

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455762	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER San Antonio Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #1) reviewed for accuracy of medical records.LVN N failed to document Resident #1's wound care treatment on Resident #1's medication administration record for December 26, 2025.This deficient practice could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment.Findings included:Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses that included encephalopathy (a disease in which the function or structure of the brain is affected, typically caused by infection, tumor, or stroke) and dementia (a general term for impaired ability to remember, think, or make decisions).Record review of Resident #1's quarterly MDS assessment dated , 12/07/2025, revealed Resident #1 had short term and long term memory deficits and severely impaired cognitive skills for decision making[KH2] . Section M- Skin revealed Resident #1 had 2 Stage III pressure injuries.Record review of Resident #1's comprehensive care plan revealed a care plan, dated 12/08/2023 and revised 11/14/2025, that revealed Resident #1 had potential for pressure ulcer development and had a Stage III pressure ulcer to the left medial foot and left medial foot superior. An intervention revealed, administer treatments as ordered and monitor for effectiveness.Record review of Resident #1's December 2025 MAR revealed an order, wound care: Left medial foot inferior, pressure injury; Cleanse with NS, pat dry: Apply [NAME] Blue to wound and cover with dry dressing: 3x week and PRN every day shift every Mon, Wed, Fri, order date 12/01/2025 and discontinued date 12/29/2025. The MAR revealed a check mark and staff member initials on 12/03/25, 12/05/2025, 12/08/2025, 12/10/2025, 12/12/2025, 12/15/2025, 12/17/2025, 12/19/2025, 12/22/2025 and 12/24/2025. On 12/26/2025, the MAR was blank. The MAR revealed an order, Wound care: Left medial foot superior, pressure injury: Clean everyday NS/WC, pat dry; Apply [NAME] Blue to wound bed, cover with dry dressing: 3x/week and PRN every day shift Mon, Wed, Fri., order date 12/01/2025 and discontinued date 12/29/2025. The MAR revealed a check mark and staff member initials on 12/03/25, 12/05/2025, 12/08/2025, 12/10/2025, 12/12/2025, 12/15/2025, 12/17/2025, 12/19/2025, 12/22/2025 and 12/24/2025. On 12/26/2025, the MAR was blank. During an interview with LVN A, 01/14/2026 at 1:30 p.m., LVN A stated when a wound care was completed for a resident, the nurse would sign the MAR for the wound care date and stated a blank on the MAR could have indicated that the treatment was not completed. LVN A stated she provided wound care to Resident #1 on 12/22/2025 and stated she was not sure if she was assigned to Resident #1 on 12/26/2025 and stated if she was assigned to Resident #1, she would have completed the wound care treatments by following the orders on the resident MAR.During an interview with Treatment Nurse J, 01/15/2026 at 10:35 a.m., Treatment Nurse J stated she was responsible for overseeing and performing resident wound care. Treatment Nurse J</p> <p>(continued on next page)</p>		

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated she completed Resident #1's wound care on 12/24/2025 and was off on 12/26/2025. Treatment Nurse J stated when she was off, the charge nurses or administrative nurses were responsible for completing resident wound care. During an interview with LVN N, 01/16/2026 at 12:00 p.m., LVN N stated she was the staffing coordinator at the facility and provided wound care to Resident #1 on 12/26/2025. LVN N stated she followed the treatment orders for Resident #1 on the MAR but forgot to document in the medical record. LVN N stated she remembered that she did not document the wound treatment on the MAR after she got home from her shift and tried to log into the medical record system but no longer had remote access. LVN N stated she planned to update Resident #1's MAR the following day but totally forgot. During an interview with the DON, 01/15/2026 at 2:44 p.m., the DON stated if the treatment nurse was not scheduled for the day, the charge nurse was responsible for performing wound care for residents according to their orders on the MAR. The DON stated when treatments were completed, the treating nurse was responsible for signing the MAR to indicate that a treatment was completed. The DON stated staff had received training on documentation and stated it was important to document in the clinical record, so the record indicated the treatment was completed. Record review of a facility policy titled, Documentation-Nursing date revised 01/2025, revealed, Nursing documentation will be concise, clear, pertinent, accurate and evidence based. Procedure 1. Nursing Documentation.H. Medication administration records and treatment administration records are completed with each medication or treatment completed. K. Documentation will be completed by the end of the assigned shift.</p>		