STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455817	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio North Nursing and Rehabilitation	501 Ogden San Antonio, TX 78212

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to 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 (Resident #1) of 8 residents reviewed for medications. Facility nurses did not update Resident #1's physician order regarding Acetaminophen Capsule 500 mg - Give 2 capsules by mouth three times a day for chronic pain - Give with Tramadol when the resident's primary care physician changed the resident's Tramadol from schedule medication to PRN (as needed for pain) medication on 06/04/2026. This failure could place the residents at risk of not receiving therapeutic doses of their medication. Findings included:Record review of Resident #1's face sheet, dated 06/23/2026, revealed the resident was a 66-years-old female and admitted to the facility on [DATE] with diagnosis of chronic systolic heart failure (specific type of heart failure that occurs in the heart's left ventricle), peripheral vascular disease (slow and progressive disorder of the blood vessels), and non-pressure chronic ulcer of other part of right and left lower legs (persistent open sore that develops due to factors other than prolonged pressure). Record review of Resident #1's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident cognitive was intact, and in Section M (Skin conditions), it was coded that Resident #1 had venous and arterial ulcers to the resident's right and left leg. Further record review of the MDS revealed the resident had frequently limited day-to-day activities because of pain in Section J (Health Conditions). Record review of Resident #1's comprehensive care plan, dated 09/15/2025, revealed as follows:[Resident #1] had altered skin integrity non-pressure related to vascular wound left and right lower leg. For intervention, treatment as order PRN (as needed) wound treatment is available for wound care. [Resident #1] has acute/chronic pain related to headache, history of left hip and knee fracture, and vascular wounds. For intervention, administer analgesia as per orders. Record review of Resident #1's physician order, dated 04/09/2026, revealed the resident had the order of Acetaminophen Capsule 500 MG (Acetaminophen) - Give 2 capsule by mouth three times a day for Chronic Pain DO NOT GIVE MORE THAN 3GM/24HR PERIOD - Give with Tramadol. Further record review of the physician order revealed the physician changed the resident's Tramadol from traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth three times a day for Chronic Pain to traMADol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours as needed for chronic pain on 06/03/2026. Interview on 06/25/2026 at 2:28 p.m. with MA-A said she did not give Resident #1's Tramadol with Acetaminophen anymore because the order of Tramadol was changed from scheduled to PRN (as needed) on 06/03/2026, and she told to the nurses that the order of Acetaminophen 500 MG give 2 capsule three times a day with tramadol should have been changed or updated to Acetaminophen 500 MG give 2 capsule three times a day, and the nurse said they would contact the resident's physician. Interview on 06/25/2026 at 2:11 p.m. with LVN-B stated the resident's order of Acetaminophen 500 MG give 2 capsule three times a day with tramadol should have been changed or updated to Acetaminophen 500 MG give 2 capsule three times a day because the resident's doctor changed the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's Tramadol from schedule to PRN (as needed), and the LVN-B said he did not know what reason the facility nurses, including himself, did not update the order, and physician order should have been updated accurately to prevent possible medication errors. Interview on 06/25/2026 at 2:32 p.m. with the DON said facility nurses should have updated Resident #1's Acetaminophen and Tramadol accurately to prevent possible medication errors, such as nurses might give Tramadol with Acetaminophen. Record review of the facility policy, titled Maintenance of Electronic Clinical Records, revised 5/16/2025, revealed This facility will maintain electronic clinical records for each resident in accordance with acceptable standards of practice. 1. A complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized for appropriate personnel to deliver the appropriate level of care for each resident while maintaining the confidentiality of the residents' information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 2 (Resident #1 and #2) out of 8 residents reviewed for medical records in that: 1. Facility wound care nurse did not document in Resident #1's treatment administration record and nursing progress note on 06/02/2026 scheduled wound care date. 2. Facility staff did not document details of a facility reported incident that reportedly occurred on 6/8/2026 at 10:10am in Resident #2's electronic health record. Theses failures could place residents at risk for missed treatment and medications which could result in decline in healing and well-being. Findings included:1. Record review of Resident #1's face sheet, dated 06/23/2026, revealed the resident was a 66-years-old female and admitted to the facility on [DATE] with diagnosis of chronic systolic heart failure (specific type of heart failure that occurs in the heart's left ventricle), peripheral vascular disease (slow and progressive disorder of the blood vessels), and non-pressure chronic ulcer of other part of right and left lower legs (persistent open sore that develops due to factors other than prolonged pressure). Record review of Resident #1's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident cognitive was intact, and in Section M (Skin conditions), it was coded that Resident #1 had venous and arterial ulcers to the resident's right and left leg. Further record review of the MDS revealed the resident had frequently limited day-to-day activities because of pain in Section J (Health Conditions). Record review of Resident #1's comprehensive care plan, dated 09/15/2025, revealed as follows:[Resident #1] had altered skin integrity non-pressure related to vascular wound left and right lower leg. For intervention, treatment as order PRN (as needed) wound treatment is available for wound care. [Resident #1] has acute/chronic pain related to headache, history of left hip and knee fracture, and vascular wounds. For intervention, administer analgesia as per orders. Record review of Resident #1's physician order, dated 03/27/2026, revealed the resident had the order of Clean with wound cleanser, pat dry, Apply triamcinolone cream to right and left low leg, topically every Tuesday and Friday for venous stasis ulcers, wrap with kerlix, wrap with ace bandage twice weekly until resolved every day shift every Tuesday and Friday. Record review of Resident #1's Treatment Administration Record from 06/01/2026 to 06/30/2026 revealed the resident received wound care as ordered, except 06/02/2026 (Tuesday) which was blank without any nurse's initial or document. Record review of Resident #1's nursing progress note on 06/02/2026 revealed there was no nursing note on the progress notes. Interview on 06/24/2026 at 12:30 p.m. with the nurse practitioner for wound care said she provided wound care to Resident #1 on 06/03/2026 (Wednesday) when she visited the facility for assessing the resident's wound, and providing wound care on 06/03/2026, instead of 06/02/2026, was fine. Interview on 06/25/2026 at 2:32 p.m. with the DON said the wound care nurse on 06/02/2026 did not document anything to the resident's treatment administration record and nursing progress note and left blank, and the wound care nurse did not work anymore since 06/03/2026 at the facility. The wound care nurse did not show up for work since 06/03/2026 with private reason, and the facility could not contact the wound care nurse anymore. The DON stated she did not know if the wound care nurse provided wound care to the resident on 06/02/2026 as ordered or not because of no documents in the resident's medical record, but the nurse practitioner for wound care visited and provided wound care on 06/03/2026. The DON said the wound care nurse should have documented something on the treatment administration record or nursing progress note such as the nurse's initial if the nurse provided wound care successfully or resident refused wound care, and documenting accurately was very important because inaccurate documenting might affect inappropriate cares, such as missing wound care or over doses of wound care. 2. Record review of Resident #2's face sheet dated 6/24/2026 revealed an [AGE] year old male (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted on [DATE] with diagnoses which included: senile degeneration of the brain (condition affecting memory, reasoning and ability to perform everyday activities), dementia (impaired ability to think, remember or make decisions due to brain cell damage), depression (mood disorder causing feelings of sadness and loss of interest), anxiety (condition in which a person has excessive worry and feelings of fear, dread or uneasiness) and violent behavior. Record review of Resident #2's care plan, printed 6/24/2026 indicates focus of at risk for behaviors r/t demonstrates physically abusive behaviors. Hx of him throwing chair at staff, grabbing med cart and trying to rip computer off, throwing items off cart, trying to hit staff with fork. Date initiated: 06/03/2026, Revision on: 06/08/2026. There is a corresponding goal of will not demonstrate physically abusive behaviors through next review date Date initiated: 06/03/2026, Target date: 06/21/2026. Interventions include documenting physically abusive behaviors in the clinical record which is dated 06/03/2026. Record review of Form 3613-A (Provider Investigation Report) faxed to complaint and incident intake department dated 6/15/2026 indicated that there was an incident involving Resident #2 and another resident on 6/8/2026 at 10:10am. The investigation documentation reviewed includes an assessment section that lists a description of the physical assessment performed, treatment provided, provider response and immediate interventions provided. Record review of Resident #2's electronic health record progress notes revealed documentation of an interdisciplinary team meeting held on 6/10/2026 at 9:47am to discuss the resident-to-resident altercation involving Resident #2 pushing his roommates wheelchair - roommate then made contact with (Resident #2). Root cause analysis and effectiveness of interventions were also documented within this note. Record review of progress notes for Resident #2 from 6/8/2026-6/24/2026 did not reveal documentation in the electronic health record about the details of facility reported incident that had occurred on 6/8/2026 at 10:10am. During an interview with the DON on 6/25/2026 at 2:38pm, the DON verified that the interdisciplinary team had met on 6/10/2026 to discuss the incident involving Resident #2 that had occurred on 6/8/2026 at 10:10am and verified that this was documented in the electronic health record. DON attempted to locate documentation of the 6/8/2026 incident in the electronic health record then stated that it was not present. She did not name who was responsible for the missed documentation and stated that the nurse must have forgotten to document the incident with so much going on with the resident and due to his discharge shortly thereafter. She stated that the incident should have been documented so that the resident's medical records would be complete and accurate. Record review of the facility policy, titled Maintenance of Electronic Clinical Records, revised 5/16/2025, revealed This facility will maintain electronic clinical records for each resident in accordance with acceptable standards of practice. 1. A complete and accurate electronic clinical record will be maintained on each resident and kept accessible and systematically organized for appropriate personnel to deliver the appropriate level of care for each resident while maintaining the confidentiality of the residents' information.