

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Inspiration Hills Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1939 Bandera Rd San Antonio, TX 78228	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 4 residents (Resident #1) reviewed for care plans: The facility failed to ensure Resident #1's comprehensive care plan was completed in a timely manner and included behaviors she had refusing care or being combative during care. This deficient practice could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. The findings included: The findings included: Record review of Resident #1's admission record, dated 11/26/25, revealed a [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses including lack of coordination, dementia, and adult failure to thrive. Record review of Resident #1's admission MDS assessment, dated 11/07/25, revealed Resident #1's cognition was severely impaired. Record review of Resident #1's Comprehensive Care Plan, initiated on 11/01/25, last revised on 11/18/25, did not contain a focus or interventions for when the resident became combative during care. Record review of Resident #1's progress note, dated 11/05/25, stated .Pt (patient) aggressive with staff, pending psych eval. written by the physician. Record review of Resident #1's progress note, dated 11/05/25, stated Resident refused a.m shower. Multiple attempts made x3 to shower resident. Final attempt to shower resident continued to refuse and became combative by scratching and punching staff members. RP was notified, vm left. Plan of care continues. Written by RN A. Record review of Resident #1's progress note, dated 11/07/25, stated Resident refused scheduled showers for a.m shift. Multiple attempts made x3 to get resident to comply with showers but was unsuccessful. Resident did comply with peri-care after multiple attempts. RP was notified, VM left. No distress noted. Plan of care continues. Written by RN A. Record review of Resident #1's progress note, dated 11/12/25, stated RP returned phone call to this nurse. RP stated that resident was resistant of care and forcefully pulling hands away when RP was attempting to provide nail care and trim residents very long nails. RP stated resident pulled her hands away several times and in the process hit herself in the face. RP was notified of the bruise to this residents face as well as the skin tear to residents hand. Resident denies pain when asked and shows no signs of distress. She is resting peacefully in bed at this time. Written by MDS Coordinator. Record review of Resident #1's psych noted, dated 11/12/25, stated Staff report Patient is aggressive, combative during care. She is refusing her PO meds. She is not eating good as well. [AGE] year-old female with h/o Dementia with agitation. Written by PMHNP C. Record review of Resident #1's progress note, dated 11/12/25, stated Resident refused scheduled shower. Multiple attempts made by staff to shower but was unsuccessful. Bed bath was offered and was also refused. Written by RN A. Record review of Resident #1's progress note, dated 11/24/25, stated This nurse was doing treatment; resident was combative with this nurse and CNA that was helping. Resident scratched, hit and bit this nurse, and was hitting CNA. Dressing was changed and intact. Told residents nurse to monitor behaviors. Written by Treatment Nurse B. During an interview on 11/26/25 at 2:32 p.m. Treatment Nurse B stated Resident #1 was sometimes not calm during care and would fight staff. She stated 2 staff went into the residents room for care. She stated the aides would call the nurse to come talk to the resident if she was refusing care like a shower and if she became combative they would stop care and return at a later time to try again. She stated the resident had recently bit and scratched her. The nurse raised her arm to show a purplish raised area on her forearm. During an interview on 11/26/25 at 3:00 p.m. Resident #1's RP stated she was a difficult patient because she will scratch and lash out at staff. Resident #1's RP stated she does a lot of self-inflicting scratches due to her long nails and behaviors. Resident #1's RP stated she experienced trauma in the past, had anxiety, and would pick at herself or lash out. The RP stated they would redirect Resident #1 and ask her to rub her hands to warm them up instead. During an observation on 11/26/25 at 3:16 p.m. Resident #1 was laying in bed scratching her arm, constantly rubbing her arms together, and picking under her nails. During a joint interview on 11/26/25 at 4:15 p.m. The SW and the MDS Coordinator stated they would normally complete a care plan meeting and comprehensive care plan for residents within 21 days of them being admitted to the facility. They stated they added a focus area on 11/26/25 day for the resident resistance to care and behaviors because they had not done it prior and should have. They stated there was an incident on 11/12/25 where the resident was being combative and hit</p>		