STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455762	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio Wellness & Rehabilitation	One Heartland Dr San Antonio, TX 78247

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures for 2 of 6 residents (Residents #12, and #18) reviewed for freedom from abuse and misappropriation.1. The facility failed to report the incident of misappropriation on 5.2.25 for Resident # 12 missing a gold diamond necklace. 2. The facility failed to report the incident of alleged abuse on 05/01/2025 for Resident #18.These failures could put the residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychosocial harm. The findings were:Based on, interview, and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse,or not later than 2 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury , to the administrator of the facility and to other officials including the state Survey Agency where state law provides for jurisdiction in long term care facilities in accordance with State law through established procedures doe 2 of 6 (Residents #12, and #18) reviewed for freedom from abuse, neglect, and misappropriation. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The facility failed to report the incident of misappropriation on 5.2.25 for Resident # 12 missing a gold diamond necklace. 2. The facility failed to report the incident of alleged abuse on 05/01/2025 for Resident #18.These failures could put the residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychosocial harm. The findings were:1. Record review of Resident # 12's face sheet, dated 7/02/25, revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: Dementia (is the loss of thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) , hypertension. (happens when the force of your blood pushing against the walls of your blood vessels is too high) and Osteoporosis (a bone disease that develops when bone mineral density and bone mass decrease. Record review of Resident #12's admission MDS assessment, dated 05/02/2025, revealed the resident's BIMS score was 13, which indicated intact cognition. Record review of the facility's inventory sheet for Resident # 12, dated 4.30.25, did not reveal a gold diamond cross necklace on the inventory sheet . Record review of the facility's grievance's dated 5.13.25 revealed an allegation of a missing gold diamond necklace for Resident # 12 . Further review revealed the Administrator reimbursed the family for Resident # 12 , $1500 , for the missing gold diamond cross necklace. Record review of Texas Unified Licensure Information Portal (TULIP) on 7/02/25 at 8:25 A. M. revealed that no self-reported incidents regarding allegations of misappropriation were reported for Resident #12. An interview with Resident #12's representative party was attempted via phone on 7.2.25 at 9:30 AM and was unsuccessful. Resident # 12 was discharged to another facility on 5.15.25. During an interview on 07/02/2025 at 1:25 PM, the Administrator confirmed he received a report from Resident #12's representative party regarding a missing diamond gold necklace on 5/13/25 . The Administrator stated he did not report the misappropriation to HHSC because of the internal arbitration agreement, and because he reimbursed Resident # 12's family for the gold diamond necklace. After the Administrator familiarized himself with the Long-term care provider letter dated 8/29/25, he acknowledged that incidents that must be reported are exploitation, misappropriation, and failing to report the allegation could have resulted in Resident #12 being subjected to abuse. 2. Record review of Resident #18's Face Sheet, dated 07/02/2025, reflected a [AGE] year-old resident with an initial admission date of 12/16/2023 and diagnosis including Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), Depression, and morbid obesity. Record review of Resident #18's Comprehensive Person-Centered Care Plan, dated printed 07/01/2025, reflected Resident #18, consistently denies assistance with care tasks, including hygiene, repositioning, and transfers.Record review of facility grievance written by the LSW and dated 05/01/2025 revealed:This writer spoke with [Resident #18] at her request this morning. She stated she had not had a shower in three weeks, and she would like to have a shower today. When asked what days she has her showers, she stated, 'Monday, Wednesday, and Friday in the morning.'She stated the CNA ([CNA A]) today did not put her brief on correctly, and she went on to show this writer how the brief was placed on her (it was very low in the front and she stated it was up to her shoulder blades in the back.) She stated the CNA was 'rough' with her while providing care. She specifically stated the CNA 'pushes and squeezes' her when she does give her a shower, and [Resident #18] tries to explain to her (even though she knows she does not understand English) how to assist her without hurting her due to her diagnosis of fibromyalgia and arthritis. She stated [CNA A] only 'gives me a deadpan look and goes 'uh' in response.'SW asked [Resident #18] if she feels [CNA A] is rough with her on purpose, and [Resident #18] responded, 'Oh yes. She knows what she is doing. She doesn't listen. Today, when I was asking to have my diaper fixed, I kept saying wait, wait. She just kept doing it. When I said wait over and over and she didn't stop, I finally told her to leave. After telling her to leave three times, I thought maybe she didn't understand what 'please leave' meant, so I said, 'go'. She just stared at me. After I said 'go' a few times, I said go and did this (she made a motion with her hand). [CNA A] then said 'go' and did the same motion with both her hands.She makes fun of me like that.' SW asked [Resident #18] if this has happened before (being made fun of). [Resident #18] stated [CNA A] has done it many times before.[Resident #18] stated she no longer wants [CNA A] to take care of her in any way. She stated today was 'the last straw' and she doesn't want her in her room at all any longer.Interview on 07/02/2025 at 7:46 AM, LSW stated she is not aware of a follow-up to the grievance she wrote on behalf of Resident #18. LSW stated that after she told the Administrator about the incident and handed off the grievance to him, that is where her role in the grievance process stops. The LSW stated when

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have evidence that all allegations of abuse, neglect, exploitation, or mistreatment, were thoroughly investigated for 1 of 8 residents (Resident #18) reviewed for abuse and neglect. The facility did not investigate an incident in which Resident #18 made a grievance that a staff member was rough with her and did not stop perineal care when requested. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included:Record review of Resident #18's Face Sheet, dated 07/02/2025, reflected a [AGE] year-old resident with an initial admission date of 12/16/2023 and diagnoses including Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), Depression, and morbid obesity. Record review of Resident #18's Comprehensive Person-Centered Care Plan, dated printed 07/01/2025, reflected Resident #18, consistently denies assistance with care tasks, including hygiene, repositioning, and transfers.Record review of facility's grievance written by the LSW and dated 05/01/2025 revealed:This writer spoke with [Resident #18] at her request this morning. She stated she had not had a shower in three weeks, and she would like to have a shower today. When asked what days she has her showers, she stated, 'Monday, Wednesday, and Friday in the morning.' She stated the CNA ([CNA A]) today did not put her brief on correctly, and she went on to show this writer how the brief was placed on her (it was very low in the front, and she stated it was up to her shoulder blades in the back.) She stated the CNA was 'rough' with her while providing care. She specifically stated the CNA 'pushes and squeezes' her when she does give her a shower, and [Resident #18] tries to explain to her (even though she knows she does not understand English) how to assist her without hurting her due to her diagnosis of fibromyalgia and arthritis. She stated [CNA A] only 'gives me a deadpan look and goes 'uh' in response.' SW asked [Resident #18] if she feels [CNA A] is rough with her on purpose, and [Resident #18] responded, 'Oh yes. She knows what she is doing. She doesn't listen. Today, when I was asking to have my diaper fixed, I kept saying wait, wait. She just kept doing it. When I said wait over and over and she didn't stop, I finally told her to leave. After telling her to leave three times, I thought maybe she didn't understand what 'please leave' meant, so I said, 'go'. She just stared at me. After I said 'go' a few times, I said go and did this (she made a motion with her hand). [CNA A] then said 'go' and did the same motion with both her hands. She makes fun of me like that.' SW asked [Resident #18] if this has happened before (being made fun of). [Resident #18] stated [CNA A] has done it many times before.[Resident #18] stated she no longer wants [CNA A] to take care of her in any way. She stated today was 'the last straw' and she doesn't want her in her room at all any longer.Interview on 07/02/2025 at 7:46 AM, LSW stated she was not aware of a follow-up to the grievance she wrote on behalf of Resident #18. LSW stated that after she told the Administrator about the incident and handed off the grievance to him, that was where her role in the grievance process stops. The LSW stated when a resident addresses a concern to her, she will generally inform the DON/ADON and write a grievance and from there the Administrator handles it.Interview on 07/02/2025 at 8:18 AM, the Administrator stated they would not ordinarily report a grievance such as the one described with Resident #18 to the State because they did a grievance, the Resident has a history of false reporting, and because once he interviewed the Resident she was happy with the resolution of CNA A not working with her any longer. The Administrator stated that it was likely that Resident #18 felt as though CNA A was rough because Resident #18 was overweight. The Administrator stated after the resolution with the Resident they completed the grievance process and there was no further investigation. Interview attempt on 07/02/2025 at 8:30 AM, Resident #18 did not remember the incident occurring and stated she did not have any concerns for her care.Interview on 07/02/2025 at 2:27 PM, CNA A stated she has never been rough with a resident and would report to the DON and Administrator if she saw another staff member become rough with a resident. Record review of Texas Unified Licensure Information Portal (TULIP) on 07/02/2025 at 8:25 AM revealed that no self-reported incidents regarding allegations of neglect were reported for Resident #18.Record review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated revised 4/20212, reflected, If the Administrator receives a report of an incident or suspected incident of resident abuse, mistreatment, neglect, injuries of an unknown source of crime, the Administrator or designee, may appoint a member of the Facility's management team (the investigator) to investigate the alleged incident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 1 of 6 residents (Resident #15) reviewed for care plan revisions.The facility failed to ensure Resident #15's care plan was comprehensive and updated to reflect Resident #15 had an incident of resident-to-resident aggression. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included:Record review of Resident #15's face sheet dated 07/02/2025 revealed an [AGE] year-old admitted to the facility on [DATE] with diagnoses that included unspecified dementia (group of thinking and social symptoms that interferes with daily functioning), anxiety disorder, and personal history of covid-19. Record review of Resident #15's most recent admission MDS assessment dated [DATE] revealed the resident was severely cognitively impaired. Record review of Resident #15's comprehensive care plan, undated, did not reveal anything related to aggression or altercations with other residents. Record review of Resident #15's progress note, dated 5/6/2025, reflected, While in the dinning [sic] room for dinner, patient was involved in a physical altercation with another patient after an accidental bumping into the other patient wheelchair. In response, this patient wrapped his hands around the other patient's neck. Staff intervened immediately, separating the individuals and redirecting both patients to ensure safety. During the incident, this resident sustained an abrasion to his left cheek, likely resulting from the physical struggle. The area was assessed and cleaned per protocol; no active bleeding was noted. The Administrator, MD, D.O.N and family was notified. Monitoring will continue per protocol. During an interview on 07/02/2025 at 7:18 AM, MDS Coordinator B stated they go through incident reports during their morning meeting. MDS Coordinator B stated she remembers the incident and believes that MDS Coordinator C was in charge of changing Resident #15's comprehensive care plan, as she changed the other resident involved in the resident-to-resident altercation's care plan. During an interview on 07/02/2025 at 7:41 AM, MDS Coordinator C stated because Resident #15 did not have any psychological trauma or physical injuries they did not update his care plan. Record review of the facility document titled Care Planning with revision date 10/24/2022 revealed in part, The IDT will revise the Comprehensive Care Plan as needed at the following intervals: . D. To address changes in behavior and care