STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676136	A. Building B. Wing	10/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huebner Creek Health & Rehabilitation Center	8306 Huebner Rd San Antonio, TX 78240

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 41937 Based on observations, interviews, and record reviews the facility failed to protect and facilitate resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to a telephone for 1 of 1 facility's phone system reviewed for operation. The facility did not provide a staff member to monitor the facility secured entrance to allow visitors and providers access to residents and only provided a signage with the facility's phone number; however, the phone at the nurse station was unable to ring and alert anyone of an incoming call. This failure could place residents at risk for denying access to the residents to include a physician and or family. The findings included: During an observation on 10/12/2024 at 10:15 AM revealed the facility's main entrance glass door to be secured, there was no doorbell and there was a small sign with the facility's phone number with direction to call for assistance. Observation through the glass door revealed a reception hallway with a receptionist desk and office doors. Continued observation revealed no staff in the vicinity. The surveyor called the telephone number listed and proceeded to ring without anyone answering for more than 5 minutes. The surveyor pulled on the door for longer than 15 seconds and triggered the automatic release mechanism which released the door and allowed for entrance into the facility and simultaneously sounded an audio alarm. During an observation tour on 10/12/2024 at 10:46 AM of the facility revealed the facility's nurse station with LVN B, RN A, and the Manager on Duty (MOD), which was the Activities Director, in and within the nurse station area. The surveyor gave the MOD a report on the inability to call the facility and demonstrated the phone number dialed which the MOD identified as the facility's phone number. The Surveyor dialed the number from their cell phone and the MOD and the Surveyor observed the vicinity and could not identify the sounds and or alerts for the incoming call. The MOD approached the phone on the desk and identified a call was incoming and identified the number as the surveyors. The MOD stated if calls were incoming no one would know to answer the phone. (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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a joint interview on 10/13/2024 at 1:00 PM the Administrator and the DON stated the facility had no weekend receptionist and expected visitors to call the facility's phone and staff could answer and allow entry for visitors and care providers. The Administrator and the DON were not aware the phone had failed to ring and have since replaced the telephone and provided a doorbell at the front door to alert staff of any visitors. The Administrator stated the facility had hired a weekend receptionist who would report for their first day of work next week (10/19/2024). A record review of the facility's RESIDENT RIGHTS policy dated 11/28/2016, reflected, Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 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 as required under this subpart. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility. Contact with external entities: A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman, and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder, regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record reviews the facility failed to be adequately equipped to allow Residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside for 2 of 6 residents (Residents #2 and #4) reviewed for a nurse call system. 1. Resident #4 was placed in his room on 10/12/2024, without a call light system in place for Resident #4 to alert staff for assistance and or emergencies. 2. Resident #2 used his call light on 10/12/2024 to alert staff however Resident #2's call light system was inoperable due to a malfunctioning illuminator outside of his room. Resident #2 did not receive assistance for 36 minutes until the surveyor intervened and alerted staff Resident #2 needed assistance. These failures could place residents at risk for harm by residents' inability to call for help and staff's inability to respond to residents who ask for assistance. Findings included: 1. Record reviews of Resident #4's admission record dated 10/12/2024 reflected an admitted [DATE] with diagnoses which included cerebral infarction (stroke), metabolic encephalopathy (a change in how your brain works due to an underlying condition), and anxiety disorder. A record review of Resident #4's quarterly MDS assessment dated [DATE] reflected Resident #4 was an [AGE] year-old male admitted for long term care and assessed with a BIMS score of 99 which indicated severe cognitive impairment. Further review revealed Resident #4 was assessed as a high fall risk with a need for total maximal assistance with activities of daily life. During an observation on 10/12/2024 at 10:56 AM revealed Resident #4 was in his room, in bed, calling out, vocalizing calls sounds Mmm, . Ahooow . Resident #4 was observed without a nurse call light system in place. During an interview on 10/12/2024 at 11:20 AM Resident #4 was asked by the surveyor How would you call for help? and Resident #4 could not effectively participate in a conversation but did reply he would call 911. 2. A record review of Resident #2's admission record dated 10/12/2024 reflected an admitted [DATE] with diagnoses which included paraplegia (a paralysis of the lower extremities), need for assistance with personal care, and colostomy status (a surgery to create an opening for the colon (large intestine) through the belly / abdomen). A record review of Resident #2's quarterly MDS assessment dated [DATE] reflected Resident #2 was a [AGE] year-old male admitted for long term care, assessed as medically complex, with a need for total assistance with personal hygiene and activities of daily life. Resident #2 was assessed with a BIMS score of 15 out of a possible 15 which indicated intact cognition. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/12/2024 at 10:36 AM Resident #2 stated he needed assistance with his colostomy bag that burst and leaked feces on himself and his bedding. Resident #2 stated, I used my call light 30 minutes ago . no one has come . this happens daily . can you help me? Resident #2 presented in bed semi covered in a feces soiled blanket. Resident #2 was supporting, with his left bare hand, an over filled swollen colostomy bag full of feces which was applied over his stoma on his left side of his abdomen. The colostomy bag had come loose and was spilling watery semi loose stool over Resident #2's abdomen, his hand, his bedding, and mattress. During an observation and interview on 10/12/2024 at 10:36 AM revealed the facility's call light system box, was located at the nurse's station. Further observation revealed Resident #2's room was represented by a light labeled with his room number and was visually and audibly alerting a call for assistance. Further observation revealed the call light light located above Resident #2's room was not illuminated. Further observation revealed nursing staff to include LVN A, RN B, and the Activities Director, who was the Manager on Duty for the day, within the nurse's station and not recognizing nor observing the call alert for Resident #2's room. Continued observation from 10:36 AM to 11:12 AM revealed no staff recognized the alert for Resident #2 until the Surveyor intervened and alerted the DON, who intervened with staff, to attend Resident #2. Total observation revealed he was waiting for help for 36 minutes until the Surveyor intervened and reported the failed illuminator outside of his room. The DON stated he was not aware his staff had not observed the call light and immediately took action to have LVN B assess Resident #2. During an interview on 10/12/2024 at 11:30 AM Resident #2 stated he often waits for colostomy care while soiled. Resident #2 stated staff rarely empty his colostomy bag and waits until his bag bursts and then he uses his call light and waits for prolonged periods of time, usually an hour or longer, Resident stated this practice makes him feel pain due to the prolonged fecal exposure to his stoma and surrounding skin. Resident #2 stated he feels unimportant and a bother to staff and has come to expect prolong wait times where his bag is changed daily and not emptied routinely. During a joint interview on 10/13/2024 at 1:30 PM the DON and the Administrator stated the facility's policy and expectations were for Residents to have their call lights answered in a timely manner. The DON stated the call light light bulb was burned out and the maintenance director had replaced the light as soon as the light was recognized as burnt out. The DON stated Resident #4 was provided a new call light cord and the staff were in-serviced to include to always ensure a Resident is provided a call light within their reach while un-monitored. Record review of the facility's undated policy Answering the Call Light reflected, . Staff need to be sure that the call light is plugged in and functioning at all times