STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 1 Resident (Resident #1) whose records were reviewed for dignity and respect. The facility failed to return Resident #1's identification card, social security card and debit card upon request. This deficient practice could contribute to residents believing staff do not care about their wishes. The findings were:Review of Resident #1's face sheet, dated 1/6/26, revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke), Major Depressive Disorder (Clinical depression causes a persistently low or depressed mood and a loss of interest in activities that you used to enjoy) and Hemiplegia (paralysis) unspecified affecting left non-dominant side. Review of Resident #1's admission MDS assessment, dated 10/10/25, revealed her BIMS score was 15 out of 15 reflective of no cognitive impairment, she required substantial to maximum assistance with ADL's while in bed and was dependent for toileting. Review of Resident #1's Care Plan, revised 1/5/26, revealed she had impaired cognition and was at risk of further decline in cognition and functional abilities related to mild cognitive impairment. The goal was Resident would have needs met in a timely manner, dignity will be maintained, and current level of functioning will be maintained by the next review date. Observation and interview on 1/6/26 at 12:36 PM with Resident #1 revealed she was lying in bed. Resident #1 engaged in conversation easily. She stated upon admission she gave her identification and social security card to one of the staff at the front office. She stated the staff also had her bank card and asked for it last week but staff had not returned the items. Resident #1 stated staff told her they would get it to her but had not returned with her items. Resident #1 stated she had her belongings in storage and had to make a payment. Interview on 1/6/26 at 4:26 PM with the BOM revealed she had worked at the facility for almost 2 years. The BOM stated she had Resident #1's debit card. She stated upon admission staff locked Resident #1's debit card in the medication cart and then Resident #1 agreed to have it locked in the safe. The BOM stated Resident #1 requested her debit card last week; maybe Wednesday and she had not taken it to the resident because she had been busy with the end of the month tasks. The BOM commented she was concerned that something would happen to it; someone would take it or it would get lost. She stated Resident #1 had not asked for her debit card again. The BOM stated they could provide Resident #1 a locked box for her room to safe keep her important belongings but had not discussed it or offered Resident #1 that option. The BOM stated she did not know what expenses or reason Resident #1 would need her debit card but not providing it might cause the resident anxiety. She stated Resident #1 could also become distressed about not having it available to take care of financial obligations. The BOM stated she did not have Resident #1's ID or SS card. Interview on 1/7/26 at 4:15 PM with the ADON revealed she had Resident #1's keys and her (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
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wallet with her ID, SS and VA card. She stated she locked up the items in one of the filing cabinets in her office and thought other staff new she had Resident #1's items. She stated she had not thought about them until the BOM was talking about it. The ADON stated she should have asked Resident #1 what she wanted to do with the items. She stated she understood Resident #1 had the right to ask and get her personal items upon request. The ADON stated she understood Resident #1 was probably feeling stressed and anxious about not having her belongings. Interview on 1/7/26 at 3PM with the DON revealed she learned Resident #1 asked staff for her debit card, ID and SS card. She stated staff should have provided Resident #1 with her personal items upon request and not a week later. The DON stated Resident #1 was probably feeling anxious and like staff was not listening to her. The DON stated withholding her personal items was a violation of the resident's rights. Review of a facility policy, Resident Rights, revised 1/1/25, read in relevant part, Policy: The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility. a. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 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 observation, interview and record review the facility failed to make prompt efforts to resolve grievances the resident may have for 1 of 1 Resident (Resident #1) reviewed for grievances. LVN B failed to follow the grievance process when Resident #1 reported a concern against staff. This deficient practice could result in the resident's concerns not being resolved and to the continuation of poor resident care. The findings were: Review of Resident #1's face sheet, dated 1/6/26, revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke), Major Depressive Disorder (Clinical depression causes a persistently low or depressed mood and a loss of interest in activities that you used to enjoy) and Hemiplegia (paralysis) unspecified affecting left non-dominant side. Review of Resident #1's admission MDS assessment, dated 10/10/25, revealed her BIMS score was 15 out of 15 reflective of no cognitive impairment, she required substantial to maximum assistance with ADL's while in bed and was dependent for toileting. Review of Resident #1's Care Plan, revised 1/5/26, revealed she was incontinent of bowel and bladder, required frequent checks for wetness and soiling and was hemiplegia and required extensive assistance with toileting. Observation and interview on 1/6/26 at 12:36 PM revealed Resident #1 was lying in bed. She engaged in conversation easily and talked non-stop. Resident #1 stated she had diarrhea for 1-week. She stated she would have to bang on the wall to get staff to help her, it would take staff hours to come to her room. Resident #1 stated sometimes the call light was not within reach. She stated she was paralyzed on her left side and could not grab the call light with left hand when staff placed it on her left side. Resident #1 stated there was a male and a female CNA who were verbally aggressive and one time they woke her up at 3:00 AM and insisted on showering her. She stated the staff manhandled her during the shower. Resident #1 stated she preferred bed baths and preferred to use a bed pan when toileting. Resident #1 stated the female CNA would talk to her in a loud tone, would talk down to her and give her a hard time. Resident #1 stated the female CNA wanted her to use the brief, but she did not want to because she did not like to feel dirty. Resident #1 stated she had expressed her concerns to different nursing staff. Interview on 1/6/26 at 3:12 PM with CNA A revealed she had worked at the facility for almost 1 year. She stated she was familiar with Resident #1 and would work with her. CNA A stated Resident #1 told her a few weeks ago that some staff were rough and would give her a hard time about putting her on the bed pan or about giving her a bed bath instead of a shower. CNA A stated Resident #1 would get confused with the shifts staff worked so it was difficult to determine who Resident #1 was talking about. Resident #1 was not able to provide staff names. CNA A stated she reported Resident #1's concerns to one of the charge nurses but could not remember the nurse's name. Observation and interview on 1/6/25 at 5:20 PM with Resident #1 and LVN B revealed Resident #1 was lying in bed. Resident #1 re-iterated verbatim what she reported to Surveyor during her individual interview on this same date, 1/6/26 at 12:36 PM. She reported the same concerns to LVN B. Interview on 1/6/25 at 5:46 PM with LVN B revealed he identified Resident #1's concerns regarding a black CNA talking loudly and giving Resident #1 a hard time about putting her on the bedpan, not wanting to give her bed baths and staff taking a long time to help her when she asked for help. LVN B stated Resident #1 also mentioned staff manhandling her during a shower. LVN B stated he did not remember Resident #1 saying anything about an African American male CNA. LVN B stated he would report Resident #1's concerns to the DON. He stated he was required to write a progress note related to Resident #1's concerns. He would follow up with anything else the DON instructed him to do. Interview on 1/7/25 at 2:45 PM with the ADM revealed she was the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grievance officer but department heads would get involved when addressing resident concerns. She stated she would ensure the grievance was addressed and a resolution was reached. She stated she would then talk to the resident or resident representative about the outcome. The ADM stated she did not know anything about Resident #1 concerns regarding customer service. Interview on 1/7/26 at 2:54 PM with LVN B revealed he told the ADON/DON yesterday about Resident #1's concerns after meeting with Resident #1 and after talking with the Surveyor. LVN B stated the DON and ADON stated they were already looking into it. LVN B stated he did not enter a progress note which he should have done and did not complete a grievance about Resident #1's concerns. He stated he worked for the facility on a PRN basis and was new to long-term care. He stated he should have asked about the grievance process and wrote up Resident #1's concerns at the time she reported them to him. He stated writing a grievance would ensure staff followed up with Resident #1's concerns. LVN B stated if he did not follow protocol then there was a possibility the resident would continue to have the same experiences and it could affect the resident negatively believing no one cared about her. Interview on 1/7/26 at 3PM with the DON revealed she met with Resident #1 yesterday evening and followed up with Resident #1's concern. The DON stated the only thing Resident #1 mentioned was that a black CNA would talk loudly to her during the evening shift. She stated LVN B talked with her about his conversation with Resident #1 but she again Resident #1 only told her about the one CNA and that was what she followed up on. The DON stated LVN B was a new nurse to long term care and was not sure if he was familiar with the grievance process. She stated she probably should have instructed him to complete a grievance form including all of Resident #1's concerns she reported directly to him. The DON stated LVN B should at a minimum entered a progress note. She stated upon reviewing Resident #1 progress notes, she did not see an entry by LVN B regarding his conversation with Resident #1 on 1/6/26. Review of facility policy, Grievance Policy, revised 8/1/25, read in relevant part: Residents have the right to file a grievance without the fear of reprisal. The designated grievance officer is the Administrator. Fundamental Information: Resident concerns should be taken seriously and that the ability to voice a grievance is an important right and protection for residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents received proper treatment and care to maintain good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) for 1 of 2 Residents (Resident #1) whose records were reviewed for foot care. The facility failed to ensure they referred Resident #1 for podiatry care. Resident #1's toenails were long and her right great toenail had discoloration. This deficient practice could affect any resident and contribute to a decline in the resident's health status. The findings were:Review of Resident #1's face sheet, dated 1/6/26, revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke), Hypertensive Heart Disease (a number of complications of high blood pressure that affect the heart.) and Enterocolitis (inflammation of both the small intestine and the colon) due to Clostridium Difficile (bacterium that can cause severe intestinal infections, particularly after antibiotic use.) Review of Resident #1's admission MDS assessment, dated 10/10/25, revealed her BIMS score was 15 out of 15 reflective of no cognitive impairment, she required substantial to maximum assistance with ADL's while in bed and was dependent for toileting. Review of Resident #1's Care Plan, revised 12/24/25, revealed Resident has a diagnosis of diabetes and is at risk for unstable blood sugars andabnormal lab results. The goal was Resident will have a reduced risk for complications related to diabetes through the next review date. Goals included Weekly skin checks to monitor skin for redness, circulatory problems, infection, and breakdown. Notify physician of any new skin conditions. Refer to podiatrist to treat as needed. Review of Resident #1's consolidated physician orders for January 2026 revealed an order dated 12/25/25, May be seen for evaluation and treatment of mycotic nail care and development. Review of skin noted dated 1/6/26 at 09:44 read: Skin warm & dry, skin color WNL and turgor is normal. Resident does not have an external device.Foot evaluation completed. Further review revealed there was no documentation related to Resident #1's toenails. Observation and interview on 1/6/26 at 12:36 PM with Resident #1 revealed she was lying in bed. Resident #1 engaged in conversation easily. Further observation revealed Resident #1's nails were long. Resident #1 stated they were like claws. She stated her toenails were also long and needed to get cut. Interview on 1/7/25 at 5:06 PM with LVN B revealed Resident #1 was not Diabetic and the CNAs could provide nail care on shower days including foot care. Upon reviewing Resident #1's EHR, he clarified that Resident #1 had Diabetes Type 2 (happens when the body cannot use insulin correctly and sugar builds up in the blood.) and was receiving insulin at 6AM every day. He stated nursing staff should provide nail care. He stated he rounded on Resident #1 twice on this date, 1/6/26, and did not notice if she had long fingernails and stated Resident #1 did not say anything to him. Observation and interview on 1/6/26 at 5:20 PM with Resident #1 and LVN B revealed Resident #1 was lying in bed. Upon assessment, LVN B stated Resident #1's toenails were long, needed to get cut, and he identified her right great toenail had discoloration and if it was fungus., the podiatrist would have to assess her. LVN B stated they would have to refer the resident for podiatry care. Interview on 1/7/25 at 11:10 AM with the DON revealed Resident #1 would refuse care or would state she asked for specific type of care and she had not. She stated nursing staff should document in a progress note if Resident #1 refused care and what type of care she refused. The DON stated Resident #1's foot assessment would be captured on the weekly skin assessment. She stated there was not any documentation on the skin assessment dated , 1/6/26, that reflected Resident #1's toenails were long and needed cutting including whether there was any discoloration to the right great toenail. The DON stated nursing staff should refer the Resident #1 to podiatry as needed and to her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knowledge had not been referred to podiatry care until, yesterday 1/6/26, after LVN B reported the results of Resident #1's foot assessment, condition of her toenails. The DON stated it was especially important to capture long toenails right away because Resident #1 was Diabetic. If she sustained a skin tear it would take longer to heal and she could get an infection which would create additional health problems. The DON stated Resident #1's health condition was very compromised due to her comorbidities. Review of facility policy, Special Needs, revised 2/1/25, read in relevant part To address special needs, this facility will provide the necessary care and treatment, including medical and nursing care, consistent with the professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the residents goals and preferences. This policy pertains to the following needs: podiatry.Policy Explanation and Compliance Guidelines:2. The facility will utilize a systematic approach for the management of the needs of special needs, including efforts to identify risks; stabilize, reduce, or remove underlying risks factors monitor the impact of the interventions, and modify the interventions as appropriate. 4. The facility will communicate relevant information with outside providers to ensure safe, continuous care of the resident.6. A person-centered care plan will be developed, based on specific risk factors identified in assessments and physician orders, and in accordance with the resident's goals and preferences.7. Medical conditions will be monitored and managed to prevent complications. a. The attending physician will assume responsibility for the overall care and treatment of the resident's medical conditions.b. RNs and LPNs will participate in the management of medical conditions by following physician orders, assessments of residents, and reporting changes in condition to the resident's physicians. 8. Policies and procedures related to special need will reflect current professional standards of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review the facility failed to follow the menu for 1 of 2 days of observation (1/6/26) for the lunch meal service. Dietary Staff failed to follow the lunch menu on 1/6/26 which included fried chicken, spinach, mashed potatoes, sugar cookies and buttered dinner roll. This deficient practice could contribute to resident dissatisfaction. The findings were: Review of the monthly calendar, week at a glance revealed the lunch menu for Tuesday, 1/6/26 included fried chicken, spinach, mashed potatoes, sugar cookies, buttered dinner roll. Observation on 1/6/25 at 12:07 PM of the written menu posted outside the dining room read: Lunch: fried chicken, spinach, mashed potatoes, sugar cookies and buttered dinner roll. Observation on 1/6/26 at 12:10 PM revealed some residents were served gravy with their mashed potatoes, some were served egg noodles, but not all. Further observation revealed and interviews with Resident #2 and Resident #3 revealed Resident #3was served gravy with the mashed potatoes and Resident #2 was not served gravy. Resident #2 was also served egg noodles with her meal. Interview with Resident #2 and #3 revealed they did not always get all items as reflected on the menu. They stated they had complained about not always get all items as reflected on the menu because they did not like when this happened, but it did not help. They stated they continued to receive items per the menu, and they accepted that they could not do anything about it. Interview on 1/7/26 at 5:13 PM with the DM revealed the lunch meal for 1/6/26 on the calendar a week at a glance included fried chicken, spinach, mashed potatoes, sugar cookies and a buttered dinner roll. She stated gravy was not part of the menu but per residents request the [NAME] added gravy to the mashed potatoes. She stated the menu did not call for egg noodles either. She stated the [NAME] should have followed the menu and for any substitutions he should have discussed it with her and added them to the substitution log for the Dietician's review. The DM stated the residents had a right to know in advance what they were receiving so they could choose an alternative if they did not like what was being served. She stated some residents would get upset if they were not served what the menu called for because they were either looking forward to it or they would have wanted to consider their options. Review of a policy, Menu Changes and Substitutions, dated 10/2010 read in relevant part: Any variations from the planned menu will be properly documented by the DSM and reviewed and signed by the Dietician. Menu changes and substitutions, when necessary, will be made with foods of equivalent nutritive value.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide therapeutic diets prescribed by the attending physician to 1 of 5 Residents (Resident #2) whose records were reviewed for therapeutic menus. Dietary staff failed to serve Resident #2 a renal diet according prescribed by her primary care physician. This deficient practice could result in a decline in the resident's health status. The findings were: Review of Resident #2's quarterly MDS assessment, dated 12/26/26, revealed she was admitted to the facility on [DATE] with diagnosis including Diabetes (refers to a group of diseases that affect how the body uses blood sugar (glucose). Further review revealed Resident #2's BIMS score was 13 of 15 reflective she had minimal cognitive impairment. Review of Resident #2's Care Plan revised on 4/1/25 read Nutritional Status: Resident is on a CCHO Renal diet, Regular texture, THIN LIQUIDSconsistency. One of the goals was to Provide, serve diet as ordered. Monitor intake and record q meal. Review of Resident #2's physician orders for January 2026 revealed an order dated 12/31/25 CCHO (Consistent Carbohydrate, High-Outcome diet or Controlled Carbohydrate diet) Renal Diet Regular texture, thin liquids. Review of Resident #2's CCHO-Renal menu for Tuesday Lunch 1/6/26 read Baked Chicken Breast - 3 ounces, Chicken Gravy, 2 ounces, Orange twist, 1 each. Buttered chopped spinach, 4 ounces, rice, 3 ounces, buttered dinner roll - 1 each, sugar cookies 1 individual, beverage of choice 8 ounces, hot coffee or hot tea 6 ounces.Review of the monthly calendar, week at a glance revealed the lunch menu for Tuesday, 1/6/26 included fried chicken, spinach, mashed potatoes, sugar cookies and buttered dinner roll. Observation on 1/6/25 at 12:07 PM of the written menu posted outside the dining room read: Lunch: fried chicken, spinach, mashed potatoes, sugar cookies and buttered dinner roll. Observation and interview on 1/6/26 at 12:10 PM with Resident #2 revealed she was served baked chicken, mashed potatoes, egg noodles, sugar cookie and buttered dinner roll. Further observation revealed Resident #2 had eaten about 50 % of her meal including the mashed potatoes and noodles. Resident #2 stated she was a Diabetic and understood she should limit her carbohydrate intake because it could make her sugars go up. She stated she was often served items that were not on the menu or that she should not have but she was hungry. She stated she had complained about it before, but it did not help. Interview on 1/7/26 at 3PM with the DON revealed Resident #2 was on a CCHO diet per physician orders and should not have received mashed potatoes for lunch on 1/6/26. She stated the therapeutic diet helped to regulate her carbohydrate intake and regulate her sugars. Too much sugar intake could cause a hyperglycemic (high sugar) episode and result in health complications. Interview on 1/7/26 at 5:13 PM with the DM revealed the lunch meal for 1/6/26 on the calendar a week at a glance included fried chicken, spinach, mashed potatoes, sugar cookies and a buttered dinner roll. She stated Resident #2 was on a CCHO diet prescribed by her physician and should have received rice instead of mashed potatoes. She stated the menu did not call for egg noodles either. She stated she talked to the [NAME] who stated he substituted the egg noodles for the rice which was ok but Resident #2 should not have received the mashed potatoes. The DM stated the [NAME] should have followed the menu and should have discussed any substitutions with her and added them to the substitution log for the Dietician's review. The DM stated Resident #2 was prescribed a therapeutic diet to control her sugar intake in order to regulate her sugars better. Otherwise, it could cause her sugar levels to go up and create health problems for Resident #2. Review of a facility policy Diets, Nutrition and Hydration revised on 7/2022 read in relevant part: Fundamental Information: The facility will provide each resident with three meals daily and a nourishing snack at bedtime. Each meal will be provided according to physician orders, Facility Diet Manual, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675883	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Nursing & Rehabilitation Center	4302 E Southcross Blvd San Antonio, TX 78222

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and menu spread sheet. Review of a policy, Menu Changes and Substitutions, dated 10/2010 read in relevant part: Any variations from the planned menu will be properly documented by the DSM and reviewed and signed by the Dietician. Menu changes and substitutions, when necessary, will be made with foods of equivalent nutritive value.