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	09/11/2025

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (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 0559 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 ensure residents had the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed for one of one resident (Resident #1) reviewed for room change. The facility did not provide Resident #1 with a written notice prior to a room change or the right to refuse on 06/16/2025. This deficient practice could place residents at risk for being displaced without notice and/or reason to accommodate other individuals.Findings included: Record review of Resident #1's admission Record, dated 09/10/2025, revealed a [AGE] year-old female admitted on [DATE]. Resident #1 was listed as her own responsible party with [family member] listed as financial Power of Attorney and Emergency Contact #1. Record review of Resident #1's Medical Diagnoses, undated and accessed 09/10/2025, revealed diagnoses including acute (present or experienced to a severe or intense degree) on chronic systolic (congestive) heart failure (a long-lasting condition resulting from the gradual decrease in the heart's ability to pump blood out to the rest of the body), senile degeneration of brain (loss of intellectual ability associated with old age), and unspecified dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Census tab on Resident #1's EMR, undated and accessed on 06/10/2025, revealed Resident #1 was moved from room [ROOM NUMBER]-B-A (rehabilitation unit) to 205-B (secure unit) on 06/16/2025. Record review of Resident #1's significant change MDS, dated [DATE], reflected a BIMS score of 05, indicating severe cognitive impairment. Record review of Resident #1's care plan, undated and accessed on 07/11/2025, revealed Resident #1 was an elopement risk related to dementia and impaired safety awareness. Resident #1 was noted to reside in the secure unit. The care plan focus was initiated and revised on 06/16/2025. Record review of Resident #1's progress notes, dated 06/13/2025 (day of admission) to 06/17/2025 (day after transfer to secure unit), indicated no documentation or notification to resident or emergency contact #1 about why a room change was made. Record review of Resident #1's EMR on 06/10/2025 did not reveal documentation of a notification to and/or consent by the resident or emergency contact #1 for a room change. During an interview on 09/10/2025 at 09:00 a.m., Resident #1's family member and emergency contact #1 stated she was never notified about and did not provide authorization for the room change that happened to Resident #1 on 06/17/2025. The family member did not understand why Resident #1 had been moved to a secure unit. The family member recalled she found out about the room change when another family member went to visit Resident #1. She stated she was eventually told (unable to provide who told her or when) that Resident #1 had gone to the front desk and was asking where she (family member) was. The family member stated she got no phone call, letter or verbal explanation as to why Resident #1 was moved. During an interview on 09/10/2025 at 12:10 p.m., Resident #1 stated the facility is very nice and she gets along with almost everyone. She stated she currently had a private room but would like a roommate. She stated her prior roommate was moved after it was discovered the roommate was taking Resident #1's personal items to another room. Resident #1 did not state she wanted to leave the secured unit and did not state why she was on the secured unit. She stated the activities director took the residents outside to do fun activities and the staff were amazing. During an interview on 09/11/2025 at 02:14 p.m., the DON stated Resident #1 was moved to the secure unit due to having been exit seeking and combative. The DON stated the family was informed about the changes and had told her (the DON) to not call them about Resident #1. The DON stated Resident #1's emergency contact had told her that she did not want to be bothered with Resident #1 right then. The DON stated there was no signed consent for the room change. During an interview on 09/11/2025 at 02:14 p.m. (entered room during DON interview), the ADMIN stated there was not a signed consent for Resident #1's room change in her chart. He stated he was unaware if Resident #1's family was notified immediately about Resident #1's move to the secure unit or if they provided room change consent. He stated he was aware that Resident #1's family had told him, the DON, and the ADON not to contact them regarding Resident #1. He stated he did recall Resident #1 exhibited behaviors after admission but could not provide details of Resident #1's move to the secure unit. Attempted interview with MD C on 09/11/2025 at 03:22 p.m. Call back not received. Record review of policy titled, Resident Rights, date revised 08/2020, revealed All residents have a right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility including those specified in this policy. The Facility will protect and promote the rights of the resident. A. Be informed about what rights and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 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 observation, interview and record review, the facility failed to ensure residents were free from involuntary seclusion and any physical restraint not required to treat the resident's medical symptoms for one of six (Resident #1) residents reviewed for involuntary seclusion.The facility failed to ensure Resident #1 met criteria to remain on the secure unit per secure unit criteria.This failure could place residents who resided on the secure unit at risk for feelings of isolation and anxiety.Findings included:Record review of Resident #1's admission Record, dated 09/10/2025, revealed a [AGE] year-old female admitted on [DATE]. Resident #1 was listed as her own responsible party with [family member] listed as financial Power of Attorney and Emergency Contact #1. Record review of Resident #1's Medical Diagnoses, undated and accessed 09/10/2025, revealed diagnoses including acute (present or experienced to a severe or intense degree) on chronic systolic (congestive) heart failure (a long-lasting condition resulting from the gradual decrease in the heart's ability to pump blood out to the rest of the body), senile degeneration of brain (loss of intellectual ability associated with old age), and unspecified dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 05, indicating severe cognitive impairment. Resident #1 was documented as having not exhibited any behavioral symptoms, including wandering. Record review of Resident #1's significant change MDS, dated [DATE], reflected a BIMS score of 05, indicating severe cognitive impairment. Resident #1 was documented as having not exhibited any behavioral symptoms, including wandering. Record review of Standard Assessment tab on Resident #1's EMR, undated and accessed on 06/10/2025 at 11:02 a.m., revealed one Elopement Risk Evaluation. The Evaluation had a risk score of 1.0, no risk. Record review of Resident #1's Elopement Risk Evaluation, dated and signed 06/13/2025, reflected Resident #1 was able to make decisions regarding daily living tasks and she was able to ambulate or mobilize in wheelchairs. The elopement risk evaluation had a score of 1.0, no risk for elopement. Record review of Resident #1's Elopement Risk Evaluation, dated and signed 06/13/2025, reflected Resident #1 was alert and oriented times 3, did not have a history of falls, was ambulatory, and had adequate vision. Resident #1 was noted to be able to stand but required assistance when standing and was unable to stand independently. She was documented as having taken 1-2 listed medications within the last 7 days. The care plan and interventions were not completed on the evaluation. The elopement risk evaluation had a score of 8.0, moderate risk for elopement. The risk evaluation was not completed or available in Resident #1's EMR until after investigation began, 09/10/2025 at 09:15 a.m. Record review of Resident #1's Order Summary Report, dated 09/11/2025, reflected no orders for secure unit placement. Record review of Resident #1's care plan, undated and accessed 09/11/2025, revealed Resident #1 was an elopement risk related to dementia and impaired safety awareness. Resident #1 was noted to reside in the secure unit. The care plan focus was initiated and revised on 06/16/2025. The care plan also included Resident #1 was at risk for elopement related to Elopement Evaluation risk score, date initiated and created 09/10/2025 (day of investigation entry, 09/10/2025 at 09:15 a.m.). Record review of Resident #1's progress notes, dated 06/13/2025 (day of admission) to 06/17/2025 (day after transfer to secure unit), indicated no documentation or notification to resident or emergency contact #1 about why a room change was made. Record review of Resident #1's Care Plan Conference, dated 08/12/2025 and signed 08/18/2025, revealed Resident #1, Resident #1's emergency contact, and another family member attended the care plan conference. The additional information revealed Family would like for her [Resident #1] to be evaluated to come out of skilled unit. During an interview on 09/10/2025 at 09:00 a.m., Resident #1's family member and emergency contact #1 stated she did not understand why Resident #1 had been moved to a secure unit. She stated she was eventually told (unable to provide who told her or when) that Resident #1 had gone to the front desk and was asking where she (family member) was. The family member stated she wanted Resident #1 back on the general population hall and out of the secure unit. The family member stated she voiced this request to the facility during the care planning meeting. During an observation and interview on 09/10/2025 at 12:10 p.m., Resident #1 stated the facility is very nice and she gets along with almost everyone. She stated she currently had a private room but would like a roommate. She stated her prior roommate was moved after it was discovered the roommate was taking Resident #1's personal items to another room. Resident #1 did not state she wanted to leave the secured unit and did not state why she was on the secured unit. She stated the activities director took the

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 ensure medical records, in accordance with accepted professional standards and practices, were complete and accurately documented for two of six residents (Resident #1 and Resident #2) reviewed for medical records accuracy. 1. The facility failed to ensure Resident #1's orders for facility admission and for secure unit admission were reflected in the active orders. 2. The facility failed to ensure Resident #2's orders for facility admission and for secure unit admission were reflected in the active orders. These deficient practices could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment.Findings included: 1. Record review of Resident #1's admission Record, dated 09/10/2025, revealed a [AGE] year-old female admitted on [DATE]. Resident #1 was listed as her own responsible party with [family member] listed as financial Power of Attorney and Emergency Contact #1. Record review of Resident #1's Medical Diagnoses, undated and accessed 09/10/2025, revealed diagnoses including acute (present or experienced to a severe or intense degree) on chronic systolic (congestive) heart failure (a long-lasting condition resulting from the gradual decrease in the heart's ability to pump blood out to the rest of the body), senile degeneration of brain (loss of intellectual ability associated with old age), unspecified dementia (a general term for impaired ability to remember, think, or make decisions), and essential (primary) hypertension (high blood pressure). Record review of Resident #1's admission MDS, dated [DATE], reflected a BIMS score of 05, indicating severe cognitive impairment. Resident #1 was documented as having not exhibited any behavioral symptoms, including wandering. Record review of Resident #1's significant change MDS, dated [DATE], reflected a BIMS score of 05, indicating severe cognitive impairment. Resident #1 was documented as having not exhibited any behavioral symptoms, including wandering. Record review of Standard Assessment tab on Resident #1's EMR, undated and accessed on 06/10/2025 at 11:02 a.m., revealed one Elopement Risk Evaluation. The Evaluation had a risk score of 1.0, no risk. Record review of Resident #1's Elopement Risk Evaluation, dated and signed 06/13/2025, reflected Resident #1 was able to make decisions regarding daily living tasks and she was able to ambulate or mobilize in wheelchairs. The elopement risk evaluation had a score of 1.0, no risk for elopement. Record review of Resident #1's Elopement Risk Evaluation, dated and signed 06/13/2025, reflected Resident #1 was alert and oriented times 3, did not have a history of falls, was ambulatory, and had adequate vision. Resident #1 was noted to be able to stand but required assistance when standing and was unable to stand independently. She was documented as having taken 1-2 listed medications within the last 7 days. The care plan and interventions were not completed on the evaluation. The elopement risk evaluation had a score of 8.0, moderate risk for elopement. The risk evaluation was not completed or available in Resident #1's EMR until after investigation began, 09/10/2025 at 09:15 a.m. Record review of Resident #1's Order Summary Report, dated 09/11/2025 at 12:01 p.m., reflected no orders for admission to the facility or orders for secure unit placement. Record review of Resident 1's Order Recap Report, dated 09/11/2025 at 04:36 p.m., reflected the following orders:- Admit to [facility name] under the care of [MD C] for skilled services., noted as discontinued with order date of 06/13/2025 and end date of 09/11/2025. Discontinue notation included reason, Admit to secure unit. Order updated.- ***Late entry for 6/13/25***Admit to [facility name] under the care of [MD C] for skilled services for HYPERTENSIVE URGENCY, noted as discontinued with order date of 06/15/2025 and end date of 06/16/2025. Discontinue notation did not include reason.- ***Late entry for 6/13/25***Admit to [facility name] under the care of [MD C] for skilled services for ACUTE ON CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE, noted as discontinued with order date of 06/16/2025 and end date of 07/03/2025. Discontinue notation did not include reason.- Admit to [facility name] under the care of [MD C] for long-term care/hospice on secure unit., noted as active with order date of 06/16/2025 and no end date. Order entered after investigation began, 09/10/2025 at 09:15 a.m. Record review of Order Audit Report, dated 09/11/2025 at 04:54 p.m., reflected the order Admit to [facility name] under the care of [MD C] for long-term care/hospice on secure unit., was created by the DON on 09/11/2025 at 04:48 p.m. Record review of Resident #1's care plan, undated and accessed 07/11/2025, revealed Resident #1 was an elopement risk related to dementia and impaired safety awareness. Resident #1 was noted to reside in the secure unit. The care plan focus was initiated and revised on 06/16/2025. During an interview on 09/10/2025 at 09:00 a.m., Resident #1's family member and emergency contact #1 stated she did not understand why Resident #1 had been moved to a secure unit. The