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	04/03/2026

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

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 observation, interview and record review, the facility failed to ensure that each resident received adequate supervision to prevent elopement for 1 of 14 residents (R #57) reviewed for accident hazards and supervision. The facility failed to monitor R #57 while he was on the secure unit patio. R #57 eloped from the facility between 6:45 p.m. to 7:10 p.m. on 3/29/26 and was found approximately ninety-six feet away from the facility near a busy two-lane road. This failure resulted in the identification of an IJ (Immediate Jeopardy) on 4/2/26 at 5:00 p.m. While the immediacy was removed on 4/3/26 the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to install an extension of the patio fence, complete training of PRN staff, hire an activity assistant for the secure unit, and monitor the implementation and effectiveness of its Plan of Removal. This failure could lead to residents experiencing serious injury, serious harm, serious impairment to include death.Findings include: Record review of R #57's face sheet, dated 4/1/26, revealed the resident was admitted [DATE] and was a male; age [AGE]. The RP was listed as a family member. His diagnoses included: dementia (a decline in mental ability), wandering, alcohol abuse, heart failure, and history of falling. Record review of R #57's quarterly MDS dated [DATE], reflected the resident's BIMS score was 03, indicative of severe cognition. The resident was independent in ambulation. Record review of R #57's Elopement/Wandering Risk Assessment, dated 9/6/25, reflected a risk score of 5 meaning At risk for elopement or unsafe wandering. Record review of R #57's nursing notes from 10/12-15/25 revealed R #57 was exit seeking. Record review of R #57's Nurse Note dated 10/12/25 authored by LVN C reflected the resident was seeking in the facility and needed re-direction. Record review of R #57's Nurse Note dated 10/15/25 authored by LVN D reflected the RP was notified resident was exit seeking and needed a room change [placement in the secure unit]. Record review of R #57's physician's orders revealed order dated 10/20/25 for, Resident to be transferred into memory unit; DX: Unspecified Dementia. Record review of R#57's CP, dated 11/6/26, revealed that he was a risk for elopement.secondary to dementia. An intervention listed in the CP was more frequent rounding on resident. Record review of R #57's Fall Risk Score, dated 3/5/26, reflected a rating of zero indicative of no fall risk. Record review of the Facility's Provider Report dated 3/30/26 reflected the timeline was: on 3/29/26 between 6:45 p.m. and 7:10 p.m. [gap of 25 minutes], R #57 eloped by climbing over the secure unit's patio fence (6 feet high) and was discovered off the facility's grounds at 7:10 p.m. by LVN A. The report reflected the resident using a chair next to the fence to jump the fence and eloped. The report reflected that LVN B gave R #57 access at 6:45 p.m. to the patio and lost visible contact with the resident because she was distracted by R #42 at the nurse station. Record review of R #57's Nurse Note dated 3/29/26 at 7:30 p.m. authored by the DON revealed, Resident was found outside the facility walking on the sidewalk by outgoing nurse [LVN A] . Observation and interview on 4/1/2026 at 4:45 p.m., of the path R #57 took on 3/29/26 revealed: the nurse station was not in direct eye contact with the secure unit patio instead line of sight was through the window adjacent to the nurse station. The window shade was (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	closed at the nurse station. Also, observation revealed a chair in the patio area. Entrance to the patio required entering a code in the keypad. The Regional Nurse stated the resident used a chair to lean against a 6-foot fence and climbed over. The Regional Nurse stated the keypad was triggered by LVN B. Observation with the DON revealed the resident crossed the facility's boundary of 50 feet and headed east for about another 96 feet outside the boundary of the facility with a busy two-lane road nearby. Further observation revealed the speed limit was 30 miles per hour, it was a business environment, and the temperature on 3/29/26 ranged from a low of 57 degrees Fahrenheit to a high of 84 degrees Fahrenheit. The DON stated the resident was heading back to the facility and found by LVN A. Observation and interview on 4/2/26 at 10:03 a.m., revealed R #57 was in bed, alert and oriented to self and place, with no skin tears, bruises or injuries present. The resident was ambulatory. The resident stated he did not remember eloping from the facility on 3/29/26. The resident nodded no to the question of any staff being present with him on the patio. During an observation and interview on 4/2/26 at 10:17 a.m., revealed R #42 was in his room, ambulatory, alert and oriented to self and place. The resident stated he was present with R #57 on the day of the elopement but did not remember any details involving the elopement. R #42 added that he did not remember interacting with LVN B. R #42 remembered leaving the patio. R #42 stated that there was no staff present with him or R #57 at the patio. During an interview on 4/2/26 at 10:37 AM, LVN A stated she left the facility around 6:55 p.m. and when she was driving away from the facility, she saw resident #57 outside of the facility near a shopping center. She approached the resident around 7:10 p.m. She was not aware the resident had eloped. The resident stated to her he left and wanted a Coke. LVN A stated the resident was escorted back to the facility. LVN A stated the harm the resident could have experienced included being hit by a car. LVN A stated a preventive measure for avoiding an elopement was to maintain visibility of residents and their whereabouts. During telephone interview on 4/2/26 at 11:09 a.m., LVN B stated that R #57's elopement could have occurred anytime between 6:40 PM and 7:10 PM. LVN B stated she was not aware of R #57 having a diagnosis of being a wanderer when she left him unattended in the secure unit enclosed patio. LVN B stated there was no requirement for staff to be physically present when a resident was on the secure unit patio except for line of sight. LVN B stated she became aware that the resident was missing when he was brought back to the secure unit by LVN A around 7:10 p.m. LVN B stated if R #57 had not been found the resident could have had an accident, a fall, been hit by a car, or missing in the community. During an interview on 4/2/26 at 11:33 a.m., the DON stated that a nurse working in the secure unit should know what resident a diagnosis had of being wanderer or exit seeking, which was found on the face sheet and CP. The DON stated LVN B lost line of sight of the resident on the patio because R #42 blocked her vision for about 10 minutes. The DON stated the main preventative measure to mitigate an elopement was knowing the whereabout of residents. The DON stated R #57 was located by chance by LVN A. The DON stated hypothetically if R #57 had not been located, he could have suffered a car accident, a fall, or been a missing person in the community. During an interview on 4/2/26 at 12:01 p.m., the Administrator stated the failure involving the elopement could have been the nurse [LVN B] being distracted by another resident [R #42] and losing sight of R #57. The Administrator stated that any resident was at risk for wandering in the secure unit. The Administrator stated that if the resident (R #57) was not found there could have been a negative outcome. The Administrator stated R #57 had a purpose in eloping because he wanted to get a Coke. During an interview on 4/2/26 at 2:30 PM, CNA E who was on duty on the day of the elopement incident stated she left duty around 6:06 PM and had contact with R #57 but was not present during the elopement. CNA E stated the resident had the daily habit of wandering throughout the secure unit and exit seeking. CNA E stated the staff had to monitor the residents' movements to ensure the residents did not elope from the unit. During a telephone interview on 4/2/26 at 2:45 p.m., the RP stated she was informed of the elopement on 3/29/26. The RP stated family visited the resident on 4/1/26 and the resident (R #57) could not remember he eloped from the facility or any details about the elopement. The RP added that back in October 2025 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the family made a request to put the resident in the secure unit because the resident wandered and wanted to leave the facility before he was placed in the secure unit. During interview on 4/2/26 at 3:00 p.m., the NP stated that the Medical Director's office was notified of the elopement on 3/29/26. The NP stated the facility needed to follow its elopement protocol. The NP did not have any additional details involving the elopement to share with the surveyor. Record review of the facility's Missing Resident Policy, dated revised 8/15/23, read: .The facility will: ensure residents that exhibit wandering behavior/or are at risk for elopement received adequate supervision to prevent accidents. Record review of the facility's Abuse and Neglect policy, dated 3/13/25, revealed: .purpose to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation. Neglect was defined as : The failure to provide goods or services, including medical services, necessary to avoid physical harm, pain, mental anguish, or emotional distress. The Administrator was notified of the Immediate Jeopardy (IJ) on 4/2/26 at 5:00 p.m. On 4/2/26 at 8:13 p.m., the facility provided a plan of removal, and it was accepted on 4/3/26 at 5:25 p.m. It was documented as follows: F-Tag 689 Accidents & Hazards4/2/26 at 5:10pm Immediate Jeopardy called[Facility]Medical Director [.] was notified of the IJ on 4/2/26 at 5:10pm1. Affected ResidentsResident #57 (elopement resident)Immediate action taken for the resident found to have been affected includes:On Sunday 3/29/26 at 7:10pm the resident was escorted back on the unit by the charge nurse that just clocked out from her shiftOn Sunday 3/29/26 at 7:20pm the Charge Nurse immediately completed a physical assessment - no injury foundOn Sunday 3/29/26 at 7:45pm the Charge Nurse Notification to medical provider and familyOn Sunday 3/29/26 at 7:30pm a Behavior and Monitoring log was initiated with q15 min checks for 24h then q30min checks for 3 days, as well as q shift documentation post event: all to be completed by the charge nurse. Increased supervision to be completed 4/2/26 at 7:30pmOn Sunday 3/29/26 the charge nurse checked all door/gate locking mechanisms and alarms were validated to be in working functioning order. Patio secured and restricted completed at 7:40pmOn 3/29/26 at 8:30pm the Plan of Care was reviewed and updated immediately by the DON. The DON also provided validation of all appropriate interventions updated as needed as well as Kardex [form used my nursing staff to determine the assistance a resident required for activities of daily living]On 3/29/26 at 8:35 the DON conducted an assessment for need for emotional support and found the resident was without need at this time. The Social Worker on 3/31/26 at 3:35pm completed a follow-up assessment on emotional need and residents [R #57] were assessed to be at baseline with no change.Psych Services was notified 3/29/26 at 9:00pm and informed the resident was stable without a noted change in condition and the NP on 4/2/26 at 9:18am completed a reassessment of the resident and medication management review.The Charge Nurse that left the resident unsupervised in on secure unit patio was given disciplinary action and one on one education, and was removed from the schedule at this time 3/29/26 at 9:11pmOn 3/29/26 7:45pm the NP was notified with no new orders. 3/31/26 the NP completed an evaluation of resident - labs and a UA was ordered pending results [lab results were negative]100% Elopement Risk Assessments were completed on all residents by the ADON and DON completed 3/31/26 Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring.A full investigation was conducted with a root cause analysisAs a result of the investigation and root cause analysis the assigned Nurse was terminated. The assigned nurse had multiple prior trainings and education received on requirements of direct supervision of residents residing on the secured unit and/or at risk for elopement. As a result of not following these requirements and failing to provide adequate supervision to maintain safety of residents, action was taken to remove and terminate.The DON provided education for all staff on the topic of elopement, identification of the signs, prevention of elopement, behavior resolution and redirection, Secure Unit/residents at risk for elopement supervision requirements (direct supervision), and Neglect: Started 3/29/26 at 9:20pm with 91% completion; all remaining 9% are PRN staff and are not currently scheduled. All PRN staff have been directed to be in-serviced and educated prior to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	working a shift.The DON conducted a Missing Resident Drill on 3/30/26 with completed QAPI tool. The missing resident who participated in drill was found within 4 mins and 43 sec. Staff met all procedure requirements and were deemed competent.Maintenance staff reassessed the patio of safety risks and all door mag lock systems for proper working function on 3/30/26 at 8:30am. Starting on 3/30/26 Maintenance will randomly check door functioning and locking audit 3 times daily x 3 days and then weekly thereafter.The Elopement Binder was reviewed based on findings of risk assessment as needed. The center's elopement risk binders were reviewed and validated to be current and maintained with no changes needed. Completed by DON and ADON on 3/31/26Life Safety conducted a survey/audit/test of doors, alarms and locking mechanisms on 3/31/26 during the annual survey all in proper working function, no safety or hazards identified.A motion sensor was installed on the locked unit patio and set to alarm if motion is detected on, over, under, crossing, and near fence and gate. The alarm speaker was installed inside of locked unit and can be heard from all points of location on the unit as well as all other units. In addition to the sensor alarm, secondary alarms have been installed on gates and when triggered the same speaker will alarm. Ordered 3/30/26 Delivered and Completed 4/2/26The rod iron fence and gate on the unit patio will be extended in height by 19 inches. Materials have been ordered 3/30/26 pending delivery and installed 4/3/26. Once delivered installation will be completed immediately and or the same day. Completion Date scheduled for 4/3/26Additional Action Taken for Prevention of ReoccurrenceAll current residents will have an elopement risk assessment completed quarterly, with changes as needed, readmission, and annually.All newly admitted residents will be assessed for elopement risk upon admission with a person-centered care [NAME] newly added position has been added for an activities assistant whom will primarily service the unit's needs for additional activities and add additional supervision to the unit daily.A QAPI PIP has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA meeting. Monitoring/auditing and reporting will continue for a minimum of three months. [the Quality Assurance meeting was scheduled after the survey's exit] Verification of PORKey Observations: Observation on 4/3/26 at 12:51 p.m., revealed R #57 was present in the secure unit. Observation on 4/3/26 at 1:21 p.m. of the secured unit's patio area revealed entrance to the patio required triggering of the keypad door; the motion detector sounded; and two patio doors were secured by chains and locks. Observation on 4/3/27 at 1:30 p.m. of the facility's 7 locking system and 15-second egress doors revealed all functioned. Observation and review on 4/3/26 at 1:35 p.m. of the facility revealed an Elopement Binder at the front door, central nurse station and the secure unit. The binders contained face sheets of residents at risk for elopement. For the secure unit the binder contained 14 residents. Observation on 4/3/26 at 2:25 PM, revealed the patio area had a motion alarm that worked; alarm speaker was present; and a keypad to the patio door. Key Interviews:During an interview on 4/3/26 at 1:16 p.m., the DON stated she checked all locking mechanisms, and they were secured both in the facility and the secure unit. During an interview on 4/3/26 at 2:00 p.m., the Maintenance Assistant Supervisor stated he checked the door lock systems three times per day and documented on the door lock and functioning audit log. During an interview on 4/3/26 at 2:24 p.m., the Receptionist stated she was familiar with the Elopement Binder and if a resident tried to elope, she would notify nursing staff. During an interview on 4/3/26 at 2:39 PM, the Administrator stated the next QAPI meeting was scheduled for 4/7/26. During interviews on 4/3/26 from 3:15 p.m. to 3:40 p.m. of two shifts 1 (7:00 a.m.-7:00 p.m.) and shift 2 (7:00 p.m. to 7:00 a.m. and same shift on weekends) 9 staff for shift 1 (2 Rehab, 3 LVNs, 2 CNAs, 1 Receptionist and 1 SW) , 3 staff Shift 2 (7:00 p.m.-7:00 a.m.) (2 CNAs and 1 LVN) and 4 weekend staff (1 MA, 1 kitchen staff, and 2 LVNs) revealed return demonstration on the topics of elopement, identification of the signs of elopement, prevention of elopement, behavior resolution and redirection, and supervision to include line of sight for residents in the secure unit. The staff also revealed return demonstrations on ANE to include knowing the signs and symptoms and reporting any ANE to the Abuse Coordinator (the Administrator). Key Record (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Reviews:Record review of the facility's Behavior Monitoring log dated 3/29/26 reflected q shifts were done for residents at risk for elopement. Record review of R #57's psych services note dated 3/29/26 at 9:00 pm authored by the NPMH revealed a full evaluation and the resident had no new mental health concerns and the medication review resulted in no new orders. Record review of LVN B's employee file reflected a disciplinary notice and termination notice dated 3/29/26. Last day at work was 3/29/26. Record review of 79 elopement risk assessments of residents revealed they were completed on 3/31/26. Record review of the 5-day Provider Investigation Report reflected there was a positive elopement due to a nurse [LVN B] not supervising R #57 and lost line of sight. Record review of the facility's in-service sign-in sheets for a total staffing of 57 reflected 100 % completion with training started 3/29/26 at 9:30 p.m. and ended 3/31/26 at 8:00 p.m. Record review of the facility's sign in sheet for elopement drill reflected day and night shift completed on 3/30/26. Record review of the maintenance log started on 3/30/26 at 8:30 a.m. and continuing reflected checking of all alarm doors (egress) were functioning. Record review of the facility's sign in sheet for elopement drill reflected the day and night shift completed on 3/30/26. Record review of the maintenance log started on 3/30/26 at 8:30 am and continued reflected all alarm doors (egress) were checked and functioning. Record review of an invoice dated 3/30/26 reflected an order for a motion sensor alarm and higher fence extension. Record review of the facility's admission sheet from 3/31/26 to present (4/3/26) reflected only one new admission [R #87] dated 3/31/25 and an elopement assessment was completed with a score of zero for elopement. Record review of the HR posting, undated, for a new activity assistant for the secure unit reflected the posting was present. Record review of facility's Missing Resident Drill on 3/30/26 with completed QAPI tool. Record revealed the missing resident who participated in drill was found within 4 mins and 43 sec. Drill noted that Staff met all procedure requirements and were deemed competent. The Immediate Jeopardy was removed on 4/3/26 at 5:25 p.m. While the immediacy was removed on 4/3/26 the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to install an extension of the patio fence, complete training of PRN staff, hire an activity assistant for the secure unit and monitor the implementation and effectiveness of its Plan of Removal.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: 1. The trash can next to the hand-washing sink had a lid that was closed and was not operated via foot petal.2. Freezer #1 contained approximately 1/4 inch of ice at the bottom and on the sides, a section of the lower part of the freezer was loose and hanging approximately 1 inch from the freezer, and water was dripping from the top of the inside of the freezer onto the food items below.3. Freezer #1 contained frozen garlic bread. The garlic bread was stored in a plastic bag which was open and was in a cardboard box which was also open. The surveyor was able to reach in the box and bag without moving either and touch the exposed food item.4. Freezer #1 contained frozen meat patties. The meat patties were stored in a plastic bag which was open and in a cardboard box which was also open. The surveyor was able to reach in the box and bag without moving either and touch the exposed food item.5. A scoop was located in the plastic bin which also contained oatmeal.6. Refrigerator #1 contained milk and did not have a thermometer.7. Refrigerator #1 contained a tray with approximately eight individual cups of liquid and a ramekin of food which were unlabeled and undated.8. Refrigerator #2 contained corn bread which was unlabeled and undated.9. The table on which the drinks machine was placed was soiled.10. The floor and walls of the kitchen were soiled. These deficient practices could place residents who receive meals and or snacks from the kitchen in danger of foodborne illness. The findings were: 1. Observation on 03/31/2026 at 10:10 a.m. revealed the trash can next to the hand-washing sink had a lid that was closed and was not operated via foot petal. During an interview with [NAME] G on 03/31/2026 at 10:10 a.m., [NAME] G confirmed the trash can next to the hand-washing sink had a lid that was closed and was not operated via foot petal. Observation on 04/02/2026 at 11:20 a.m. revealed the trash can next to the hand-washing sink had a lid that was closed and was not operated via foot petal. During an interview with the Dietary Corporate Representative on 04/02/2026 at 11:20 a.m., the Dietary Corporate Representative confirmed the trash can next to the hand-washing sink had a lid that was closed and was not operated via foot petal. 2. Observation on 03/31/2026 at 10:10 a.m. revealed Freezer #1 contained approximately 1/4 inch of ice at the bottom and on the sides, a section of the lower part of the freezer was loose and hanging approximately 1 inch from the freezer, and water was dripping from the top of the inside of the freezer onto the food items below. During an interview with the Dietary Manager on 03/31/2026 at 10:10 a.m., the Dietary Manager confirmed Freezer #1 contained approximately 1/4 inch of ice at the bottom and on the sides, a section of the lower part of the freezer was loose and hanging approximately 1 inch from the freezer, and water was dripping from the top of the inside of the freezer onto the food items below. The Dietary Manager stated the facility had ordered a new freezer and stated that Freezer #1 was holding temperature appropriately. 3. Observation on 03/31/2026 at 10:10 a.m. revealed Freezer #1 contained frozen garlic bread. The garlic bread was stored in a plastic bag which was open and in a cardboard box which was also open. The surveyor was able to reach in the box and bag without moving either and touch the exposed food item. During an interview with the Dietary Manager on 03/31/2026 at 10:10 a.m., the Dietary Manager confirmed Freezer #1 contained Freezer #1 contained frozen garlic bread which was exposed to potential contamination. 4. Observation on 03/31/2026 at 10:10 a.m. revealed Freezer #1 contained frozen meat patties. The meat patties were stored in a plastic bag which was open and in a cardboard box which was also open. The surveyor was able to reach in the box and bag without moving either and touch the exposed food item. During an interview with the Dietary Manager on 03/31/2026 at 10:10 a.m., the Dietary Manager confirmed Freezer #1 contained Freezer #1 contained frozen meat patties which were exposed to potential contamination. 5. Observation on 03/31/2026 at 10:10 a.m. revealed a scoop was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	located in the plastic bin which also contained oatmeal. During an interview with the Dietary Manager on 03/31/2026 at 10:10 a.m., the Dietary Manager confirmed a scoop was located in the plastic bin which also contained oatmeal. 6. Observation on 04/02/2026 at 11:22 a.m. revealed Refrigerator #1 contained milk and did not have a thermometer. During an interview with the Dietary Corporate Representative on 04/02/2026 at 11:22 a.m., the Dietary Corporate Representative confirmed Refrigerator #1 contained milk and did not have a thermometer. Further observation on 04/02/2026 at 11:42 a.m. revealed a thermometer had been placed in Refrigerator #1 and the temperature was within acceptable range. 7. Observation on 04/02/2026 at 11:22 a.m. revealed Refrigerator #1 contained a tray with approximately eight individual cups of liquid and a ramekin of food which were unlabeled and undated. During an interview with the Dietary Corporate Representative on 04/02/2026 at 11:22 a.m., the Dietary Corporate Representative confirmed Refrigerator #1 contained a tray with approximately eight individual cups of liquid and a ramekin of food which were unlabeled and undated. 8. Observation on 04/02/2026 at 11:23 a.m. revealed Refrigerator #2 contained corn bread which was unlabeled and undated. During an interview with the Dietary Corporate Representative on 04/02/2026 at 11:23 a.m., the Dietary Corporate Representative confirmed Refrigerator #2 contained corn bread which was unlabeled and undated. 9. Observation on 04/02/2026 at 11:24 a.m. revealed the table on which the drinks machine was placed was soiled. During an interview with the Dietary Corporate Representative on 04/02/2026 at 11:24 a.m., the Dietary Corporate Representative confirmed the table on which the drinks machine was placed was soiled. 10. Observation on 04/02/2026 at 11:25 a.m. revealed the floor and walls of the kitchen were soiled. During an interview with the Dietary Corporate Representative on 04/02/2026 at 11:25 a.m., the Dietary Corporate Representative confirmed the floor and walls of the kitchen were soiled. During an interview with the Dietary Corporate Representative on 04/02/2026 at 12:27 p.m., the Dietary Corporate Representative stated the above noted deficiencies had been corrected. Record review of the facility policy, Food Safety and Sanitation Plan, revised 11/2017, revealed, It is the policy of this facility to follow an effective, practical food safety program that is [NAME] on preventing food safety hazards before they occur.

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	04/03/2026

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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable environment for residents, staff, and visitors for two resident halls (B Hall and E Hall) and the Dining Room, in that: 1. The biohazard storage room located on resident B Hall was unlocked, accessible by residents, staff, or visitors, and contained biohazard material.2. The housekeeping closet on resident E Hall was unlocked, accessible by residents, staff, or visitors, and contained potentially hazardous chemical cleaning materials.3. The maintenance closet on resident E Hall was not fitted with a door that locked, was accessible by residents, staff, or visitors, and contained a hammer, power tools, and insect spray.4. A dietary storage closet in the Dining Room was unlocked, accessible by residents, staff, or visitors, and contained approximately 25 individual cans of portable food warming mechanisms which were each labeled, harmful or fatal if swallowed.5. The activities closet on B Hall was unlocked, was accessible by residents, staff, or visitors, and contained paint, nail polish, and a hot glue gun. These deficient practices could result in residents living within, staff working within, and the public visiting within an environment that is not safe, clean, and/or comfortable and potentially coming into contact with harmful materials. The findings were: 1. Observation on 03/31/2026 at 10:42 a.m. revealed the biohazard storage room located on resident B Hall was unlocked, accessible by residents, staff, or visitors, and contained biohazard material. During an interview with LVN H on 03/31/2026 at 10:42 a.m., LVN H confirmed the biohazard storage room located on resident B Hall was unlocked, accessible by residents, staff, or visitors, and contained biohazard material. 2. Observation on 03/31/2026 at 11:02 a.m. revealed the housekeeping closet on resident E Hall was unlocked, accessible by residents, staff, or visitors, and contained potentially hazardous chemical cleaning materials. During an interview with the Head of Housekeeping and Laundry on 03/31/2026 at 11:02 a.m., the Head of Housekeeping and Laundry confirmed the housekeeping closet on resident E Hall was unlocked, accessible by residents, staff, or visitors, and contained potentially hazardous chemical cleaning materials. 3. Observation on 03/31/2026 at 11:10 a.m. revealed the maintenance closet on resident E Hall was not fitted with a door that locked, was accessible by residents, staff, or visitors, and contained a hammer, power tools, and insect spray. During an interview with Maintenance Assistant J on 03/31/2026 at 11:10 a.m., Maintenance Assistant J confirmed the maintenance closet on resident E Hall was not fitted with a door that locked, was accessible by residents, staff, or visitors, and contained a hammer, power tools, and insect spray. 4. Observation on 03/31/2026 at 12:35 p.m. revealed a dietary storage closet in the Dining Room was unlocked, accessible by residents, staff, or visitors, and contained approximately 25 individual cans of portable food warming mechanisms which were each labeled, harmful or fatal if swallowed. During an interview with the DON on 03/31/2026 at 12:35 p.m., the DON confirmed a dietary storage closet in the Dining Room was unlocked, accessible by residents, staff, or visitors, and contained approximately 25 individual cans of portable food warming mechanisms which were each labeled, harmful or fatal if swallowed. 5. Observation on 03/31/2026 at 12:48 p.m. revealed the activities closet on B Hall was unlocked, was accessible by residents, staff, or visitors, and contained paint, nail polish, and a hot glue gun. During an interview with the Activities Director on 03/31/2026 at 12:48 p.m., the Activities Director confirmed the activities closet on B Hall was unlocked, was accessible by residents, staff, or visitors, and contained paint, nail polish, and a hot glue gun. Record review of the facility policy, Homelike Environment, dated 04/24/2025, revealed, A homelike environment is essential for promoting the comfort, dignity and quality of life of residents.

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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 observation, interview and record review, the facility failed to ensure each resident was treated with respect and dignity and care 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 2 out of 8 rooms (room [ROOM NUMBER] and 108), reviewed for quality of life. Rooms 107 and room [ROOM NUMBER] had no toilet paper in the secure unit. This failure could affect residents that use the secure unit's commodes to suffer a decline in quality of life and experience a denial of respect and dignity.Findings were: Initial tour observation on 3/31/26 at 9:34 a.m., reflected there was no toilet paper in rooms 107 [R #17 resident in the room] and 108 [R# 57 and #64 resided in the room] in the secure unit. During an observation on 3/31/26 at 11:55 a.m. reflected the housekeeping staff placing toilet paper in residents' bathrooms in the secure unit. During an interview at 11:52 a.m., the Housekeeping Supervisor confirmed that rooms [ROOM NUMBERS] had no toilet paper. The Housekeeping Supervisor stated that all rooms in the secure unit (8 rooms with 14 residents) had no toilet paper, because it was a way of preventing residents from stuffing the toilets. The Housekeeping Supervisor stated the facility had removed toilet paper in the unit, date unknown, to prevent residents from stuffing the commode. The Housekeeping Supervisor stated the toilet paper was stored at the nurse station and residents needed to ask nursing staff for the toilet paper. When asked, if a resident was continent and ambulatory and needed to quickly go to the bathroom would there be enough time for the resident to get toilet paper, the Housekeeping Supervisor responded there would be a delay in getting the resident the toilet paper. The Housekeeping Supervisor stated the resident had a right to dignity. During an interview on 3/31/26 at 11:52 a.m., the Administrator stated toilet paper should be installed in rooms where residents were ambulatory and could use the toilet. The Administrator gave no explanation for toilet paper stored at the nurse station and not in resident bathrooms. Record review of the facility's Resident Rights policy reviewed 1/1/25 revealed: 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.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for one of three residents (Resident #18) reviewed for privacy. The facility failed to ensure LVN F locked the computer, which exposed Resident #18's morning medication list after he walked away and left the computer unattended. This failure could place residents at risk of having medical information exposed to others and cause residents to feel uncomfortable and disrespected. The findings included: Record review of Resident #18's face sheet, dated 4/1/26, revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #18 had diagnosis that included: Dementia (is a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), Osteoarthritis (is a chronic, degenerative joint disease that causes cartilage breakdown, leading to pain, stiffness, and reduced mobility), and Mononeuropathy (is damage to a single peripheral nerve. It can cause symptoms like pain, numbness and muscle weakness). Record review of Resident #18's Quarterly MDS assessment, dated 3/13/26, reflected a BIMS score of 4, which suggested severe cognitive impairment. Observation on 4/1/26 at 9:08 am revealed a locked medication cart with a computer, unattended in the Fiesta hallway, exposing Resident #18's morning medication list. On 4/1/26 at 9:10 AM, LVN F explained that the medication aide had called in sick, so he was expected to pass his own medications. He prepared and administered medications for Resident #18, and he walked away for about five minutes to assist another Resident. As a result, he did not minimize the screen, leaving Resident #18's HIPAA information exposed. LVN F verbalized he should have minimized the computer screen when he stepped away from the medication cart. Interview on 4/2/26 at 9:21 AM, the DON stated she was not aware Resident #18's records were left open and unattended. The DON mentioned it was her expectation for the facility nursing staff to uphold HIPAA regulations and lock computer screens when they were away from them. The DON emphasized that all staff members were responsible for ensuring the protection of residents' information. The DON stated leaving residents' charts open and unattended could lead to unauthorized access. The DON also stated her ADON's would be responsible for overseeing compliance with this task, and she would monitor it by conducting random computer screen checks. Record review of the facility policy titled Residents' Rights, dated 2/20/2021, revealed: Privacy and confidentiality, the resident has the right to personal privacy and confidentiality of his or her personal and medical records.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe, clean, and homelike environment for residents, staff, and visitors for one resident halls (B Hall), in that: The resident shower room at the front of B Hall contained soiled towels in on the floor. This deficient practice could result in residents living within, staff working within, and the public visiting within an environment that is not safe, clean, and/or homelike. The findings were: Observation on 03/31/2026 at 10:57 a.m. revealed the resident shower room at the front of B Hall contained soiled towels in the floor. During an interview with Medication Aide I on 03/31/2026 at 10:57 a.m., Medication Aide I confirmed the resident shower room at the front of B Hall contained soiled towels in the floor. Record review of the facility policy, Homelike Environment, dated 04/24/2025, revealed, A homelike environment is essential for promoting the comfort, dignity and quality of life of residents.