STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675138	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inspiration Hills Rehabilitation Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident #41) reviewed for accident hazards and supervision.The facility failed to ensure Resident #41's floor mat was in place.This failure could place residents at risk for falls with the possibility of injury.Findings included:Record review of resident #41's face sheet, dated 06/02/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included unilateral primary osteoarthritis, right knee (a progressive condition characterized by cartilage degeneration, joint space narrowing and decreased function), Alzheimer's disease (a type of dementia that affects memory, thinking and behavior), unspecified fractures of the lumbar vertebra (lower back bones), shaft of left arm humerus (upper arm bone), and right femur (thigh bone).A record review of resident 41's quarterly MDS dated [DATE] revealed a BIMS of 5, indicating severe cognitive impairment.A record review of resident 41's comprehensive care plan dated 06/03/2026, revealed: resident #41 at risk for falls r/t difficulty walking, I fell on [DATE],11/8/22,06/13/23,8/18/23, 2/1/25, 4/24/26, including interventions: Anticipate and meet my needs, and May use fall mat while in bed. A record review of resident #41's order summary dated 06/04/2026 revealed: 1-2 floor mat(s) to be placed while in bed for safety, active, ordered 03/25/2026. Observations of resident #41 revealed there were no floor mats placed next to bed on 06/01/2026 at 10:30AM, 06/02/2026 at 11:00AM, 06/03/2026 at 9:15AM, and 06/04/2026 at 7:25AM while resident #41 was in bed. During an interview with CNA D on 06/03/2026 at 10:05am, CNA D stated she receives instruction from the charge nurse about individual fall interventions for residents such as fall mats. CNA D stated if a fall mat was not available for a resident, she would let the nurse know. CNA D stated she was not aware that resident #41had an order for a fall mat.During an interview with CNA E on 6/03/2026 at 10:10am, CNA E stated she was not aware of resident #41needing a fall mat. CNA E stated fall interventions are communicated to them by the nurse.During an interview with LVN B on 06/03/2026 at 4:05PM, LVN stated she was not aware that resident #41 was supposed to have a fall mat. LVN stated the resident #41 has not had a fall recently. LVN B stated she can refer to resident orders and care plans to see their fall interventions and communicate them to the CNA staff.During an interview with LVN A on 06/04/2026 at 11:05AM, LVN A stated that the interventions in place for resident #41 included a low bed and fall mat. LVN stated the charge nurses communicate to the CNAs when a fall mat is ordered. LVN stated he did not know why the fall mat was not in place for resident [NAME] on previous days. During an interview with DON on 06/04/2026 at 7:10AM, DON stated the fall interventions for resident #41 included a call light in reach, bed in low position, and she was unsure if there was an order for a fall mat, but if there was, a fall mat should be in place. During an interview with DON on 06/04/2026 at 10:45am, DON stated the importance of following care plan interventions to decrease risk of injury. DON stated the interventions such as fall mats are communicated to CNA staff by the charge nurses and the charge nurses follow the orders and the care plans.A record review of policy titles Fall and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Inspiration Hills Rehabilitation Center	1939 Bandera Rd San Antonio, TX 78228

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall Risk, Managing, dated 12/2022: 6. In conjunction with the Attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling.

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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 - Some	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** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals) for 1 of 1 resident (Resident #32) to meet the needs of the resident, in that: The facility failed to discontinue Resident #32's order for Zyprexa 10mg when order was changed to 5mg daily resulting in resident #32 receiving the wrong dose x11 days.This failure could place residents at risk of injury by not receiving medications as ordered by the physician. The findings include:A record review of resident #32's face sheet revealed an admission date of 09/18/2020 with diagnosis of Psychotic Disorder (severe mental disorders that cause abnormal thinking and perceptions) with Hallucinations (false perceptions such as hearing, seeing, or feeling something that is not here) due to known physiological condition. A record review of resident #32's MDS dated [DATE] revealed resident is rarely/never understood indicating severely impaired cognition. A record review of resident #32's care plan dated 6/02/2026 revealed: I use psychotropic medication, interventions: Consult with pharmacy, MD to consider dosage reduction when clinically appropriate, Discuss with MD, family re ongoing need for use of medication, educate me/family/caregivers about risks, benefits and the side effects, Record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles,shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. A record review of resident #32's pharmacy recommendation which stated resident #32 has orders for Zyprexa 10mg in the evening for hallucinations. Please review and consider if a Gradual Dose Reduction could be considered for the order to Zyprexa 5mg in the evening, with written physician response Decrease Zyprexa to 5mg in the evening, and signed by physician, dated 5/22/2026. A record review of resident #32's Active Order Summary Report dated 06/02/2026 revealed: Zyprexa Oral tablet 5mg, Give 1 tablet by mouth in the evening, active, start date 5/22/2026, and Zyprexa tablet 10mg, Give 1 tablet by mouth in the evening for hallucinations, active, start date 10/16/2024. A record review of resident #32's MAR in the electronic medical record revealed Zyprexa 5mg and Zyprexa 10mg had been administered daily beginning 05/22/2026 until a clarification order was entered on 06/03/2026. During an interview with LVN A on 06/04/2026 at 1:15PM, LVN stated he received the order for a gradual dose reduction for resident #32's Zyprexa on 5/22/2026. The order was given by physician to decrease the dose from 10mg to 5mg in response to a pharmacy recommendation. LVN A stated he called resident #32's hospice provider to notify of the order change and was given approval to change the order. LVN A stated he entered the new order for Zyprexa 5mg and thought he discontinued the previous order for 10mg. LVN A stated he does not know why the order for Zyprexa10mg did not show as discontinued. LVN A stated he was not aware the order for Zyprexa 10mg still existed on the MAR and that the 10mg dose was still being given. LVN A stated that if he became aware of a medication error, he would notify the DON to take care of it. LVN A stated he has been educated on medication administration.A record review of resident #32's progress note dated 5/22/2026 at 11:13am documented by LVN A read: decreased Zyprexa per MD, hospice aware.During an interview with the DON on 06/03/2026 at 4:10PM, the DON stated that the charge nurse is responsible to enter new orders into the MAR. The DON acknowledged the gradual dose reduction order for resident #32 and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she would get clarification about the medication dosage. During an interview with the DON on 06/03/2026 at 5:33PM, the DON stated she spoke to resident #32 hospice provider and the Zyprexa was to be increased to 15mg daily. The DON did not know the rationale for the order. During an interview with the DON on 06/04/2026 at 7:10AM, the DON provided a physician order from hospice to continue administering the dose of Zyprexa 15mg to resident #32, order dated 06/03/2026 at 5:38pm stating patient currently tolerating 15mg dose and should continue. Record review of policy titled Administering Oral Medications, dated 12/2025: Purpose: The purpose of the procedure is to provide guidelines for the safe administration of oral medications. 1. Verify that there is a physician's medication order for this procedure.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rates are not 5 percent (%) or greater. The facility had a medication error rate of 32% based on 8 out of 25 opportunities which involved two (2) of five (5) residents (Resident #2 and Resident #3), and one (1) of three (3) staff (MA A) observed for medication administration errors. 1. MA A administered medications to Resident #2 on 06/02/2026 at 10:30 a.m., 30 minutes after the scheduled administration window of 08:00 a.m. to 10:00 a.m. 2. MA A administered medications to Resident #3 on 06/02/2026 at 10:40 a.m., 40 minutes after the scheduled administration window of 08:00 a.m. to 10:00 a.m. These failures could place residents at risk of not receiving therapeutic effects from the medications and possibly experiencing adverse reactions. 1. Record review of Resident #2's admission Record, dated 06/02/2026, reflected an [AGE] year-old male, admitted [DATE]. Diagnoses included unspecified dementia(symptoms affecting memory, thinking and social abilities), hypertensive heart disease(chronic uncontrolled high blood pressure, which increases the workload on the heart), atherosclerosis of aorta(the accumulation of plaque-composed of fat, cholesterol, calcium, and other substances-within the inner walls of the aorta, the largest artery in the body) and embolism(Clot or embolic material travel through the bloodstream from another site and lodges in an artery) and thrombosis of arteries of extremities(when a blood clot forms locally inside an artery, blocking blood flow. Record review of Resident #2's Order Summary Report, printed 06/02/2026 with active orders for 06/02/2026, reflected the following order summaries: Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablets by mouth two times a day for pain management*give 2 tablets to equal 650mg* DO NOT EXCEED MORE THAN 3GM OF ACTEMINOPHEN FROM ALL SOURCES WITHIN 24HRS* Warfarin Sodium Oral Tablet 2mg (Warfarin Sodium) Give 1 tablet by mouth one time a day for DVT prevention Atenolol Oral Tablet 50MG (Atenolol) Give 1 tablet by mouth two times a day for HTN *hold if b/p <110/60 or HR <60* Enalapril Maleate Oral Tablet 10mg (Enalapril Maleate) Give 1 tablet by mouth one time a day for HTN *HOLD IF B/P <110/60 OR HR ,60* Record review of Resident #2's 06/01/2026 - 06/30/2026 Medication Administration Record, printed 06/02/2026, reflected the following orders with scheduled administration time (Hours): Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablets by mouth two times a day for pain management*give 2 tablets to equal 650mg* DO NOT EXCEED MORE THAN 3GM OF ACTEMINOPHEN FROM ALL SOURCES WITHIN 24HRS* Administer at 9:00am and 6:00pm Warfarin Sodium Oral Tablet 2mg (Warfarin Sodium) Give 1 tablet by mouth one time a day for DVT prevention Administer at 9:00am Atenolol Oral Tablet 50MG (Atenolol) Give 1 tablet by mouth two times a day for HTN *hold if b/p <110/60 or HR <60* Administer at 9:00am and 6:00pm Enalapril Maleate Oral Tablet 10mg (Enalapril Maleate) Give 1 tablet by mouth one time a day for HTN *HOLD IF B/P <110/60 OR HR ,60* Administer at 9:00am During an observation of medication administration and interview on 06/02/2026 from 10:30 a.m. to 10:36 a.m., MA A was observed to start preparing Resident #2's medications for administration at 10:30 a.m. On MA A's electronic medication administration record screen, Resident #2's Tylenol, Atenolol, Enalapril and Warfarin were all observed to be highlighted red and scheduled for administration at 09:00 a.m. MA A was observed to administer Resident #2's medications at 10:36 a.m. MA A stated that Resident #2's medications were due at 9:00 a.m. She stated But I don't get here until 9. When asked how late administration could impact the resident she stated that it depends but generally there is no effect since the next dose will be given an hour later as well. 2. Record review of Resident #3's admission Record, dated 06/02/2026, reflected a [AGE] year-old female admitted to facility 4/16/2026. Diagnoses included hypertensive heart disease, major depressive disorder, anxiety and chronic joint pain Record review of Resident #3's Order Summary Report, dated 06/02/2026 with active orders as of 06/02/2026, reflected the following order summaries: - Norvasc Oral Tablet 5 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day for HTN. - Cymbalta Oral Capsule Delayed Release (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sprinkle 20mg (Duloxetine HCL) Give 1 capsule by mouth one time a day for anxiety.- Gabapentin 300mg Oral Capsule Give 1 capsule by mouth three times a day for nerve pain.- Gemtesa Oral Tablet 75mg. Give 1 tablet by mouth one time a day related to overactive bladder. Record review of Resident #3's 06/01/2026 - 06/30/2026 Medication Administration Record, printed 06/02/2026, reflected the following orders with scheduled administration time (Hours): - Norvasc Oral Tablet 5 MG (Amlodipine Besylate) Give 1 tablet by mouth one time a day for HTN. Administer at 9:00 a.m.- Cymbalta Oral Capsule Delayed Release Sprinkle 20mg (Duloxetine HCL) Give 1 capsule by mouth one time a day for anxiety. Administer at 9:00 a.m.- Gabapentin 300mg Oral Capsule Give 1 capsule by mouth three times a day for nerve pain. Administer at 9:00 a.m., 1:00 p.m., 5:00 p.m.- Gemtesa Oral Tablet 75mg. Give 1 tablet by mouth one time a day related to overactive bladder. Administer at 9:00 a.m. During an observation of medication administration on 06/02/2026 from 10:36 a.m. to 10:40 a.m., MA A was observed to start preparing Resident #3's medication administration at 10:36 a.m. On MA A's electronic medication administration record screen, Resident #3's Amlodipine, Duloxetine, Gabapentin and Gemtesa were observed to be highlighted red and scheduled for administration at 09:00 a.m. MA A was observed to administer Resident #3's medications at 10:40 a.m. During an interview on 06/04/2026 at 2:30 p.m., LVN C stated that she was trained about medication administration policies in her new hire training. She stated that 9am medications can be given from 8am to 10am but if the medication is a scheduled narcotic it cannot be given earlier than the time stated in the order. If a medication is given late, she would need to contact the MD and get a one time order to administer the medication at the later time. She would also be required to notify the DON as well as the family/RP. During an interview on 06/04/2026 at 3:07 p.m., LVN B stated that she had received training regarding medication administration, but it's been awhile. She said that she was instructed about the 5 rights and the need to double check orders. In regard to medication administration times, she stated that the staff is to administer medications no earlier than one hour before or one hour after the ordered/scheduled time. If medications are late, she is supposed to notify the DON, ADON, MD and family. The purpose of giving medications at the correct time is to prevent complications, as some medications are fast acting. During a joint interview on 6/4/2026 with facility DON and ADON, DON stated that education is provided to staff regarding medication administration times. Per DON, medications can be given one hour before or one hour after the scheduled time. If administration time is outside of that, they need to let the provider know why and get clarification on the orders. If medications are given late and more than one dose is ordered for the day, the resident could be either overdosed or underdosed. If a staff member is giving medications outside of the administration times, they should notify DON or ADON, the MD and family. DON stated that there are 3 or 4 staff members available to assist, so staff should ask for help if there is a risk of passing medications outside of the acceptable times. Record review of facility's policy titled, Administering Oral Medications, dated December 2025, revealed no specific policy regarding medication administration times. Requested the Administering Medications policy referenced within this policy and the Facility Administrator stated that they do not have this policy.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food storage, preparation, and distribution. The facility failed to ensure food in refrigerators and freezers were labeled or dated and canned foods were not dented and damaged. This failure could place residents at risk for health complications, foodborne illnesses, and decreased quality of life.The findings included:During an observation and interview on 06/01/2026 at 9:10 a.m., the initial kitchen tour revealed food items in the commercial refrigerator and freezers were uncovered, unlabeled, and undated and canned foods were dented and damaged. The 102-ounce canned mangos and canned pineapples contained deep dents, deep enough to lay a finger in, the commercial freezer contained a pot roast partially unwrapped, unlabeled, and undated with freezer burn. The Dietary Manager stated she was not sure why canned foods were not labeled with date the supplier delivered them. She stated she was new in this role, for four weeks, and she had been educating dietary staff to understand the importance of labelling foods. She stated she did not know why dented cans of fruit were on the rack and she was observed removing them during the initial tour. She stated that the dented cans should have been removed from the rack and put in the trash. She stated she does not return the cans dented to the supplier as there was a long delay and process to have food replaced and she opted to throw it out completely. She stated the dietary staff were trained in labelling foods when delivered by the supplier and she planned to continue educating them.During an interview on 06/03/2026 at 11:44 a.m., the Dietary Aide stated that labeling food helped with food safety and stated dietary staff may have missed some food items.During an interview on 06/03/2026 at 10:43 a.m. requested policies for Kitchen and Food/Nutrition from the Administrator. The Administrator stated there were no specific policies for the kitchen.

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide the resident or resident representative with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays) for 1 of 8 residents (Resident #30) reviewed for record access.The facility failed to ensure Resident #30, and her RP, were provided with requested medical records. This failure could place residents at risk of not obtaining medical services needed to maintain their health.The findings included: Record review of Resident #30's admission Record, dated 06/03/2026, revealed an [AGE] year-old female admitted [DATE] and re-admitted [DATE]. Resident #30 was not listed as her own RP. Record review of Resident #30's Medical Diagnoses, undated and accessed 06/03/2026 at 6:22 p.m., revealed diagnoses including type 2 diabetes (chronic condition characterized by insulin resistance and high blood sugar levels), anxiety disorder (mental health condition characterized by excessive uncontrollable worry about everyday issues, affecting daily functioning and quality of life), adult failure to thrive (condition that affects appetite, weight, and activity), and vascular dementia (decreased blood flow to areas of your brain). Record review of Resident #30's quarterly MDS assessment, dated 05/08/2026 and signed 05/10/2026 as completed, reflected a BIMS score of 04 indicting severe cognitive impairment. Resident #30 was documented as not having exhibited any behavioral symptoms. Resident #30's functional abilities were documented as requiring dependent assistance to requiring supervision or touching assistance.Record review of Resident #30's Medical Power of Attorney, dated 01/03/2020, revealed a hospital MPOA signed by Resident #30 authorizing RP as her representative to make all and every health care decision on Resident #30's behalf.During an observation of Resident #30 on 06/02/2026 at 12:30 p.m., she was noted to be lying in bed. Attempted interview with Resident #30 revealed she was not interviewable as she responded to questions inappropriately.During an interview on 06/02/2026 at 12:30 p.m., RP stated she spoke to Medical Records, Social Worker, Director of Nursing, and the Administrator regarding access to Resident #30's medical records and they informed her that she was not her legal representative and the MPOA, or POA, she had on file for Resident #30 was not valid and she would not have access to medical records. During a telephone interview on 06/03/2026 at 9:50 a.m., the Ombudsman stated the facility was questioning Resident #30's signed POA. She stated the facility did not believe it was valid thereby denying Resident #30's RP's request for medical records.During an interview on 06/04/2026 at 4:13 p.m., the DON stated that Resident #30's RP was recently denied medical records because there were some questions regarding the validity of POA and MPOA in Resident #30's medical chart. She stated she did not know the details for the denial of request. She stated the facility found an MPOA in Resident #30's hardcopy medical chart located in storage. She stated the legal team was reviewing the MPOA for validity, but they had been out of the office for a few weeks, and she did not have a follow-up. During an interview on 06/04/2026 at 5:39 p.m., the Administrator revealed that she was aware of Resident #30's RP's concerns with the delayed request for medical records. She stated there were delays into Resident #30's RP's request for medical records due to MPOA not being valid. She stated she did not know the full details, and it would be best to address Medical Records. Record review of a facility policy titled, Resident admission Agreement, dated March 2021, revealed .If a family member or friend is your legal guardian, he or she has the right to look at all medical records about you and make important decisions on your behalf. You have the following rights regarding your medical care: To access all your records and reports, including clinical records (medical records and reports) promptly (on (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	weekdays). Your legal guardian has the right to look at all your medical records and make important decisions on your behalf.Record review of a facility policy titled, Release of Information dated December 2023, revealed . 9. A resident may have access to his or her records within 24 hours (excluding weekends or holidays) of the resident's written or oral request. 10. A resident may obtain photocopies of his or her records by providing the facility with at least a forty-eight (48) hour (excluding weekends and holidays) advance notice of such request. A fee may be charged for copying services. The facility may recommend that the resident or representative review the active chart in the presence of a knowledgeable staff person who can discuss the information and answer questions capably.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **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 voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which had not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay for 1 of 8 residents (Resident #30) reviewed for grievances. The facility failed to generate a grievance report for Resident #30's RP's grievance made on 05/14/2026 when Resident #30's RP complained that she continues to be denied access to Resident #30's medical records. The facility failed to generate a grievance report for the Ombudsman's grievance made on 05/14/2026 when the Ombudsman noted her concerns regarding the RP's denials to access Resident #30's medical records.The facility failed to generate a grievance report for Resident #30's RP's grievance made on 05/19/2026 when the RP complained that Resident #30 was injured by the facility staff. These failures could place residents at risk for demoralized spirits and low self-esteem.The findings included:Record review of Resident #30's admission Record, dated 06/03/2026, revealed an [AGE] year-old female admitted [DATE] and re-admitted [DATE]. Resident #30 was not listed as her own RP. Record review of Resident #30's Medical Diagnoses, undated and accessed 06/03/2026 at 6:22 p.m., revealed diagnoses including type 2 diabetes (chronic condition characterized by insulin resistance and high blood sugar levels), anxiety disorder (mental health condition characterized by excessive uncontrollable worry about everyday issues, affecting daily functioning and quality of life), adult failure to thrive (condition that affects appetite, weight, and activity), and vascular dementia (decreased blood flow to areas of your brain).Record review of Resident #30's quarterly MDS assessment, dated 05/08/2026 and signed 05/10/2026 as completed, reflected a BIMS score of 04 indicting severe cognitive impairment. Resident #30 was documented as not having exhibited any behavioral symptoms. Resident #30's functional abilities were documented as requiring dependent assistance to requiring supervision or touching assistance.During an observation of Resident #30 on 06/02/2026 at 12:30 p.m., she was noted to be lying in bed. Attempted interview with Resident #30 revealed she was not interviewable as she responded to questions inappropriately.During an interview on 06/02/2026 at 12:30 p.m., RP stated she had requested access to Resident #30's medical records for two years in a row and she had been denied both times. She stated she voiced her concerns and frustrations with Medical Records, Social Worker, Director of Nursing, and the Administrator and each time there was no resolve, just more delays.During a telephone interview on 06/03/2026 at 9:50 a.m., the Ombudsman stated she had a family member with recent concerns regarding medical records release. She stated this case was very strange and an ongoing thing. She stated the RP requested records on behalf of Resident #30 as her RP. She stated the facility noted Resident #30 had severely impaired cognition. She stated the facility was challenging the validity of family's POA and MPOA on file. The Ombudsman stated that she did not understand what the big deal was about requesting Resident 30's medical records. She stated that she asked the facility what was going to happen to Resident #30 if something occurred that required someone to make medical decisions on her behalf. She stated she was concerned about Resident #30's care and she addressed these concerns with the facility. She stated she believed the facility was fearful the RP was trying to gather evidence against them. She stated the RP continued to call her about the facility's denial of medical records. She stated she had never encountered these actions from a facility before. She stated the family member was very agitated and rightfully so. She stated she would like these concerns reviewed.During an interview on 06/04/2026 at 3:02 p.m., CNA A stated if a resident had a grievance or complaint they were directed to the Social Worker for assistance.During an interview on 06/04/2026 at 4:13 p.m., the DON stated (continued on next page)

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	675138	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inspiration Hills Rehabilitation Center	1939 Bandera Rd San Antonio, TX 78228

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Resident #30's RP did bring up concerns during the 05/14/2026 care plan meeting, but she did not recall all the details. She stated that she believed all was taken care of during the care plan meeting and there was no need to file grievance. She stated she was not sure what the outcome of said concerns were. She stated that Resident #30's RP contacted law enforcement as she alleged Resident #30 was injured by the facility staff. She stated that during incontinent care Resident #30 became combative with direct care staff and she scratched her right ring finger causing it to bleed. She stated that no grievance or self-report was made about the incident and law enforcement unsubstantiated the allegations as it was not a concern During an interview on 06/04/2026 at 5:03 p.m., the Social Worker revealed that she was present for the care plan meeting on 05/14/2026. She stated Resident #30's RP was hard to work with. She stated she wanted medical records. She stated the RP received another denial letter about her request for Resident #30's medical records. She stated she directed Resident #30's RP her to Medical Records staff to submit another request or to request information into the denial reason. The Social Worker stated that Resident #30's RP informed her that she never received the first denial letter. She stated she did not know the outcome of Resident #30's RP's concerns regarding delayed medical records request. She stated this concern was not a grievance and Resident #30's RP never said it was a complaint and because she helped the RP fill out the records request form that this was considered a quick resolution, and no further action was required. She stated she understood that the facility's legal team was involved with the request, but they have been away from the office for the last two weeks. She stated she did not have further information and as it was not a grievance she did not track if resolved.During an interview on 06/04/2026 at 5:39 p.m., the Administrator revealed that she was aware of Resident #30's RP's concerns with the delayed request into medical records. She stated she was aware of Resident #30's RP's first and second requests made for medical records and due to an invalid address and she believed was an invalid POA in Resident #30's chart the RP was denied access to Resident #30's medical records. She stated she was not sure of the turnaround time for medical records request but believed it could be up to two weeks at most. She stated it was only recently that the team found an old POA listing Resident #30's RP as her representative to make all and every health care decision on Resident #30's behalf s that was submitted during Resident #30's admission. She stated the hardcopy POA was in storage. Record review of a facility policy titled, Resident admission Agreement, dated March 2021, revealed .Rights of the Elderly. (f) An elderly individual may complain about the individual's care or treatment. The complaint may be made anonymously or communicated by a person designated by the elderly individual. The person providing service shall promptly respond to resolve the complaint. Record review of a facility policy titled, Resident Rights, dated December 2016, revealed, . Employees shall treat all residents with kindness, respect, and dignity. These rights include the resident's right to: . u. voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal. v. have the facility respond to his or her grievances.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source are reported immediately but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures, for 1 of 8 Residents (Resident #30) reviewed for reporting. The facility Administrator failed to report allegations of abuse and neglect following the incident on 05/19/2026 that resulted in a deep gash to Resident #30's hand and law enforcement being dispatched to the facility. This failure could place residents at risk of harm by not having alleged violations of abuse and neglect investigated.The findings included: Record review of Resident #30's admission Record, dated 06/03/2026, revealed an [AGE] year-old female admitted [DATE] and re-admitted [DATE]. Resident #30 was not listed as her own RP.Record review of Resident #30's Medical Diagnoses, undated and accessed 06/03/2026 at 6:22 p.m., revealed diagnoses including type 2 diabetes (chronic condition characterized by insulin resistance and high blood sugar levels), anxiety disorder (mental health condition characterized by excessive uncontrollable worry about everyday issues, affecting daily functioning and quality of life), adult failure to thrive (condition that affects appetite, weight, and activity), and vascular dementia (decreased blood flow to areas of your brain).Record review of Resident #30's quarterly MDS assessment, dated 05/08/2026 and signed 05/10/2026 as completed, reflected a BIMS score of 04 indicting severe cognitive impairment. Resident #30 was documented as not having exhibited any behavioral symptoms. Resident #30's functional abilities were documented as requiring dependent assistance to requiring supervision or touching assistance.During an observation of Resident #30 on 06/02/2026 at 12:30 p.m., she was noted to be lying in bed. Attempted interview with Resident #30 revealed she was not interviewable as she responded to questions inappropriately.Record review of Resident #30's EMR Misc. tab on 06/04/2026, did not reveal documentation of State Agency report of allegations of abuse made by RP on 05/19/2026.During an observation and interview of Resident #30 on 06/02/2026 at 12:30 p.m., she was noted to be lying in bed. Attempted interview with Resident #30 revealed she was not interviewable as she responded to questions inappropriately. She was noted to have a bandage on her right ring finger and bruising on her arms and hands that were healing.During an interview on 06/02/2026 at 12:30 p.m., Resident #30's RP stated that roughly three weeks back Resident #30 had an incident where she injured her finger and sustained a deep gash to her right ring finger and bruising on her hands and arms. She stated that she reported this injury to the Director of Nursing and Social Worker and was told that Resident #30 had become aggressive with CNA J and was pulling his hair during incontinent care. She stated that Resident #30 did not recall the incident. She stated the Social Worker and the Director of Nursing told her they would look into the incident and would let her know what occurred. She stated she had not received a follow-up since her request.During an interview on 06/03/2026 at 9:45 a.m., CNA F stated she received education on abuse and neglect, and the abuse coordinator was the Administrator.During an interview on 06/03/2026 at 9:45 a.m., CNA G stated she received education on abuse and neglect, and the abuse coordinator was the Administrator.During an interview on 06/03/2026 at 11:45 a.m., LVN C stated she received training on abuse, neglect, and falls/accidents.During an interview on 06/03/2026 at 4:05 p.m., LVN B stated she referred to residents' physician's orders and care plans to see their fall interventions. LVN B stated she received education on abuse and neglect.During an interview on 06/03/2026 at 4:30 p.m., CNA H stated he was trained on abuse and neglect.During an interview on 06/03/2026 at 4:35 p.m., CNA I stated she was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trained on abuse and neglect.During an observation and interview on 06/04/2026 at 2:30 p.m., the Wound Care Nurse stated she received abuse, neglect, and exploitation training frequently, the Administrator was the Abuse Coordinator, and she was required to report witnessed or suspected ANE immediately. She was knowledgeable about ANE and provided examples. She stated she was made aware of an incident on 05/19/2026 involving Resident #30. The Wound Care Nurse was observed to review Resident #30's electronic medical record to identify the incident reported on 05/19/2026. She stated Resident #30's electronic medical record documented the 05/19/2026 incident of abuse allegations. She stated that on 5/19/2026 at 9:45 p.m., LVN F entered Resident #30's room. She stated Resident #30 was yelling and being combative with CNA M when he was providing her with incontinent care. LVN F observed blood on Resident #30's fingers, he offered to help her and cleaned it up and put on a band aid. LVN F notified the provider, Wound Care Nurse, and the RP following the incident. She stated the RP arrived shortly after the notification and became upset and accused staff of abusing Resident #30 and she immediately called law enforcement. The Wound Care Nurse stated law enforcement arrived at the facility along with the Director of Nursing and Administrator. She stated that law enforcement conducted their investigation and did not find any concerns of abuse. She stated she was not aware of the bruising on Resident #30's hands and arms, but it was likely she sustained them during the physical aggression incident.During an interview on 06/04/2026 at 3:02 p.m., CNA A stated he had received education on abuse, neglect, and resident rights. He stated the abuse coordinator was the Administrator, and he would report all allegations of abuse and neglect to her. He was knowledgeable about ANE and resident rights and provided examples. He stated the impact to a resident if abused, neglected, or rights violated, could be huge and could affect the residents mentally and they could start to detach. He stated he was not present for the incident on 05/19/2026 involving Resident #30, but he was provided with information as he helped to care for her. He stated Resident #30 tends to become angry and agitated during incontinent care, and she would become physically aggressive. During an interview on 06/04/2026 at 4:13 p.m. the Director of Nursing revealed that Resident #30 was wheelchair bound, on psych meds, can become combative, had dementia, verbal and physical aggression tendencies and on 05/19/2026 she had an incident. She stated the incident resulted in a skin tear to her finger. She stated that during incontinent care Resident #30 became combative and began pulling the aide's hair. She stated she scratched herself with her nails and caused the skin to tear and bruises on her hands and arms. She stated the charge nurse notified the provider, the RP, and nursing management. She stated the RP was contacted to help with calming down Resident #30. She stated instead the RP alleged the facility staff caused the injuries. The RP alleged the facility was abusing Resident #30 and called law enforcement. She stated that she and the Administrator were notified of the incident as law enforcement was present at the facility. The Director of Nursing stated law enforcement investigated the matter and informed the facility and the RP that the allegations of abuse was not substantiated. She stated that the incident was not reported to the State Agency as it was investigated by law enforcement. She stated any further investigation or report to the State Agency would be the responsibility of the Abuse Coordinator, the Administrator.During an interview on 06/04/2026 at 5:03 p.m., the Social Worker revealed that she provided ANE and resident rights education to the staff. She was knowledgeable of ANE and resident rights and provided examples. She stated the Administrator was the Abuse Coordinator and staff were expected to report ANE immediately. She stated she was aware of the incident on 05/19/2026 that caused a wound to Resident #30's skin. She stated that she was not present but was made aware of it on her following shift. She stated that the Administrator was responsible for conducting abuse and neglect allegations and she was unsure if this incident was reported.During an interview on 06/04/2026 at 5:39 p.m., the Administrator revealed that she and the Social Worker provided ANE and resident rights education to facility staff. She stated that she was the Abuse Coordinator and the expectation was for staff to report ANE immediately. She stated allegations of ANE needed to be reported to the State Agency within 2 hours after being reported to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her. She stated she would observe the situation, find out what occurred, and make the decision about what to call into the State Agency. She would then complete the provider investigation report. She stated not following this process could be detrimental to a resident and set the tone to staff that they could do anything they wanted to a resident. She stated it started with her; she was responsible for these residents as well as the staff. She stated she was notified by the Director of Nursing about the incident on 05/19/2026 involving Resident #30. She stated during her provider investigation she found that on 5/19/2026 Resident #30 was aggravated, upset, angry and scratched herself while combative with incontinent care. She stated the RP was notified and she arrived at the facility and she called the police as she felt staff caused Resident #30's injury to her ring finger. She stated Resident #30's RP alleged that Facility #1's staff abused Resident #30. She stated the police arrived and investigated the incident and found the allegations unsubstantiated and no further action was taken. She stated that law enforcement's investigation was sufficient to unsubstantiate the allegations made by Resident #30's RP and she did not believe the incident was reportable. She stated she did not investigate the incident further.Record review of a facility policy titled, Abuse Investigation and Reporting dated March 2017, revealed .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 3. The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility.Record review of a facility policy titled, Resident admission Agreement dated March 2021, revealed .Rights of the Elderly. (2) has the right to be free from abuse, neglect, and exploitation. c. An elderly individual has the right to be free from physical and mental abuse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet the resident's psychosocial needs for 3 of 8 residents (Residents #26, Resident #27, and Resident #34) reviewed for comprehensive care planning. The facility failed to ensure residents' preferences for activities and leisure were addressed in the comprehensive care plans for Resident #26 and Resident #34.The facility failed to ensure residents' preferences for device to treat a medical symptom was no longer necessary and was addressed in the comprehensive care plan for Resident #27. This failure could place residents at risk for decreased quality of life. The findings included: 1. Record review of Resident #26's admission Record, 06/04/2026, revealed a [AGE] year-old female admitted [DATE]. Resident #26 was listed as her own RP with her [family member] listed as Emergency Contact #1.Record review of Resident #26's Medical Diagnoses, undated and accessed 06/04/2026 at 12:45 p.m., revealed diagnoses including coronary artery disease (CAD) (narrowing of coronary arteries), hypertension (condition of high pressure in the vessels that carry blood from the heart to the rest of the body), Renal Failure, or End-Stage Renal Disease (ESRD) (gradual loss of kidney function), Diabetes Mellitus (DM) (characterized by impaired ability of the body to produce or respond to insulin), Cerebrovascular Accident (CVA) (commonly known as a stroke), and Depression (mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of emotional physical problems. Record review of Resident #26's quarterly MDS assessment, dated 03/14/2026 and signed 03/28/2026 as completed, reflected a BIMS score of 13, indicating cognition intact. Resident #26 was documented as having pain occasionally and receiving pain management care. Resident #26's functional abilities were documented as requiring dependent to setup or clean-up assistance and requiring manual wheelchair for ambulating.Record review of Resident #26's care plan, undated and accessed 04/06/2026 at 12:47 p.m., revealed Resident #26's focus I will attend activities of my choice date initiated and last revised on 05/05/2026 and goal I will maintain involvement in cognitive stimulation, social activities as desired through review date dated initiated 07/03/2025 and last revised on 04/22/2026 and interventions I need assistance/escort activity function.Invite me to scheduled activities. Provide a program of activities that is of interest and empowers the resident byencouraging/allowing choice, self-expression and responsibility initiated and last revised on 08/15/2025; however, additional comments not provided and independent bedbound room activities not noted as an intervention.Record review of Resident #26's Activity Progress Note dated 05/05/2026, revealed . [Resident #26] participates in activities of choice weekly. Bingo, Loteria, salon visits, socials, Resident council meetings, music, parties, family visits, TV, phone (social media) and others of choice. AD [Activity Director] provides visits and activities calendar. Resident currently prefers activities in room, such as cell phone, social media, visits with family on phone, games, texting, and reading daily chronicle. AD [Activity Directory] will cont. [continue]to encourage to OOR [out of room] activities.Record review of Resident #26's Pressure Ulcer Risk Evaluation dated 05/01/2026, revealed .Activity: Bedfast. Resident [Resident #26] is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.Record review of Resident #26's Social Service Assessment, dated 04/07/2026, revealed . Resident is alert and oriented x3 and she requires assistance with some ADLs that includes transfers. Resident has been in bed more and is now needing assistance due to incontinency. She will sit in a wheelchair but prefers to stay in bed. Resident eats independently with meal set up in her room per her choice. She is on psych services due to DX [history] of Depression, Anxiety, and Mood disorder. She does her own independent activities and also attends large group activities.Record review of Resident #26's Nurse's Note dated 03/03/2026, revealed .Resident [Resident #26] complains of bilateral knee pain limiting her ability to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stand. Resident also voices difficulty self propelling her wheel chair due to decreased strength to bilateral upper extremities.During an observation and interview of Resident #26 on 06/01/2026 at 11:18 a.m. she was noted to be lying down in bed watching television. She stated that due to pain in her lower extremities it is difficult to walk and she is unable to participate in group activities. She stated that when she was ambiguating on her own, she would participate in numerous group activities offered by Facility #1. She stated now that she is bedbound, she cannot participate in group activities, she stated she did not believe the staff provided in-room activities as they are constantly busy and seem to be in a hurry. She stated she would enjoy in-room activities if it were offered to her. 2. Record review of Resident #27's admission Record, dated 06/03/2026, revealed a [AGE] year-old male admitted [DATE]. Resident #27 was not listed as his own RP with her [family member] listed as Emergency Contact #1.Record review of Resident #27's Medical Diagnoses, undated and accessed 06/03/2026 at 2:32 p.m., revealed diagnoses including coronary artery disease (CAD) (narrowing of coronary arteries), hypertension (condition of high pressure in the vessels that carry blood from the heart to the rest of the body), Diabetes Mellitus (DM) (characterized by impaired ability of the body to produce or respond to insulin), non-Alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform their usual personal, social, or occupational activities), and depression (mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of emotional physical problems). Record review of Resident #27's quarterly MDS, 05/07/2026 and signed 05/21/2026 as completed, reflected a BIMS score of 14, indicating cognition intact. Resident #27's functional abilities were documented as requiring supervision or touching assistance to set up or clean-up assistance.Record review of Resident #27's care plan, undated and accessed 06/03/2026 at 2:45 p.m., revealed Resident #27's focus .Risk for Wandering/Elopement Identified Wander guard in place. date initiated 01/13/2026 and last revised on 04/12/2026 and goal .The resident will not leave facility unattended.The Resident's safety will be maintained. date initiated 01/13/2026 and last revised during survey, 06/02/2026. Did not reveal mention of Resident's ability to sign himself out of the facility and leave into the community unattended. Did not reveal updates to the alarm (wanderguard) being used to sound alarms when Resident #27 gets near an exit door, but that it would be turned off during the day.Record review of Resident #27's Interdisciplinary Team Care Conference dated 05/28/2026, revealed . Resident [Resident #27] is oriented and alert x2-3 [oriented to person and place, and time] w [with]/some forgetfulness. He requires limited assistance with ADLs and is now using a walker. He also is a big part of resident life and he also signs himself out to visit his girlfriends who lives in the community from time to time. and did not reveal mention of Resident #27's elopement risk level was reduced and that he returned to the facility daily.During an observation and interview with Resident #27 on 06/02/2026 at 11:00 a.m. he was noted to be sitting upright in his bed. He was agitated and upset. He stated that he and 15 other residents are the chosen ones that are required to wear the WanderGuard alarm bracelet. He stated that he does not want to wear the WanderGuard and he compared it to an ankle bracelet worn by prisoners or individuals on parole. He stated due to an incident a few months back he was informed by the Administrator that he would need to wear the WanderGuard if he wanted to remain a resident at Facility #1. He stated he is allowed to leave on his own and signs out of Facility #1 daily. He stated he goes into the community and takes a bus all over town, but he cannot remove the WanderGuard. He stated that he feared his medical care would end if he did not wear WanderGuard. 3. Record review of Resident #34's admission Record, dated 06/04/2026, revealed a [AGE] year-old male admitted [DATE] and re-admitted [DATE]. Resident #34 was not listed as his own RP with his (family member) listed as his Emergency Contact #1.Record review of Resident #34's Medical Diagnoses, undated and 06/04/2026 at 12:09 p.m., revealed diagnoses including hypertension (condition where the force of blood against the artery walls is consistently too high), peripheral vascular disease (condition characterized by narrowed arteries that reduce blood flow to the limbs), renal insufficiency (renal failure), neurogenic bladder (condition that affects bladder (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function due to nervous system problems, diabetes mellitus (condition that occurs when the body cannot properly use blood sugar) cerebrovascular accident (sudden interruption of blood flow to the brain, which can lead to brain damage), hemiplegia (paralysis or severe weakness affecting one side of the body, and anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations.Record review of Resident #34's quarterly MDS, dated [DATE] and signed 05/22/2026 as completed, reflected a BIMS score of 07, indicating severe cognitive impairment. Resident #34's functional abilities were documented as requiring dependent to substantial/maximal assistance and requiring manual wheelchair for ambulating.Record review of Resident #34's care plan, undated and accessed 06/04/2026 at 12:34 p.m., revealed Resident #34's focus Resident [Resident #34] attends activities of choice date initiated and last revised on 05/01/2026 and goal Resident will participate in activities of choice through the next review date date initiated 02/02/2026 and last revised on 06/02/226 with interventions Encourage resident to participate in activities.Invite resident to group activities. however, additional comments not provided and psychiatric treatment recommendations not noted as an intervention.Record review of Resident #34's psychiatric services dated 05/23/2026, revealed .Treatment Recommendations: Participation in an exercise program, if approved by the treating physician, and physical therapy may support mood, stress management, and muscle strength. Patient needs intervention related to current medical conditions. Patient should continue social functions including spending time with friends and family, which may help prevent further cognitive decline. Continue to engage in cognitively stimulating activities, including reading the newspaper. Patient may benefit from listening to audiobooks and/or using online brain exercise programs. During an observation and interview of Resident #34 on 06/01/2026 at 9:28 a.m. he was noted to be lying in bed. Attempted interview with Resident #34 revealed he had difficulties with speech and could not be understood. He was noted to have his right hand in a splint, foley in privacy bag hung at bedside. When asked resident was able to locate call light clipped to bedding. During an interview on 06/04/2026 at 1:24 p.m. the MDS Coordinator stated that care plans required the Interdisciplinary Team to come together and this usually consisted of the Social Worker, Assistant Director of Nursing, Director of Nursing, Therapy Manager, Activity Director, and Dietary Manager and each would make changes pertaining to their department. She stated she was unsure of the last time she received training on care plans. She stated care plans gave a picture of the specific care that a resident needs. She stated a care plan gave specific care instructions for staff to follow, such as a guide. She stated if the care plan was not updated and depending on what area of the care plan it could range from less serious to possibly something more serious. The MDS Coordinator stated that immediately following the IDT meeting the care plan should be updated to avoid any delays in care.During an interview on 06/04/2026 at 3:02 p.m., CNA A stated he reviewed the resident care plans for specific care to provide a resident in his hall. He stated if the care plans not updated there could be a delay in care.Record review of a facility policy titled, Comprehensive Assessments and the Care Delivery Process, dated December 2025, revealed . Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions. (1) Gather relevant information from multiple sources, including: (f) consultant reports. a. Selecting and Implementing interventions, based on the results. a. Periodically reviewing progress and adjusting treatments. (1) Continue to define or refine objectives of specific treatments as well as overall care and services.Record review of a facility policy titled, Care Planning - Interdisciplinary Team dated September 2013, revealed . Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.

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Inspiration Hills Rehabilitation Center	1939 Bandera Rd San Antonio, TX 78228

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 of 8 residents (Residents #26 and Resident #34) reviewed for activities. The facility failed to ensure Resident #26 and Resident #34 were provided individual and independent activities to meet the residents' psychosocial needs and preferences during February 2026 - June 2026. This failure could result in decreased psychosocial well-being or decreased quality of life. The findings included: 1. Record review of Resident #26's admission Record, 06/04/2026, revealed a [AGE] year-old female admitted [DATE]. Resident #26 was listed as her own RP with her [family member] listed as Emergency Contact #1.Record review of Resident #26's Medical Diagnoses, undated and accessed 06/04/2026 at 12:45 p.m., revealed diagnoses including coronary artery disease (CAD) (narrowing of coronary arteries), hypertension (condition of high pressure in the vessels that carry blood from the heart to the rest of the body), Renal Failure, or End-Stage Renal Disease (ESRD) (gradual loss of kidney function), Diabetes Mellitus (DM) (characterized by impaired ability of the body to produce or respond to insulin), Cerebrovascular Accident (CVA) (commonly known as a stroke), and Depression (mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of emotional physical problems. Record review of Resident #26's quarterly MDS, dated [DATE] and signed 03/28/2026 as completed, reflected a BIMS score of 13, indicating cognition intact. Resident #26 was documented as having pain occasionally and receiving pain management care. Resident #26's functional abilities were documented as requiring dependent to setup or clean-up assistance and requiring manual wheelchair for ambulating.Record review of Resident #26's care plan, undated and accessed 04/06/2026 at 12:47 p.m., revealed Resident #26's focus I will attend activities of my choice date initiated and revised on 05/05/2026 and goal I will maintain involvement in cognitive stimulation, social activities as desired through review date dated initiated 07/03/2025 and last revised on 04/22/2026 with interventions I need assistance/escort activity function.Invite me to scheduled activities. Provide a program of activities that is of interest and empowers the resident byencouraging/allowing choice, self-expression and responsibility initiated and last revised on 08/15/2025; however, additional comments not provided and independent bedbound room activities not noted as an intervention.Record review of Resident #26's Activity Progress Note dated 05/05/2026, revealed . [Resident #26] participates in activities of choice weekly. Bingo, Loteria, salon visits, socials, Resident council meetings, music, parties, family visits, TV, phone (social media) and others of choice. AD [Activity Director] provides visits and activities calendar. Resident currently prefers activities in room, such as cell phone, social media, visits with family on phone, games, texting, and reading daily chronicle. AD [Activity Directory] will cont. [continue]to encourage to OOR [out of room] activities.Record review of Resident #26's Pressure Ulcer Risk Evaluation dated 05/01/2026, revealed .Activity: Bedfast. Resident [Resident #26] is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.Record review of Resident #26's Social Service Assessment, dated 04/07/2026, revealed . Resident is alert and oriented x3 and she requires assistance with some ADLs that includes transfers. Resident has been in bed more and is now needing assistance due to incontinency. She will sit in a wheelchair but prefers to stay in bed.,, She is on psych services due to DX [history] of Depression, Anxiety, and Mood disorder. She does her own independent activities and also attends large group activities.Record review of Resident #26's Nurse's Note dated 03/03/2026, revealed .Resident [Resident #26] complains of bilateral knee pain limiting her ability to stand. Resident also voices difficulty self propelling her wheel chair due to decreased strength to bilateral upper extremities.During an observation and interview of Resident #26 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 06/01/2026 at 11:18 a.m. she was noted to be lying down in bed watching television. She stated that due to pain in her lower extremities it is difficult to walk and she is unable to participate in group activities. She stated that when she was ambiguating on her own, she would participate in numerous group activities offered by Facility #1. She stated now that she is bedbound, she cannot participate in group activities, she stated she did not believe the staff provided in-room activities as they are constantly busy and seem to be in a hurry. She stated she would enjoy in-room activities if it were offered to her. 2. Record review of Resident #34's admission Record, dated 06/04/2026, revealed a [AGE] year-old male admitted [DATE] and re-admitted [DATE]. Resident #34 was not listed as his own RP with his (family member) listed as his Emergency Contact #1.Record review of Resident #34's Medical Diagnoses, undated and 06/04/2026 at 12:09 p.m., revealed diagnoses including hypertension (condition where the force of blood against the artery walls is consistently too high), peripheral vascular disease (condition characterized by narrowed arteries that reduce blood flow to the limbs), renal insufficiency (renal failure), neurogenic bladder (condition that affects bladder function due to nervous system problems, diabetes mellitus (condition that occurs when the body cannot properly use blood sugar) cerebrovascular accident (sudden interruption of blood flow to the brain, which can lead to brain damage), hemiplegia (paralysis or severe weakness affecting one side of the body, and anxiety disorder (frequently have intense, excessive and persistent worry and fear about everyday situations.Record review of Resident #34's quarterly MDS, dated [DATE] and signed 05/22/2026 as completed, reflected a BIMS score of 07, indicating severe cognitive impairment. Resident #34's functional abilities were documented as requiring dependent to substantial/maximal assistance and requiring manual wheelchair for ambulating.Record review of Resident #34's care plan, undated and accessed 06/04/2026 at 12:34 p.m., revealed Resident #34's focus Resident [Resident #34] attends activities of choice date initiated and last revised on 05/01/2026 and goal Resident will participate in activities of choice through the next review date date initiated 02/02/2026 and last revised on 06/02/226 with interventions Encourage resident to participate in activities.Invite resident to group activities.Record review of Resident #34's Activity Progress Note dated 06/02/2026, revealed .AD [Activity Director] went to provide room visit to resident [Resident #34] today. Resident [Resident #34] was sleeping.Record review of Resident #34's psychiatric services dated 05/23/2026, revealed .Treatment Recommendations: Participation in an exercise program, if approved by the treating physician, and physical therapy may support mood, stress management, and muscle strength. Patient needs intervention related to current medical conditions. Patient should continue social functions including spending time with friends and family, which may help prevent further cognitive decline. Continue to engage in cognitively stimulating activities, including reading the newspaper. Patient may benefit from listening to audiobooks and/or using online brain exercise programs.Record review of Resident #34's Activity Progress Note dated 05/01/2026 revealed .AD [Activity Director] went to visit resident [Resident #34] today and invite to OOR [out of room] programs. Resident declined and stated he prefers family visits, TV, snacks, and music. Resident [Resident #34] states he is not interested in large group activities at this time. AD [Activity Director] will cont. [continue] to visit and invite to all programs. During an observation and interview of Resident #34 on 06/01/2026 at 9:28 a.m. he was noted to be lying in bed. Attempted interview with Resident #34 revealed he had difficulties with speech and could not be understood. He was noted to have his right hand in a splint, foley in privacy bag hung at bedside. When asked resident was able to locate call light clipped to bedding. During an observation and interview on 06/04/2026 at 2:09 p.m., the Activities Director stated that if residents do not come out of their room, she will visit them. She stated bedbound residents are provided with in-room activities 3 times per week. She stated individual activities provided for a bedbound resident were documented in their electronic medical record or on the hard copy daily activity roster. She stated if a resident who is bedbound was not receiving activities could cause them to become depressed, isolated, and no stimulation. She stated she was unsure why Resident #26's electronic medical record only documented one activity progress (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note for a 12-week period (03/04/2026 to 06/04/2026). The Activity Director was observed reviewing her hard copy daily activity roster and activity progress notes and stated Resident #26 should have been documented in the report, but she could not find it. The Activity Director stated she had recently gone to visit Resident #26 in her room, and she observed her on her phone. She stated she could not recall the date, and she was unsure as to why she did not return to Resident #26's room to offer individual activities. She stated that Resident #34 had declined in-room activities. She stated she would do a compassion visit and Resident #34 does not show any interest in playing cards. She stated she was unsure why Resident #34's electronic medical record only documented two activity progress notes for a 16-week period (02/01/2026 to 06/04/2026). The Activity Director was observed reviewing her hard copy daily activity roster and activity progress notes and stated Resident #34 should have been documented in the report, but she could not find it.Record review of a facility policy titled, Activities dated November 2017, revealed .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility?sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independence and interaction within the community. 1. Each resident's interest and needs will be assessed on a routine basis. The assessment shall include, but is not limited to: . b. Activity assessment to include resident's interest, preferences and needed adaptations. 2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness. b. Promote or enhance physical activity. c. Promote or enhance cognition. d. Promote or enhance emotional health. e. Promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. 4. Activities may be conducted in different ways: a. One-to-One Programs. b. Person Appropriate - activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for. c. Program of Activities - to include a combination of large and small groups, one-to-one, and self-directed as the resident desires to attend. 9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include, but are not limited to, considerations for: e. Residents who have withdrawn from previous activity interest/customary routines, and isolates self in room/bed most of the day.

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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 observation, interview, and record review, the facility failed to ensure that each resident who was incontinent of bowel/bladder and each resident with an indwelling catheter received appropriate treatment and services to prevent urinary tract infections, for 2 (Resident #7 and Resident #34) of 2 residents reviewed for incontinent care and indwelling urinary catheters. 1. The facility failed to ensure Resident #7's indwelling urinary catheter tubing was secured during personal care to prevent dislodgement and injury. 2. The facility failed to ensure while providing incontinent care, CNA J and CNA G cleaned the inner thigh areas and the right buttock area for Resident #34.These failures could place residents who require incontinence care at risk for cross contamination, skin breakdown, the development of skin or urinary tract infections and risk of accidental pulling of the catheter tubing and/or injury The findings include: 1. Record review of Resident #7's face sheet, dated 06/02/2026, reflected an [AGE] year-old female with current admission date of 05/14/2026. Diagnosis included obstructive and reflux uropathy (a blockage of urine flow causing urine to back up and exert pressure on the kidneys). Record review of Resident #7's MDS dated [DATE] revealed resident #7 is rarely/never understood and has an indwelling catheter. Record review of Resident #7's physician order dated 05/15/2026 revealed: Foley Catheter 16F with 10 ml balloon DX for Foley Catheter use: Obstructive Uropathy, and Monitor Foley Catheter leg strap for proper placement QShift and PRN as needed. Record review of Resident #7's comprehensive care plan dated 06/02/2026 revealed: I have Indwelling Catheter 16fr 10ml balloon Dx: obstructive and reflux, with goals: I will be/remain free from catheter-related trauma through review date, and I will show no s/sx of Urinary infection through review date, date initiated: 05/15/2026. Observation of indwelling urinary catheter care on 06/03/2026 at 10:25AM for resident #7 performed by CNA D and CNA E revealed foley catheter was not secured to resident #7's leg. During an interview with CNA D on 06/03/2026 10:45am CNA D stated she did not realize resident #7 did not have a catheter anchoring device while providing care. CNA D stated catheters are supposed to be secured to the residents' leg to avoid twisting or pulling of the catheter which could result in injury to the resident. During an interview with CNA E on 06/03/2026 at 10:45am. CNA E stated she did not notice resident #7 did not have her catheter secured during catheter care. CNA E stated the catheter should be secured so the moving of the resident does not cause trauma by pulling on the catheter. CNA E stated the nurse applies the leg strap or leg device to secure the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 06/04/2026 at 11:05AM, LVN stated urinary catheters should be secured to the resident's leg to keep the tubing from getting tangled up or being pulled but sometimes they come off and the CNA staff should notify the nurse so it can be reapplied. An interview with the DON on 06/03/2026 at 4:10PM, the DON stated indwelling catheters should be secure to prevent pulling of the catheter and possible injury. A record review of policy titled Catheter Care, Urinary, dated 06/18/2018: Changing Catheters, 2. Ensure the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh) and Steps in Procedure, 19. Secure catheter utilizing a leg band. 2. Record review of Resident #34's face sheet, dated 06/01/2026, indicated that the resident was a [AGE] year-old male, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnoses which include: cerebral infarction(when the blood supply to part of the brain is blocked or reduced. This prevents brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes.), flaccid hemiplegia(occurs when one side of the body becomes paralyzed and the muscles are soft, floppy, and unable to contract voluntarily.) affecting right dominant side and neuromuscular dysfunction of bladder(occurs when nerve damage disrupts communication between the brain, spinal cord, and bladder, leading to urinary control problems). Record review of Resident #34's quarterly MDS assessment, dated 05/20/2026, indicated Resident #34's BIMS score was 7 out of 15 which indicated that the resident had severe cognitive impairment. Resident #34 was always incontinent of bowel while urinary continence was not rated due to presence of indwelling catheter. Resident #34 required substantial/maximal assistance with mobility and personal hygiene and was noted to be dependent on staff for toileting, shower/bathing, as well as upper and lower body dressing. Record review of Resident #34's comprehensive care plan, dated 03/16/2026, indicated I have bowel incontinence r/t immobility The goal stated: I will remain clean, dry and comfortable with timely incontinence care after each episode: Interventions include: cleanse perineal area with mild cleanser after each episode. Observation on 06/03/2026 at 10:44am., revealed CNA J and CNA G unfastened Resident #34's brief and rolled it down between his legs. CNA J wiped both sides of penis head and under penis (scrotum), then wiped catheter tubing downwards towards the legs using different wipes each time. Resident was assisted by CNA G to turn to his left side. CNA J rolled old brief and pushed it under the resident. CNA J cleansed left buttock with wipe then resident produced small bowel movement. CNA J wiped perineum thoroughly. Resident was rolled slightly to the right and CNA G removed the soiled brief and disposed of it in a nearby trash can. CNA J and CNA G washed hands and changed gloves. CNA G turned Resident #34 slightly to the left side and CNA J pushed a clean brief under resident. Resident #34 was rolled to the right side (to straighten out clean brief) then laid onto his back. New brief was then pulled up between his legs and fastened closed without either CNA cleaning the resident's inner thigh areas or the right buttock area. During a joint interview on 06/03/2026 at 11:26 a.m., following the incontinence care observation, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA J stated that she was not aware that she had not cleaned Resident #34's inner thighs or right buttock area and said that she should have wiped the areas to make sure that Resident #34 was clean. She said that they usually provide incontinent care to Resident #34 3x a day or more often if he has a bowel movement. CNA G stated that she had received training on incontinent care and remembers to wash hands and change gloves while providing care. CNA G stated, if the inner thigh and buttocks areas were not properly cleaned, I guess he could like get an infection or something. During an interview on 06/04/2026 at 2:47 p.m., CNA K stated that he had worked at the facility for 9 months. He said that he received training in incontinent care at the facility. He said that he was instructed to be sure to wipe top to bottom, pat the skin instead of scrubbing it, change gloves and sanitize his hands between handling of the dirty and clean items, lower bed and place call light within reach after care. He stated that it is important to clean all of the areas during incontinent care or the resident could get sores on the skin or get an infection. During a joint interview on 6/04/2026 at 3:07 p.m. with the facility DON and ADON, the expectations for CNAs providing incontinent care to the residents include hand hygiene; sanitizing hands before and after care. Training is offered to CNAs on a yearly basis typically, unless they notice that UTI rates are increasing – then they would offer training sooner than that. DON stated that it is important to keep the residents safe and free from infections. Record review of the facility's Perineal/Incontinent Care policy, dated December 2025, indicated the following: For a male resident: Continue to wipe the perineal area including the penis, scrotum and inner thighs and Wipe the rectal area thoroughly, including the area under the scrotum, the anus and the buttocks.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 resident (Resident #34) reviewed for enteral feeding (method to provide nutrition and fluids directly into digestive tract via a feeding tube). CNA G and CNA J failed to contact nurse to stop Resident #34's tube feeding infusion prior to laying the head of the bed flat and providing incontinence care. This deficient practice could place residents who receive enteral nutrition at increased risk for experiencing nausea and vomiting, choking, aspiration, infection, and abdominal discomfort.The findings included: Record review of Resident #34's face sheet, dated 06/01/2026, indicated that the resident was a [AGE] year-old male, originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE] with diagnoses which included: cerebral infarction (stroke), dysphagia following unspecified cerebrovascular disease (difficulty swallowing food or liquids) and encounter for attention to gastrostomy (surgical procedure in which a tube is inserted directly into the stomach through the abdominal wall to provide a way to deliver nutrition, fluids, or medications).Record review of Resident #34's quarterly MDS assessment dated [DATE] indicated the resident BIMS score was 7 out of 15 which indicated that the resident had severe cognitive impairment. Resident displayed signs and symptoms of a possible swallowing disorder and utilized an abdominal feeding tube. Resident has unclear speech and sometimes his verbal expressions are not clearly understood. Resident #34 is dependent on staff to complete his ADLs, and he receives substantial/maximal assistance from staff for mobility needs.Record review of Resident #34's Order Summary Report dated 06/01/2026 revealed the following physician orders: NPO and/or TUBE FEEDING diet NPO texture, NPO consistency Enteral Feed Order every shift Isosource 1.5 @ 75ml/hr. This provides 2475 kcal, 112 g pro and 1146 mlfree water. Addl fluid needs are 1300 ml/day Enteral Feed Order every shift Ensure HOB elevated 30-45 degrees QShift Record review of Resident #34's comprehensive care plan with initiation date of 1/28/2026 reflected he has ADL self-care performance deficit r/t CVA (cerebrovascular activity) with interventions which included: Eating - I am NPO and receive Tube Feedings so I am totally dependent of staff for my daily nutrition.Observation on 06/03/2026 at 10:44 a.m. of Resident #34's incontinence care revealed that CNA G and CNA J lowered Resident #34's head of the bed to the flat position while enteral feeding pump continued to infuse feeding. CNA J stated We usually let the nurse know to come and stop the pump. The CNAs continued to provide incontinent care while the feeding infused. By 10:55 a.m., Resident #34 grunted and patted the top of his head. CNA G asked, Are you okay? Do you want a pillow? CNA G placed a pillow behind Resident #34's head and said We're almost done. Resident #34 produced a bowel movement which required additional cleaning. The resident was observed to grasp handrail, groaned and appeared to be in discomfort. Incontinent care was completed at 11:20 a.m. and the head of Resident #34's bed was returned to 30 degrees. Resident then appeared comfortable and in no distress after lying with head of bed flattened for 36 minutes while enteral feeding was infusing.During an interview on 06/03/2026 at 11:27 a.m., CNA J stated she should have but had forgotten to call the nurse in to stop the pump before they began incontinent care. She stated that she had received training in the past about Gtubes and knows that the resident could possibly choke if his head is lowered while the feeding is going.During an interview on 06/03/2026 at 12:53 p.m., with LVN C, she stated the CNAs will call her into the room to stop the feeding pump when they needed to provide care. LVN C stated CNAs providing incontinent care for approximately 30 minutes with Resident #34's head flat and feeding infusing is not the norm. She stated that the pump must be off when he is flat or he could aspirate.During an interview on 6/04/2026 at 2:20 p.m. with CNA L, she stated that she has frequently been assigned to work with Resident #34. She said that she received (continued on next page)

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	675138	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inspiration Hills Rehabilitation Center	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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training regarding Gtube care. CNA L stated that she was trained not to mess with it and if she were to see something concerning, she would get the nurse to check the Gtube to be sure. If she needs to reposition Resident #34 to provide care, she said that she calls the nurse to stop the tube feeding because he could start coughing or choke.During an interview on 6/04/2026 at 2:47 p.m., CNA K, stated that he has received training on Gtube care. If he needs to provide care to a resident with a Gtube, he stated that he would first ask the nurse to disconnect the feeding so that the resident would not get hurt.During a joint interview with DON and ADON on 6/04/2026 at 3:15 p.m., regarding Gtube care, DON stated that the CNAs are trained to call the nurse for assistance with the feeding tube and pump. Only the nurses are allowed to handle the Gtubes and the pumps. DON stated that the resident could potentially aspirate if the head of the bed was in the flat position for more than 30 minutes with the tube feeding infusing.Record review of facility policy titled Enteral Nutrition dated December 2025 revealed: 1. Staff caring for residents with feeding tubes will be trained on potential adverse effects of tube feeding, such as: Reduced opportunity for socialization;Diminished sensory experience;Restriction of movement; andFeeding-tube associated complications.Staff caring for residents with feeding tubes will be trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube, such as:Aspiration;Leaking and skin breakdown around insertion site;Perforation of the stomach or small intestine leading to peritonitis;Esophageal swelling, strictures, fistulas; andClogging of the tube.Staff caring for residents with feeding tubes will be trained on how to recognize and report complications relating to the administration of enteral nutrition products, such as:Nausea, vomiting, diarrhea and abdominal cramping;Inadequate nutrition;Metabolic abnormalities:Interactions between feeding formula and medications; andAspiration. Risk of aspiration will be assessed by the Nurse and Physician and addressed in the individual care plan. Risk of aspiration may be affected by:Diminished level of consciousness;Moderate to severe swallowing difficulties;Improper positioning of the resident during feeding; andFailure to confirm placement of the feeding tube prior to initiating the feeding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675138	A. Building B. Wing	06/04/2026

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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 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 observations, interviews, and record reviews, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences in 1 (Resident #7) of 2 residents reviewed receiving supplemental oxygen via nasal cannula. The facility failed to ensure that Resident #7's oxygen tubing was handled properly to prevent contamination. Resident 7's nasal cannula was on the floor in her room and CNA C placed it back on resident. This failure could put residents receiving supplemental oxygen via nasal cannula at risk for cross-contamination and respiratory infection.The findings included: Record review of Resident #7's face sheet, dated 06/02/2026, reflected an [AGE] year-old female with current admission date of 05/14/2026. Diagnosis includes hypertensive heart disease (high blood pressure causes damage to the heart) and atherosclerotic heart disease (hardening of the arteries). Record review of Resident #7's MDS dated [DATE] revealed resident #7 is rarely/never understood and receives oxygen therapy. Record review of Resident #7's physician order dated 05/14/2026, indicated Oxygen at 2 lpm via nasal cannula continuously every shift. Record review of Resident #7's comprehensive care plan dated 06/02/2026 revealed: Impaired Gas Exchange r/t Respiratory Failure. Oxygen at 2 lpm via nasal cannula to maintain O2Sats > 92%, Date Initiated: 06/02/2026. Observation on 06/01/2026 at 11:10 am, resident #7 in bed with head of bed elevated approximately 30 degrees, oxygen concentrator located on left side of bed was running and set at 2 L/min with tubing above resident's head and nasal cannula lying on the floor on right side of bed. CNA C came into room and while surveyor was checking the oxygen concentrator filter, CNA C picked up nasal cannula from the floor and placed it back on resident's face with prongs in the nares. LVN A entered the room at this time. LVN A stated the cannula was contaminated and immediately changed it out. During an interview with CNA C on 06/01/2026 at 11:15am, CNA C stated she put resident 7's nasal cannula back on because she didn't think it had touched the floor. CNA C stated the nasal cannula could be contaminated and cause infection by touching the floor. CNA C stated resident#7 receives oxygen continuously. CNA C stated if she found respiratory equipment on the floor, she should notify the nurse to replace it.During an interview on 06/01/2026 at 11:20am, LVN A stated he changed out the nasal cannula and tubing for resident #7 because it had touched the floor and was contaminated which can cause infection. LVN A stated resident #7 has been receiving continuous oxygen since recently returning from the hospital. DON interview 06/01/2026 at 3:20pm, DON stated her expectation is that if tubing or nasal cannula were on the floor, they are to be changed out to prevent infection. Review of policy titled Oxygen Administration dated 12/2025, did not specify preventing or procedure for contamination of oxygen equipment.