STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675690	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Estates Rehabilitation Center	130 Spencer LN San Antonio, TX 78201

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident's responsible party was informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose alternative options is he or she preferred for 1 (Resident #6) of 7 residents reviewed for resident rights. The facility failed to notify Resident #6's responsible party on 09/16/2025, prior to Resident #6 being administered an anti-anxiety medication, Alprazolam.This failure could affect residents and/or responsible parties by placing them at risk for not getting consent for medications and unknown side effects.Findings included:Record review of Resident #6's undated face sheet revealed Resident #6 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included Dementia (a general term for impaired ability to remember, think or make decisions), Depression (a mood disorder that causes persistent feelings of sadness and loss of interest) and Anxiety (a feeling of worry, nervousness or unease). The face sheet revealed Resident #6 was admitted to the facility for hospice respite. Record review of Resident #6's discharge MDS assessment, dated 09/18/2025, revealed Resident #6 had a BIMS score of 01, indicating severe cognitive impairment. Section E- Behaviors revealed Resident #6 displayed no behaviors during the 14-day look back time period. Section GG - Functional Abilities revealed Resident #6 required partial to moderate assistance with ADLs, bed mobility and transfers. Section O -Special Treatments, Procedures and Programs revealed Resident #6 was on hospice services while a resident at the facility. Record review of Resident #6's September 2025 MAR revealed Resident #6 had an order for Alprazolam .5mg give 1 tablet by mouth every 4 hours as needed for anxiety, start date 09/13/2025. The MAR revealed Resident #6 was administered the medication on 09/18/2025 at 6:52 a.m.Record review of Resident #6's hospice orders, dated 09/13/2025 at 4:50 p.m., revealed, do not give Alprazolam before calling POA [phone number and name].Record review of a progress notes by LVN J, dated 09/13/2025 at 8:04 p.m., revealed, Alprazolam prn is not to be administered without calling POA on file. Record review of Resident #6's baseline care plan assessment, dated 09/14/2025, revealed Resident #6 was on an antianxiety medication and the goal revealed, I will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date.Record review of Resident #6's Alprazolam medication consent revealed the medication side effects included drowsiness, loss of coordination, falls, slurred speech, weakness, confusion, dizziness, drug dependence, dry mouth, constipation/diarrhea. The consent revealed a check mark for I do not consent to the above psychoactive medication and was signed by a facility representative on 09/16/2025 at 4:32 p.m. and by Resident #6's responsible party on 09/16/2025 at 4:43 p.m.During an interview with Resident #6's responsible party, 11/20/2025 at 2:21 p.m., the responsible party stated she was aware that Resident #6 had an order for Alprazolam prn but was not educated on the risks or side effects by the facility and did not give consent for the medication to be administered. The responsible party stated she received the medication consent on 09/16/2025 and signed it in the afternoon stating she did not give consent for the medication to be administered. The responsible party stated she visited Resident #6 on 09/17/2025 and stated Resident #6 appeared drowsy. The responsible party stated she spoke to LVN A and asked if Resident #6 had been administered the Alprazolam and LVN A reviewed the MAR and informed the responsible party that Resident #6 was administered the Alprazolam around 6:00 a.m. on 09/16/2025. The responsible party stated hospice, and the facility were aware that Resident #6 should not be administered Alprazolam without the responsible party's permission because she observed the hospice orders provided to the facility when the resident admitted . The responsible party stated she administered Alprazolam to Resident #6 when Resident #6 was at home on occasion but did not give the facility permission to administer the medication without notifying the responsible party in advance. The responsible party stated Alprazolam could make Resident #6 drowsy when administered. During an interview with LVN A, 11/20/2025 at 3:20 p.m. , LVN A stated antianxiety medication consents should be obtained upon admission or when an antianxiety medication was ordered for a resident, and a resident should not be administered the medication prior to consent being obtained. LVN A stated nurses were responsible for obtaining consent for the medications from the resident or responsible party. LVN A stated Resident #6's responsible party notified him on 09/17/2025 that Resident #6 was drowsy and asked if Resident #6 had received the Alprazolam. LVN A stated he reviewed the MAR, and the MAR revealed that Resident #6 was administered Alprazolam on the morning of 09/16/2025. During an interview with RN D, 11/21/2025 at 9:55 a.m., RN D stated antianxiety

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that the MDS assessment accurately reflected the resident's status for 1 of 7 (Resident #1) whose MDS assessments were reviewed in that:1. Resident #1 had a diagnosis of Schizophrenia that was not coded on the MDS assessment. 2. Resident #1 had orders for a lidocaine patch and antibiotic that was not coded on the MDS assessment. This deficient practice could place residents at risk for inadequate care and services to meet their needs based on inaccurate MDS assessments.Findings included:Record review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Schizophrenia (a chronic mental illness characterized by delusions, hallucinations, and disorganized thinking), Cerebral Palsy (a disorder that affects a person's ability to move and maintain balance and posture) and Dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #1's quarterly MDS assessment, dated 09/19/2025, revealed Resident #1 had a BIMS score of 07, indicating severe cognitive impairment. Section I - Active Diagnoses, psychiatric/mood disorder for Schizophrenia was not coded. Section J - Health Conditions revealed a section for pain management and included the question, At any time in the last 5 days, has the resident: Received scheduled pain medication regimen?. The question was coded, 0. No. Section N - Medications revealed a section for High-Risk Drug Classes: Use and Indication and F. Antibiotic was not coded in column 1 that indicated Resident #1 was taking an antibiotic during the last 7 days. Section Z - Assessment Administration revealed the MDS Nurse signature that indicated The MDS Nurse completed sections C, I, J and N and was dated 09/19/2025.Record review of Resident #1's September 2025 MAR revealed Resident #1 had an order, Lidocaine external patch 4% to be applied one time a day for pain, start date 01/11/2025. The MAR revealed Resident #1 was administered the lidocaine patch daily in the month of September. The MAR revealed an order for Cipro 500 mg 1 tablet by mouth two times a day for a UTI for 5 days, start date 09/10/2025 at 6:00 p.m. Resident #1 received Cipro once on 09/10/2025 and 09/15/2025 and twice a day on 09/11/2025, 09/12/2025, 09/13/2025 and 09/14/2025. During an interview with the MDS Nurse, 11/21/2025 at 11:46 a.m. the MDS Nurse stated he was responsible for completing Resident #1's MDS assessment and stated he obtained the information coded on the MDS through record review of Resident #1's MAR and EMR documentation. The MDS Nurse stated the look back time frame for diagnoses was 7 days, UTIs was 30 days and medications was 7 days. The MDS Nurse stated if a resident was on an antibiotic within 7 days of the look back period, the antibiotic should be coded on the MDS. The MDS Nurse stated if a resident had orders for a lidocaine patch, it should have been coded under the pain section of the MDS and stated resident diagnoses like Schizophrenia should have been coded under active diagnoses on the MDS. The MDS Nurse stated Resident #1 had an active diagnosis of Schizophrenia and he should have coded it on the MDS. The MDS Nurse stated he did not recall if Resident #1 had received any pain medication and stated Resident #1 was on an antibiotic, and it should have been coded on the MDS. The MDS Nurse stated he received training on MDS accuracy and stated it was important for the MDS to be accurate, to get the most accurate level of care for the patient. During an interview with the Administrator, 11/21/2025 at 12:22 p.m., the Administrator stated the MDS Nurse was responsible for accurately coding resident information on the MDS, and the MDS Nurse had been trained on MDS accuracy. The Administrator stated it was important for the MDS to be accurate because, it reflects the resident, and it is a great reference guide for all staff to go in and learn about the resident and it helps develop the guidelines and care needs for the resident. Record review of the facility's policy entitled, Certifying Accuracy of the Resident Assessment revised December 2009 revealed, All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the daily nursing staffing formation that included the facility name, the current date, the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses, certified nurse aides and resident census in a prominent place readily accessible to residents, staff, and visitors for (11/19/2025 and 11/20/2025) in that:The facility failed to post the daily staffing posting information on 11/19/2025 and 11/20/2025.This failure could place residents and visitors at risk of not being able to review the facility's daily staffing hours. The findings included:During an observation on 11/20/2025 at 9:47 a.m. and 10:46 a.m., a daily staffing poster was observed on a bulletin board in the front lobby that was titled, Daily Care Report and was dated 11/18/2025. Record review of the staffing schedule, dated 11/19/2025, revealed the facility had 14 CNAs, 2 MAs, 1 DON, 1 ADON, 1 MDS Nurse, 1 Treatment Nurse and 6 LVN/RNs scheduled throughout the day. Record review of the staffing schedule, dated 11/20/2025, revealed the facility had 14 CNAs, 2 MAs, 1 DON, 1ADON, 1 Treatment Nurse, 1 MDS Nurse and 6 LVN/RNs scheduled throughout the day. During an interview with MA F, 11/21/2025 at 12:55 p.m., MA F stated he was responsible for posting the staffing posters daily in the front lobby. MA F stated if he was not scheduled to work, the DON was responsible for posting the staffing numbers. MA F stated it was important to post the staffing numbers so people would know how many staff were in the facility each day and he had received training in posting the staff numbers daily. During an interview with the Administrator, 11/21/2025 at 12:22 p.m., the Administrator stated MA F was responsible for posting the daily staffing number each morning and stated if MA F was not scheduled to work, the DON was responsible for posting the staffing numbers. The Administrator stated MA F had received training on posting the staffing numbers daily and stated it was important to post the numbers daily, so we know how many staff members are in the building and so families can read it as well. During an interview with the DON, 11/21/2025 at 1:17 p. m., the DON stated MA F or herself were responsible for posting the daily staffing numbers and stated, I was supposed to do it yesterday and I did not do it. The DON stated the staffing posters were to be posted in the morning each day, and it was important, because it is a regulation to post the staffing ratios.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 7 residents (Resident #6) reviewed for accuracy of medical records.Resident #6 had an order from hospice upon admission on [DATE] to notify Resident #6's responsible party prior to administration of Alprazolam .5mg prn. The instructions to notify the responsible party were not included in Resident #6's Alprazolam order. This deficient practice could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment. Findings included:Record review of Resident #6's undated face sheet revealed Resident #6 was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses that included Dementia (a general term for impaired ability to remember, think or make decisions), Depression (a mood disorder that causes persistent feelings of sadness and loss of interest) and Anxiety (a feeling of worry, nervousness or unease). The face sheet revealed Resident #6 was admitted to the facility for hospice respite. Record review of Resident #6's discharge MDS assessment, dated 09/18/2025, revealed Resident #6 had a BIMS score of 01, indicating severe cognitive impairment. Section E- Behaviors revealed Resident #6 displayed no behaviors during the 14 day look back time period. Section GG - Functional Abilities revealed Resident #6 required partial to moderate assistance with ADLs, bed mobility and transfers. Section O -Special Treatments, Procedures and Programs revealed Resident #6 was on hospice services while a resident at the facility. Record review of Resident #6's baseline care plan assessment, dated 09/14/2025, revealed Resident #6 was on an antianxiety medication and the goal revealed, I will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date.Record review of Resident #6's September 2025 MAR revealed Resident #6 had an order for Alprazolam .5mg give 1 tablet by mouth every 4 hours as needed for anxiety, start date 09/13/2025. The order did not include directions to contact Resident #6's responsible party prior to administration. The MAR revealed Resident #6 was administered the medication on 09/18/2025 at 6:52 a.m.Record review of Resident #6's hospice orders, dated 09/13/2025 at 4:50 p.m., revealed, do not give Alprazolam before calling POA [phone number and name].Record review of a progress notes by LVN J, dated 09/13/2025 at 8:04 p.m., revealed, Alprazolam prn is not to be administered without calling POA on file. During an interview with Resident #6's responsible party, 11/20/2025 at 2:21 p.m., the responsible party stated she was aware that resident #6 had an order for Alprazolam prn but stated hospice had written an order for the facility to not administer the medication without notifying the responsible party prior to administration. The responsible party stated she visited Resident #6 on 09/17/2025 and stated Resident #6 appeared drowsy. The responsible party stated she spoke to LVN A and asked if Resident #6 had been administered the Alprazolam and LVN A reviewed the MAR and informed the responsible party that Resident #6 was administered the Alprazolam prn the morning of 09/16/2025. The responsible party stated she was not notified prior to Resident #6 receiving the Alprazolam and stated she did not give the facility permission to administer the medication. During an interview with LVN A, 11/20/2025 at 3:20 p.m., LVN A stated Resident #6's responsible party notified him on 09/17/2025 that Resident #6 was drowsy and asked if Resident #6 had received the Alprazolam. LVN A stated he reviewed the MAR, and the MAR revealed that Resident #6 was administered Alprazolam on the morning of 09/16/2025. During an interview with RN D, 11/21/2025 at 9:55 a.m., RN D stated she administered Alprazolam to Resident #6 on 09/16/2025 because Resident #6 was agitated and aggressive during ADL care. RN D stated there was an order for the prn medication, so RN D administered the medication. RN D stated she was not aware of Resident #6's responsible party's request to be notified prior to administration of the medication and stated the order should have included instructions to notify the responsible party prior to administration. RN D stated she would have notified Resident #6's responsible party prior to administering Alprazolam if the order included those instructions. During an interview with Hospice RN, 11/21/2025 at 10:09 a.m., Hospice RN stated she completed Resident #6's respite admission to the facility on [DATE], and Resident #6 was scheduled to be on respite services for 5 days before returning home with the responsible party. Hospice RN stated she provided the facility with written orders that included the Alprazolam .5 mg prn and stated she wrote in the orders for Resident #6's responsible party to be notified prior to medication administration. The Hospice RN stated the facility should have included the responsible party notification in Resident #6's MAR so any nurses administering Alprazolam would be aware