 at 2:15 PM and again on 05/20/2026 at 4:51 PM but was not provided prior to exit.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review, the facility failed to provide mandatory training on abuse prevention and dementia management training for 1 (RN D) of 28 employees reviewed for training, in that: The facility failed to ensure abuse prevention training was provided to Activity Director annually. The facility failed to ensure dementia management training was provided to RN D annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings include: Record review of personnel record for Activity Director revealed hire date of 11/04/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Activity Director completed abuse prevention training annually. Record review of personnel record for RN D revealed hire date of 07/25/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the RN D completed dementia management training annually. Interview with HR O on 05/20/2026 at 2:15 PM revealed newly hired employees were to complete their new hire training within 21 days of hire. HR O stated new employees signed an agreement at orientation that stated they would complete their training and that it was the employee's responsibility to complete training timely. When asked, HR O did not state how staff not completing their training could affect the residents. A group interview with HR P, DON and Operations Manager on 05/20/2026 at 4:51 PM revealed new employees signed a training agreement in orientation agreeing that they would complete training within 21 days of hire. HR P stated, per facility policy, employees were to complete their training within 21 days of hire or they could be suspended or terminated. DON and Operations Manager stated it was the responsibility of the employees to complete their training on time. DON and Operations Manager stated supervisors were responsible to ensure staff completed training within 21 days and annually. When asked, HR P and Operations Manager stated they were new in their positions and were unaware that staff had not completed their training or how it could affect the residents. DON stated residents could be at risk for poor quality of care by staff not completing their training. Record review of the facility's new employee training acknowledgement, not dated, revealed New Hire LMS Training is due within the first 21 days of your start date. A policy addressing annual employee training was requested from the Operations Manager and DON on 05/20/2026 at 2:15 PM and again on 05/20/2026 at 4:51 PM but was not provided prior to exit.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interview and record review the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of its QAPI program for 2 (CNA J and Operations Manager) of 28 employees reviewed for training requirements. The facility failed to ensure required QAPI training was provided to Operations Manager within 21 days of hire, per facility's training policy. The facility failed to ensure required QAPI training was provided to CNA annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings include: Record review of personnel record for Operations Manager revealed hire date of 04/24/2026. Review of the training log provided by human resources revealed no evidence that the Operations Manager completed their initial training of effective communications, resident rights, QAPI program, infection control, behavioral health, HIV, restraint reduction, prevention of falls, or emergency preparedness within 21 days of hire. Record review of personnel record for CNA J revealed hire date of 02/21/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the CNA J completed effective communications, QAPI program, ethics, HIV, restraint reduction, prevention of falls, or emergency preparedness training annually. Interview with HR O on 05/20/2026 at 2:15 PM revealed newly hired employees were to complete their new hire training within 21 days of hire. HR O stated new employees signed an agreement at orientation that stated they would complete their training and that it was the employee's responsibility to complete training timely. When asked, HR O did not state how staff not completing their training could affect the residents. A group interview with HR P, DON and Operations Manager on 05/20/2026 at 4:51 PM revealed new employees signed a training agreement in orientation agreeing that they would complete training within 21 days of hire. HR P stated, per facility policy, employees were to complete their training within 21 days of hire or they could be suspended or terminated. DON and Operations Manager stated it was the responsibility of the employees to complete their training on time. DON and Operations Manager stated supervisors were responsible to ensure staff completed training within 21 days and annually. When asked, HR P and Operations Manager stated they were new in their positions and were unaware that staff had not completed their training or how it could affect the residents. DON stated residents could be at risk for poor quality of care by staff not completing their training. Record review of the facility's new employee training acknowledgement, not dated, revealed New Hire LMS Training is due within the first 21 days of your start date. A policy addressing annual employee training was requested from the Operations Manager and DON on 05/20/2026 at 2:15 PM and again on 05/20/2026 at 4:51 PM but was not provided prior to exit.		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interview and record review, the facility failed to include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program for 2 (Activity Director and Operations Manager) of 28 employees reviewed for training, in that: The facility failed to ensure standards, policies, and procedures for an infection prevention and control program training was provided to Operations Manager within 21 days of hire, per facility's training policy. The facility failed to ensure standards, policies, and procedures for an infection prevention and control program training was provided to Activity Director annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings include: Record review of personnel record for Operations Manager revealed hire date of 04/24/2026. Review of the training log provided by human resources revealed no evidence that the Operations Manager completed their initial training in infection control within 21 days of hire. Record review of personnel record for Activity Director revealed hire date of 11/04/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Activity Director completed infection control training annually. Interview with HR O on 05/20/2026 at 2:15 PM revealed newly hired employees were to complete their new hire training within 21 days of hire. HR O stated new employees signed an agreement at orientation that stated they would complete their training and that it was the employee's responsibility to complete training timely. When asked, HR O did not state how staff not completing their training could affect the residents. A group interview with HR P, DON and Operations Manager on 05/20/2026 at 4:51 PM revealed new employees signed a training agreement in orientation agreeing that they would complete training within 21 days of hire. HR P stated, per facility policy, employees were to complete their training within 21 days of hire or they could be suspended or terminated. DON and Operations Manager stated it was the responsibility of the employees to complete their training on time. DON and Operations Manager stated supervisors were responsible to ensure staff completed training within 21 days and annually. When asked, HR P and Operations Manager stated they were new in their positions and were unaware that staff had not completed their training or how it could affect the residents. DON stated residents could be at risk for poor quality of care by staff not completing their training. Record review of the facility's new employee training acknowledgement, not dated, revealed New Hire LMS Training is due within the first 21 days of your start date. A policy addressing annual employee training was requested from the Operations Manager and DON on 05/20/2026 at 2:15 PM and again on 05/20/2026 at 4:51 PM but was not provided prior to exit.		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on interview and record review, the facility failed to provide mandatory ethics training for 2 (CNA J and RN D) of 28 employees reviewed for training, in that: The facility failed to ensure ethics training was provided to CNA J or RN D annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings include: Record review of personnel record for CNA J revealed hire date of 02/21/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the CNA J completed ethics training annually. Record review of personnel record for RN D revealed hire date of 07/25/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the RN D completed ethics training annually. Interview with HR O on 05/20/2026 at 2:15 PM revealed newly hired employees were to complete their new hire training within 21 days of hire. HR O stated new employees signed an agreement at orientation that stated they would complete their training and that it was the employee's responsibility to complete training timely. When asked, HR O did not state how staff not completing their training could affect the residents. A group interview with HR P, DON and Operations Manager on 05/20/2026 at 4:51 PM revealed new employees signed a training agreement in orientation agreeing that they would complete training within 21 days of hire. HR P stated, per facility policy, employees were to complete their training within 21 days of hire or they could be suspended or terminated. DON and Operations Manager stated it was the responsibility of the employees to complete their training on time. DON and Operations Manager stated supervisors were responsible to ensure staff completed training within 21 days and annually. When asked, HR P and Operations Manager stated they were new in their positions and were unaware that staff had not completed their training or how it could affect the residents. DON stated residents could be at risk for poor quality of care by staff not completing their training. Record review of the facility's new employee training acknowledgement, not dated, revealed New Hire LMS Training is due within the first 21 days of your start date. A policy addressing annual employee training was requested from the Operations Manager and DON on 05/20/2026 at 2:15 PM and again on 05/20/2026 at 4:51 PM but was not provided prior to exit.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure CNAs received the required minimum 12 hours annual in-services for 3 of 8 (CNA J, CNA K, CNA M) CNAs reviewed for trainings requirements. The facility failed to provide the required 12 hours of annual training to CNA J, CNA K, and CNA M. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings were: Record review of personnel record for CNA J revealed hire date of 02/21/2024. Review of the training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Record review of personnel record for CNA K revealed hire date of 03/10/2023. Review of the training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Record review of personnel record for CNA M revealed hire date of 08/16/2023. Review of the training log for the previous 12 months provided by human resources r revealed evidence of less than 12 hours per year of required in-service training being provided annually. Interview with HR O on 05/20/2026 at 2:15 PM revealed newly hired employees were to complete their new hire training within 21 days of hire. HR O stated new employees signed an agreement at orientation that stated they would complete their training and that it was the employee's responsibility to complete training timely. When asked, HR O did not state how staff not completing their training could affect the residents. A group interview with HR P, DON and Operations Manager on 05/20/2026 at 4:51 PM revealed new employees signed a training agreement in orientation agreeing that they would complete training within 21 days of hire. HR P stated, per facility policy, employees were to complete their training within 21 days of hire or they could be suspended or terminated. DON and Operations Manager stated it was the responsibility of the employees to complete their training on time. DON and Operations Manager stated supervisors were responsible to ensure staff completed training within 21 days and annually. When asked, HR P and Operations Manager stated they were new in their positions and were unaware that staff had not completed their training or how it could affect the residents. DON stated residents could be at risk for poor quality of care by staff not completing their training. Record review of the facility's new employee training acknowledgement, not dated, revealed New Hire LMS Training is due within the first 21 days of your start date. A policy addressing annual employee training was requested from the Operations Manager and DON on 05/20/2026 at 2:15 PM and again on 05/20/2026 at 4:51 PM but was not provided prior to exit.		

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and record review, the facility failed to provide mandatory behavioral health training for 4 of 28 (Dietary Supervisor, Activity Director, Operations Manager, ADON L) employees reviewed for training requirements was completed. The facility failed to ensure behavioral health training was provided to Dietary Supervisor, Operations Manager, or ADON L within 21 days of hire, per facility's training policy. The facility failed to ensure behavioral health training was provided to Activity Director annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings include: Record review of personnel record for Dietary Supervisor revealed hire date of 09/05/2025. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Dietary Supervisor completed their initial training of behavioral health within 21 days of hire. Record review of personnel record for Operations Manager revealed hire date of 04/24/2026. Review of the training log provided by human resources revealed no evidence that the Operations Manager completed their initial training of behavioral health within 21 days of hire. Record review of personnel record for ADON L revealed hire date of 02/18/2026. Review of the training log for the previous 12 months provided by human resources revealed no evidence that ADON L completed behavioral health training within 21 days of hire. Record review of personnel record for Activity Director revealed hire date of 11/04/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Activity Director completed behavioral health training annually. Interview with HR O on 05/20/2026 at 2:15 PM revealed newly hired employees were to complete their new hire training within 21 days of hire. HR O stated new employees signed an agreement at orientation that stated they would complete their training and that it was the employee's responsibility to complete training timely. When asked, HR O did not state how staff not completing their training could affect the residents. A group interview with HR P, DON and Operations Manager on 05/20/2026 at 4:51 PM revealed new employees signed a training agreement in orientation agreeing that they would complete training within 21 days of hire. HR P stated, per facility policy, employees were to complete their training within 21 days of hire or they could be suspended or terminated. DON and Operations Manager stated it was the responsibility of the employees to complete their training on time. DON and Operations Manager stated supervisors were responsible to ensure staff completed training within 21 days and annually. When asked, HR P and Operations Manager stated they were new in their positions and were unaware that staff had not completed their training or how it could affect the residents. DON stated residents could be at risk for poor quality of care by staff not completing their training. Record review of the facility's new employee training acknowledgement, not dated, revealed New Hire LMS Training is due within the first 21 days of your start date. A policy addressing annual employee training was requested from the Operations Manager and DON on 05/20/2026 at 2:15 PM and again on 05/20/2026 at 4:51 PM but was not provided prior to exit.		