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	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio Wellness & Rehabilitation	1 Heartland Drive 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for nutrition services.The facility failed to ensure the commercial bar soda/juice gun dispenser was free from dirt and debris buildup.The facility failed to ensure that the DNS, Cook, and Dietary Aide were wearing hair restraints during food preparation during the initial brief tour of the kitchen.The facility failed to ensure that the DNS, Cook, and Dietary Aide were wearing hair restraints appropriately during follow-up visits to the kitchen. The facility failed to ensure the DNS was practicing hand hygiene when exiting and reentering the kitchen during follow-up visits to the kitchen. The facility failed to ensure LVN-L was using proper hygienic practices and serving food under sanitary conditions during observation of the first meal upon entrance into the facility. These failures could lead to contamination and foodborne illness. Findings included:On 02/17/2026 at 9:15 AM the following was observed in the facility's only kitchen:DNS and [NAME] were not wearing hair nets.DNS and [NAME] did not have beard guards covering their facial hair (beard). The facility's commercial bar soda/juice gun dispenser handle had buildup of dried juice and dark slime on the inside of the handle.On 02/17/2026 at 12:45 PM the following was observed in one of the three dining rooms during the initial lunch service:LVN-L was observed passing out silverware and didn't sanitize or wash hands first.LVN-L was also observed touching a resident while patting her on the back. LVN-L didn't wash or sanitize his hands and proceeded to continue passing out the silverware to residents.LVN-L was observed pulling down his mask and wiping his nose with bare hands and then began putting ice into water cups and passing them out to residents without washing or sanitizing his hands.On 02/19/2026 at 10:45 AM the following was observed:Dietary Aide was observed going into the kitchen and back out wearing the same plastic gloves and not sanitizing or washing hands or changing gloves.Dietary Aide was also observed going into the kitchen and back wearing a baseball cap on his head with hair showing visibly on the sides and back of his head from under the cap and not wearing a hair net.Dietary Aide went into the kitchen and back out wearing a face mask pulled down past his beard around his neck without covering his beard with it.On 2/19/2026 at 11:30 AM the DNS was observed exiting the kitchen and returning to the kitchen on three separate occasions and did not wash his hands after reentering each time. In an interview on 2/19/2026 at 11:15 AM, the DNS said the commercial juice gun dispenser used for nectar water and other juices was sanitized nightly and deep cleaned two times per month. He said all dietary aid staff are responsible for cleaning the juice dispenser, but he did not have a cleaning log and could not confirm who had cleaned it last. DNS said the commercial juice gun dispenser needs to be cleaned properly to prevent bacteria from building up, which could make residents ill. During an interview and observation on 02/19/2026 at 11:38 AM Dietary Aide was observed sitting in the dining room directly across from the kitchen rolling silverware for meal service. He was observed wearing his beard guard on his chin. He entered the kitchen to demonstrate use of the commercial dishwasher. He did not wash or sanitize his hands upon entering the kitchen nor when returning to the dining room to handle silverware.In an interview on (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 - Many	02/19/2026 at 1:00 PM, LVN-L stated he has had infection control training. He stated he had training in infection control and yes you must keep your hands clean the nurses [NAME]. LVN-L said he had training online and understood the importance of infection control. He said washing hands, using PPE, and practicing infection control protocol was important, for example if you had a person that had shingles, you don't want to spread. He said, you mask up, gloves the whole thing, and wash your hands before you leave. He stated he sometimes just gets busy and forgets to wash and sanitize his hands when he served the lunch trays on 02/19/2026. He said, wow when he was told what procedure he was observed not following. He stated he does understand the importance of infection control, washing and sanitizing and following proper procedure. He said O, man, I just do it so much I didn't pay attention. LVN-L said he appreciated what was being brought to his attention and thanked the surveyor.During observation and interview on 02/20/2026 at 11:20 AM, Dietary Aide was observed rolling cutlery in the dining room, wearing gloves, a baseball cap without a hair net and a face mask below his chin exposing his facial hair. He was observed leaving the area and going back and forth into the kitchen. He was observed returning to the dining room back to his activity without changing out his gloves or washing and sanitizing hands. The Dietary Aide said he has received training on infection control, specifically hand washing, hair nets, beard coverings and gloves. He said practicing proper infection control is important because people touch everything with their hands and could spread their germs to others especially those with a weak immune system especially in a place like this. When non-compliance of hair net and hand hygiene was brought to his attention he said, Wow yea, yea, I did have gloves on. He said it is cross contamination when you wear something into one area then another area without practicing proper hand hygiene and without wearing a hair net and beard guard.In an interview on 02/20/2026 at 11:38 AM, the [NAME] said he has received training on infection control and hygiene procedures. He said he has had lots training. He said it is important to practice hand hygiene to avoid cross contamination. He said not following procedures could make a resident sick. When brought to his attention that he was not practicing proper hand hygiene and wearing a hair net or beard guard during the initial observation of the kitchen he insisted he was wearing a hair net and beard guard. He said cross contamination can cause a resident to become sick and he understood the importance of hand hygiene and wearing hair net.In an interview on 02/20/2026 at 11:51 AM, the DNS said he has received training on infection control, food handling, food temperature danger zones, the use of proper vendors and measurements. He said he is aware of cross contamination and understands it could make a resident sick. When brought to his attention the observation of him not wearing a hair net or beard guard during the initial observation of the kitchen he denied it. He also said he would be reviewing the facility recordings to confirm this information. He also added that he hasn't been employed here at the facility long and expressed he didn't want to get fired or be in trouble for not following facility procedures on hand hygiene and wearing hair nets and beard guard. Record review of the facility policy titled, Kitchen Sanitation - Operation and Cleaning dated 1/1/2025, reflected the following: To maintain the highest standard of cleanliness and sanitation in the facility's kitchen and food service areas, ensuring the safety and well-being of our residents by preventing food borne illness and complying with all state, local, and federal regulations. This policy applies to all staff in the dietary department, including dietary managers, cooks, dietary aides, registered dietitians, and any other staff or contractors working in or around the kitchen area. I. Staff Hygiene All kitchen staff must: A. Wash hands thoroughly before starting work, after breaks, after restroom use, changing tasks, before meal service, and after handling raw food or waste. C. Hairnets while in the kitchens, beard guard when needed, may where a cap with a hair net under cap. II. Cleaning and Sanitizing A. Daily Cleaning Tasks: ii. Sanitize countertops, carts, meal carts, beverage dispensers. III. Equipment and Utensils A. All food prep equipment must be: i. Cleaned and sanitized after each use. ii. Stored in a sanitary manner.Record review of the facility policy titled, Nutrition Services Personnel Guidelines dated 1/1/2026, reflected the following: To describe important personnel guidelines followed by Food and Nutrition Services to promoteprofessionalism (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	within the department. The dietary department employs sufficient employees, competent employees, and employees who practice good hygiene while carrying out the functions of the department. Dress Code:XXV. Hair must be fully covered with a hairnet or hair bonnet always within the department. Hairnet must be worn regardless of the amount of hair. XXVI. Facial hair is to be groomed, and mustache and beards are to be covered with hair restraint (Beard Guard).Record review of the facility policy titled, Hand Hygiene Infection Control Manual dated 6/2020, reflected the following: To ensure that all individuals use appropriate hand hygiene while at the facility. The Facility considers hand hygiene the primary means to prevent the spread of infections. I. Facility Staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Ill. Facility Staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors. IV. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policy. V. Facility Staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited to .A. Wash hands with soap and water: i. Before eating; ii. After using the bathroom; iii. When soiled with visible dirt or debris; iv. After unprotected (ungloved and damaged gloves) contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, intact skin soiled with blood and other body fluids, wound drainage and soiled dressings; v. After contact with intact and non-intact skin, clothing and environmental surfaces of residents with active diarrhea even if gloves are worn; vi. Before and after food preparation.Record review of the facility policy titled, Nutrition Services Department - General dated 1/1/2025, reflected the following: To ensure that the nutrition services department has the requisite organization to meet the nutritional needs of residents. I. The primary objectives of the nutrition services department include: C. Maintenance of standards for sanitation and safety. IV. Training Program A. The Dietary manager and/or Registered Dietitian are responsible for planning and providing nutrition staff with in-service education. B. In-service topics may include: v. Infection Control/Food Safety v. Sanitation. C. The Dietary Manager and/or Registered Dietitian is also responsible for the day-to-day education of nutrition staff regarding topics such as sanitation, food preparation, etc.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles and stored in locked compartments for 2 of 3 residents (Residents #36 and #21) and 1 of 11 medication carts reviewed for storage. 1. Resident #36's insulin Glargine (Lantus) Solos Flex Pen for diabetes had no open date, found inside 500 and 600-hall nursing cart on 02/18/2026. 2. Resident #21's insulin Novolog 70/30 Flex Pen for diabetes had no open date, found inside 200-hall nursing cart on 02/18/2026. 3. The facility failed to ensure 1 of 11 medication carts was kept locked or under direct observation of authorized staff in an area where residents could access it on 2/19/2026. These failures could place residents at risk of clinically significant adverse consequences and not having therapeutic effects by using old insulins. The findings were: 1. Record review of Resident #36's face sheet, dated 02/20/2026, revealed Resident #36 was a [AGE] year-old male and admitted to the facility 05/05/2023 and re-admitted to the facility 02/11/2026 with diagnoses of influenza (an infection of the nose, throat, and lungs), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), and hypertension (high blood pressure). Record review of Resident #36's admission MDS, dated [DATE], revealed the resident's BIMS score was 14 out of 15, which indicated the resident's cognition was intact, and the resident was receiving insulin injections every day as ordered. Record review of Resident #36's physician's order, dated 02/11/2026, revealed the resident had the order of Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-Lantus) Inject 10 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. Record review of Resident #36's medication administration record, dated from 02/01/2026 to 02/28/2026, revealed the resident was receiving Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-Lantus) Inject 10 unit subcutaneously in the morning for type 2 diabetes mellitus at 8:00 am as ordered. Observation on 02/18/2026 at 1:44 p.m. revealed Resident #36's Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-Lantus) Inject 10 unit subcutaneously in the morning for diabetes with no open date was found inside the 500 and 600-hall nursing cart. Further observation revealed the insulin pen had a label, and the label said, discard after 28 days. Interview on 02/18/2026 at 1:56 p.m. with RN-E stated Resident #36's Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-Lantus) Inject 10 unit subcutaneously in the morning for diabetes with no open date was found inside the 500 and 600-hall nursing cart, and the insulin pen should have been discarded 28 days after opening it per the label from the insulin pen. If the insulin pen did not have any open date, nurses did not know when they have to discard the insulin pen. Interview on 02/18/2026 at 1:57 p.m. with DON said the facility nurses should have written open date on Resident #36's Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine-Lantus) Inject Pen because the label from the insulin pen said, discard after 28 days, and using old insulin (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	might affect Resident #36 to not reach therapeutic effects. 2. Record review of Resident #21's face sheet, dated 02/20/2026, revealed Resident #21 was a [AGE] year-old male and admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (progressive disease that destroy memories and other important mental functions), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), and hypertension (high blood pressures). Record review of Resident #21's quarterly MDS assessment, dated 02/18/2026, revealed the resident's BIMS score was 4 out of 15, which indicated the resident had severe cognitive impairment, and the resident was receiving insulin injections every day as ordered. Record review of Resident #21's physician's order, dated 09/27/2025, revealed the resident had the order of NovoLOG Mix 70/30 FlexPen Subcutaneous Suspension Pen-injector (70-30) 100 UNIT/ML (Insulin Aspart Protamine & Aspart (Human)) Inject 36 unit subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Hold for blood sugar less than 100. Record review of Resident #21's medication administration record, dated from 02/01/2026 to 02/28/2026, revealed the resident was receiving NovoLOG Mix 70/30 FlexPen Subcutaneous Suspension Pen-injector (70-30) 100 UNIT/ML (Insulin Aspart Protamine & Aspart (Human)) Inject 36 unit subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Hold for blood sugar less than 100 for diabetes at 7:00 am. Observation on 02/18/2026 at 2:18 p.m. revealed Resident #21's insulin Novolog 70/30 Flex Pen for diabetes with no open date was found inside the 200-hall nursing cart. Further observation revealed the insulin pen had label, and the label indicated open and store at room temperature for 14 days. Interview on 02/18/2026 at 2:29 p.m. with DON stated Resident #21's insulin Novolog 70/30 Flex Pen for diabetes with no open date was found inside the 200-hall nursing cart, and the insulin pen should have been discarded 14 days after opening it because the label said, open and store at room temperature for 14 days. If the insulin pen did not have any open date, nurses did not know when they have to discard the insulin pen, and using old insulin might affect Resident #21 to not reach therapeutic effects, and the facility did not have specific policy for insulin but following professional guidelines. Record review of the professional guidelines, titled Mount [NAME] (https://www.mountsinai.org/health-library/special-topic/insulin-and-syringes-storage-and-safety), dated 06/20/2025, revealed Discard insulin after 28 days from the date of opening. 3. Unsecured Medication Cart Observation on 2/19/2026 at 2:26 PM revealed a medication cart unlocked and with no direct observation of authorized staff in the area. The medication cart was parked in the 300 hallways directly in front of the nurse's station. The charge nurses were in the middle of shift change. There were four residents sitting near the nurses' station roughly 6 feet away from the unsecured medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 2/19/2026 at 2:45 PM, ADON was notified that the medication cart was left unlocked and has been unsupervised for more than 20 minutes. ADON immediately left the interview and proceeded to the unlocked medication cart to secure it. She notified the charge nurse that the cart was left unlocked. In an interview on 2/20/2026 at 12:51 PM, Medication aide-C said she was certified as a medication aide and certified nursing aide. She said she was provided with in-services on medication administration and securing medications. She said it is important to resident safety to secure medication carts and screens. She said the facility protocol is to make sure medication carts are always locked. She said the impact of leaving a medication cart opened and unsecure could negatively affect a resident as it would be a health concern and they could accidently take medications without knowing it and it could harm them or cause death from these actions. In an interview on 2/20/2026 at 1:07 PM, Medication aide-J said she receives training every 90 days on medication administration and securing medications properly. She said if there was an issue to be addressed, in-services were given immediately. She said securing medication carts was necessary for safety. She said only a handful of staff have access to keys. She said medication aids have access to keys, charge nurse also has access to keys. She said the impact of a medication cart staying unlocked was anyone could get into it, it would be a disaster, they could get wrong medications, can be taken out, and resident could have an allergic reaction or death. In an interview on 2/20/2026 at 1:17 PM LVN-K said medication carts should always be locked and for any reason if it was not locked staff should not be away from it. He said it was the responsibility of the charge nurse to ensure the medication cart is locked for their hallway. He said leaving a medication cart unlocked or unsecured can be dangerous for residents. He said staff were provided with training on medication administration and securing medications properly. He said he was not responsible for the 300-hallway medication cart and he was not aware of it remaining open the prior day. In an interview on 2/20/2026 at 1:47 PM, ADON said medication carts should always be locked unless they are physically taking something out from it. She said the impact of leaving a medication cart unlocked or unsecured could allow for a resident or family member to get into them and take something they shouldn't take. She said a resident could be harmed, have an allergic reaction and all kinds of dangerous outcomes. She said LVN-L was responsible for the medication cart that was left unlocked the prior day. She said LVN-L did not give the medication cart keys to the oncoming charge nurse prior to ending his shift at 2:00 PM. She said he should have switched it out and given it to the next charge nurse. She said it was not his cart and it was a cart that belonged to Medication aide-M, but the key was handed over to him after her count and ending her shift. She said Medication aide-M counted the medications with LVN-L and handed keys over to him. She said regularly medication aides will count with her at the end of their shifts, but she was busy yesterday, and Medication aide-M made the decision to do the count and hand over the medication cart keys to LVN-L, which occurs at times. She said some medication aides will finish their shift early and count out with the charge nurse for their hallway. She said no medications were taken by residents, but she understands there could be harm if this occurs in the future. She said she counseled LVN-L on the importance of securing medication carts. In an interview on 2/20/2026 at 2:01 PM LVN-L said he has been provided training and in-serviced on medication administration and securing medications. He said normally medication aids will count and hand off medication cart keys to the oncoming medication aid. He said if there is an issue with the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	count he would be notified. He said yesterday's shift he did not have an oncoming medication aide prior to the end of his shift so he was responsible for the end of shift count with Medication aide-M, and he had taken the medication cart keys from her. LVN-L said he was then responsible to hold onto the medication cart key until the next medication aide or charge nurse completes shift change and he hands the key over to them. He said all medication aids and charge nurses are responsible for securing the medication carts, and they should always be locked. He said if medication carts stay open medications could go missing. He said if the medications go missing the residents will not be able to get their medications and residents will have a very bad afternoon and night and be uncomfortable. He said he was made aware that he had left the medication cart open and unlocked the previous day. He said the ADON counseled him on this incident, and he did receive a write up. LVN-L said he will be more diligent with medication carts and ensure they are secure during his shift and at the end of each shift. Record review of the facility policy titled, Medication Storage dated 1/2026, reflected the following: Purpose To establish standards that safeguard residents by preventing unauthorized access to medications and ensuring compliance with applicable federal and state pharmacy regulations. Policy Medication carts must remain locked and always secured unless under direct and continuous supervision of authorized personnel during medication administration. These standards are required to ensure resident safety and regulatory compliance. Procedure Scope This policy applies to all licensed nurses, medication aides (where permitted, pharmacy staff, providers, and facility leadership. Security & Access Medication rooms, carts, and cabinets must remain locked at all times. Access is restricted to, authorized, licensed staff. Carts must be locked whenever they are not actively attended. 1. Locking Requirements The medication cart must be locked: When entering a resident's room (if the cart remains in the hallway) When turning away from the cart. Direct Observation Standard: A cart may remain unlocked only when it is continuously within the authorized staff member's direct, unobstructed line of sight, without requiring significant head turning or repositioning. 2. Key Control Requirements Key Security – Keys must always remain on the authorized staff member's person. – Keys must never be left in the cart lock, placed on the cart, left on surfaces, given to unlicensed personnel, or left unattended.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder and bowel received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Resident #4) reviewed for incontinence care. When LVN-A was providing incontinent care to Resident #4 on 02/19/2026, LVN-A did not clean the resident's left side area of buttock. These failures could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: Record review of Resident #4's face sheet, dated 02/20/2026, revealed Resident #4 was a [AGE] year old male, admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with the diagnoses of epilepsy (happens as a result of abnormal electrical brain activity also known as a seizure), obstructive and reflux uropathy (a blockage in urinary tract), benign prostatic hyperplasia (prostate to increase in size), and down syndrome (genetic condition caused when an unusual cell division). Record review of Resident #4's Medicare-5 days MDS, dated [DATE], revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment, and the resident was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to sit to stand, chair to bed transfer, and toilet transfer. Further record review of the MDS indicated Resident #4 had urinary indwelling catheter and was always bowel incontinent. Record review of Resident #4's comprehensive care plan, dated 07/06/2023, revealed the resident had the care plan of Check the resident frequently and as required for incontinence. Wash, rinse, and dry perineum. Change clothing as needed after incontinence episodes and check tubing for kinks and maintain the drainage bag off the floor for urinary indwelling catheter. Observation on 02/19/2026 at 2:27 p.m. revealed LVN-A washed her hands with water, put on gloves and gown, opened the old and dirty brief of Resident #4, then cleaned the resident's penis with a circular motion, right and left groin area, and scrotum area. LVN-A turned Resident #4 to side and cleaned the resident's rectum area because the resident had bowel movement and right buttock area, then put new and clean brief under the resident after changing gloves to new one without cleaning left buttock area of the resident. Interview on 02/19/2026 at 2:36 p.m. with LVN-A she stated she did not clean Resident #4's left buttock area. Further interview with LVN-A she said she was very nervous, so she forgot cleaning Resident #4's left buttock area, and the resident's left buttock was visually clean. LVN-A stated she should have cleaned the resident's left buttock area to prevent possible infection even though the area was visually clean. Interview on 02/19/2026 at 3:36 p.m. with DON stated LVN-A should have cleaned Resident #4's left buttock area even though the area was visually clean per the facility policy to prevent possible infection. Record review of the facility policy, titled Perineal Care, revised 06/2020, revealed . VII. Turn resident to side. VIII. Wash, rinse and dry buttocks and peri-anal area without contaminating perineal area.

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	455762	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio Wellness & Rehabilitation	1 Heartland Drive San Antonio, TX 78247

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 (Resident #6) of 1 resident reviewed for intravenous fluids. LVN-B flushed the medication port of Resident #6's central line (inserted central catheter: used to deliver medications and other treatments directly to the large central veins near the heart) with 10 ml normal saline when administering antibiotic dose. However, the physician order said, Flush IV (intravenous) line with 5 ml normal saline before and after medication administration. This failure could affect residents by placing them at risk for receiving diluted medication. Findings included: Record review of Resident #6's face sheet, dated 02/20/2026, revealed the resident was a [AGE] year-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of acute hematogenous osteomyelitis (infection that primarily affects the most vascularized regions of the growing skeleton), sepsis (the body's extreme response to an infection), peripheral vascular disease (slow and progressive disorder of the blood vessels), and dysphagia (difficulty in swallowing). Record review of Resident #6's significant change MDS assessment, dated 01/24/2026, revealed the resident's BIMS score was 0 out of 15 which indicated the resident had severe cognitive impairment, and the resident was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) to chair to bed transfer. Further record review of the MDS assessment revealed the resident had intravenous therapy. Record review of Resident #6's comprehensive care plan, dated 02/26/2025, revealed The resident is on intravenous antibiotic therapy related to osteomyelitis. For intervention - administer medications as ordered. Record review of Resident #6's physician order, dated 01/21/2026, revealed flush intravenous line with 5 ml normal saline before and after medication administration Further record review of the physician order revealed Meropenem intravenous solution reconstituted 500 mg - use 500 mg intravenously every 6 hours for wound infection for 38 days. Observation on 02/19/2026 at 11:11 a.m. revealed Resident #6 had two lumens of central line (one was for medication port, and the other was for blood port) for intravenous therapy. LVN-B hung Resident #6's Meropenem 500 mg intravenous solution to a pole and flushed one lumen for medication port of the resident's central line with 10 ml normal saline, then connected the medication to the lumen for medication port. Interview on 02/19/2026 at 1:25 p.m. with LVN-B she stated she flushed the lumen for medication port of Resident #6's central line with 10 ml normal saline when administering the antibiotic dose. LVN-B said she thought the physician order said to flush 10 ml normal saline before and after medication, but the physician order said, flush intravenous line with 5 ml normal saline before and after medication administration. Further interview with LVN-B said she should have flushed the lumen with 5 ml normal saline as ordered to prevent possible damage of the central line. Interview on 02/19/2026at 3:36 p.m. with DON said LVN-B should have flushed the lumen with 5 ml normal saline before administering the antibiotic to Resident #6 because the physician order said, flush intravenous line with 5 ml normal saline before and after medication administration, flushing central line and following the physician order was nurse's responsibility, and it might cause some damage to the central line. Record review of the facility policy, titled Flushing guidelines for peripheral venous catheter, revised 02/2019, revealed 1. Peripheral intravenous catheter will be flushed prior to each infusion to assess catheter patency and function, and after each infusion to clear the catheter lumen of medication and to prevent contact between incompatible medications

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice for 1 (Residents #77) of 4 residents reviewed for respiratory care. Resident #77's CPAP (continuous positive airway pressure) mask was not covered in a plastic bag when it was not used on 02/17/2026. This failure could affect residents with oxygen therapy and could lead them to lack of care including possible infection by not following infection control.The findings included: Record review of Resident #77's face sheet, dated 02/20/2026, revealed the resident was a [AGE] year-old female and originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of cellulitis of left lower limbs (skin infection), chronic pulmonary embolism (sudden blockage in a lung artery), anemia (not enough red blood cells), and sleep apnea (breathing stops and restarts many times while sleeping). Record review of Resident #77's Medicare-5 days MDS assessment, dated 02/13/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognition was intact and had non-invasive mechanical ventilator, which was CPAP (continuous positive airway pressure). Record review of Resident #77s physician order, dated 02/10/2026, revealed the resident had the order of apply CPAP (continuous positive airway pressure) at night and as needed at bedtime for sleep apnea. Observation on 02/17/2026 at 10:27 a.m. revealed Resident #77 was on the bed and watching television in her room. Resident #77's CPAP (continuous positive airway pressure) mask connected to a machine was on the nightstand uncovered. Interview on 02/17/2026 at 10:28 a.m. with Resident #77 stated she was using her CPAP (continuous positive airway pressure) every night when she was sleeping. Interview on 02/17/2026 at 11:33 a.m. with LVN-B stated Resident #77's CPAP (continuous positive airway pressure) mask was on the nightstand without a plastic bag. Further interview with LVN-B said the resident's CPAP (continuous positive airway pressure) mask should have been covered in a plastic bag when it was not used to prevent possible infection. Interview on 02/19/2026 at 3:36 p.m. DON stated Resident #77's CPAP (continuous positive airway pressure) mask should have been covered in a plastic bag when it was not used to prevent possible infections. Record review of the facility policy, titled Oxygen Administration, revised 06/2020, revealed . III. Infection control. B. Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use.

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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 observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (400-500-600-hall medication aide cart) out of 6 medication carts and 1 (Resident #73) out of 3 residents reviewed for pharmacy services. 1. There was one bottle of Nutricia Pro-Stat expired 01/02/2026 found inside 400-500-600-hall medication aide cart on 02/18/2026. 2. Facility nurses opened Resident #73's insulin pen (Glargine-Lantus) on 01/07/2026 and used the insulin on 02/18/2026. However, the label of the insulin indicated Discard 28 days after opening, and 28th day was 02/04/2026. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: 1. Observation on 02/18/2026 at 1:40 p.m. revealed there was one bottle of Nutricia Pro-Stat found inside 400-500-600-hall medication aide cart, and the bottle of Nutricia Pro-Stat for increasing protein needs was expired on 01/02/2026. Interview on 02/18/2026 at 1:42 p.m. with Medication Aide-C confirmed there was one bottle of Nutricia Pro-Stat expired 01/02/2026 found inside 400-500-600-hall medication aide cart, and she opened it on 02/16/2026 and used it. The Medication Aide-C said she did not know what reason she did not check the expiration date when opening it, and she stated she usually checked expiration date whenever she passed medications to residents. Interview on 02/18/2026 at 1:43 p.m. with DON stated there was one bottle of Nutricia Pro-Stat expired 01/02/2026 found inside 400-500-600-hall medication aide cart, it was used for increasing protein needs, and medication aides should have discarded all expired medications. Further interview with DON said using expired medications might affect that residents did not have therapeutic effects, such as decreasing protein. 2. Record review of Resident #73's face sheet, dated 02/20/2026, revealed the resident was a [AGE] year-old female and admitted to the facility on [DATE] with diagnoses of muscle wasting and atrophy (loss of skeletal muscle mass), anemia (not enough red blood cells), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels). Record review of Resident #73's admission MDS assessment, dated 02/12/2026, revealed the resident's BIMS score was 10 out of 15 which indicated the resident had moderate cognitive impairment and received insulin injection for type 2 diabetes mellitus as ordered. Record review of Resident #73's comprehensive care plan, dated 02/03/2026, revealed the resident had the care plan of The resident has Diabetes Mellitus. For interventions - diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #73's physician order, dated 02/02/2026, revealed the resident had the order of Insulin Glargine (Lantus) Subcutaneous Solution Pen-injector 100 unit/ml - inject 10 unit subcutaneously at bedtime related to type 2 diabetes mellitus. Record review of Resident #73's medication administration record from 02/01/2026 to 02/28/2026 revealed the resident was receiving Insulin Glargine (Lantus) Subcutaneous Solution Pen-injector 100 unit/ml - inject 10 unit subcutaneously at bedtime related to type 2 diabetes mellitus every night at 08:00 p.m. as ordered. Observation on 02/18/2026 at 2:18 p.m. revealed there was one insulin Glargine (Lantus) Subcutaneous Solution Pen-injector 100 unit/ml inside 200-hall nursing cart, and on the Pen-injector open date was 01/07/2026. Further observation revealed the Pen-injector had label, and the label indicated Discard after 28 days once it was opened. Interview on 02/18/2026 at 2:18 p.m. with LVN-D said there was Resident #73's one insulin Glargine (Lantus) Subcutaneous Solution Pen-injector 100 unit/ml inside 200-hall nursing cart, and on the Pen-injector open date was 01/07/2026, and the label said, Discard after 28 days once it was opened. Further interview with LVN-D said facility nurses used the insulin every night and should have discarded it on 02/04/2026 because the date was 28th days after it was opened. Interview on 02/18/2026 at 2:29 p.m. with DON said facility nurses should (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have discarded Resident #73's one insulin Glargine (Lantus) Subcutaneous Solution Pen-injector 100 unit/ml on 02/04/2026 because the date was 28th days after it was opened per the label of the insulin Discard after 28 days once it was opened, and it might affect Resident #73 to not reach therapeutic effects. Record review of the facility policy, titled Medication-Administration, undated, revealed . V. Additional considerations include: . c. The Rule of 3 - the licensed nurse administering medications will perform 3 checks comparing the physician's order, pharmacy label, and medication administration record. ^

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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 observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 (Resident #106 and #132) of 24 residents reviewed for infection control practices. 1. Medication Aide-C measured Resident #106's blood pressure without cleaning the blood pressure cuff on 02/19/2026. 2. When CNA-F was providing peri care to Resident #132 on 02/19/2026, CNA-F changed her gloves without washing or sanitizing her hands. This deficient practice could place residents at risk for cross contamination and infections.The findings included: 1. Record review of Resident #106's face sheet, dated 02/20/2026, revealed the resident was a [AGE] year-old male and admitted to the facility on [DATE] with diagnoses of aftercare following amputation (removal of a body part), heart failure (the heart can't pump enough oxygen-rich blood to meet your body's needs), and type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels). Record review of Resident #106's admission MDS assessment, dated 01/08/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognitive was intact and was Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity) to chair to bed and toilet transfer. Record review of Resident #106's physician order, dated 01/05/2026, revealed Metoprolol Succinate Extended-Release Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for hypertension HOLD MEDICATION FOR Systolic Blood Pressure <110, Diastolic Blood Pressure<60, and/orHeart Rate < 60. NOTFIY MD IF HELD. DO NOT CRUSH OR CHEW.[sic] Observation on 02/19/2026 at 8:40 a.m. revealed Medication Aide-C came out from another resident's room with a blood pressure cuff and machine. Further observation revealed the medication aide opened the computer and entered Resident #106's room and measured the resident's blood pressure without cleaning the blood pressure cuff and machine. During an interview on 02/19/2026 at 8:42 a.m. with Medication Aide-C stated she measured Resident #106's blood pressure without cleaning the blood pressure cuff and machine that she already used on another resident. The medication aide said she should have cleaned the blood pressure cuff and machine before measuring Resident #106's blood pressure to prevent possible infection, and it was her mistake. 2. Record review of Resident #132's face sheet, dated 02/20/2026, revealed the resident was an [AGE] year-old female and admitted to the facility on [DATE] with diagnoses of cerebral infarction (disruption to blood supply that is sever enough and ling enough in duration to result in tissue death), type 2 diabetes mellitus (body does not insulin properly, resulting in high blood sugar levels), and hypertension (high blood pressure). Record review of Resident #132's admission MDS assessment was in progress because the resident was admitted to the facility on [DATE]. Record review of Resident #132's baseline care plan, dated 02/18/2026, revealed Monitor/document resident's abilities for Activity of Daily Livings and assist resident as needed. Encourage resident to do what he/she is capable of doing for self. Observation on 02/19/2026 at 10:30 a.m. revealed that while CNA-F was providing peri care to Resident #132, the CNA cleaned the resident's right and left groin area and genital area and turned the resident to side. Further observation revealed CNA-F changed her gloves without washing or sanitizing her hands and cleaned the resident's buttock and rectum area, then the CNA changed her gloves again without washing or sanitizing her hands. The CNA put the new brief under the resident and closed it. Interview on 02/19/2026 at 10:38 a.m. with CNA-F stated she just changed her gloves without washing or sanitizing her hands while she was providing peri care to Resident #132, and she said she should have washed or sanitized her hands whenever she changed her gloves to prevent infection. Interview on 02/19/2026 at 3:36 p.m. with DON said Medication Aide-C should have cleaned the blood pressure cuff and machine before using it to Resident #106, and CNA-F should have washed or sanitized her hands whenever she changed her gloves to prevent (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection. Record review of the facility policy, titled Infection Prevention and Control Program, undated, revealed the ensure the facility establish and maintains an infection control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirement. Further record review of the facility policy, titled Perineal care, undated, revealed XII. Remove gloves. Wash hands or use alcohol-based hand sanitizer. XIII. Put on clean gloves.